

SOUTHERN CALIFORNIA IBEW-NECA RETIREE HEALTH PLAN



Benefits for Eligible Southern California IBEW-NECA Retirees and Their Eligible Spouses

Summary Plan Description as of February 1, 2013

Este folleto contiene un resumen en Inglés de su plan de derechos y beneficios del Southern California IBEW-NECA Health Trust Fund. Si usted tiene dificultad para entender cualquier parte de este folleto, comuníquese con la Oficina Administrativa al 6023 Garfield Avenue, Commerce, California 90040. Las horas de servicio son de 9:00 AM a 5:00 PM de lunes a viernes. También puede llamar a la Oficina Administrativa al (800) 824-6935 ó al (323) 221-5861 para solicitar una copia del "Summary Plan Description" en Español.

This document is also available online at www.scibew-neca.org

IMPORTANT NOTICE TO ALL PLAN PARTICIPANTS

The Board of Trustees has the sole and absolute authority and discretion to interpret the provisions of this Plan and determine any and all disputed issues of fact related to eligibility under the Plan or the amount of benefits payable under the Plan. Any and all such interpretations and determinations adopted in good faith by the Board of Trustees shall be final and binding upon all parties including, but not limited to, all Participants and beneficiaries. Any such interpretation or determination may be overturned by an arbitrator or court only if such arbitrator or court finds that the Board of Trustees' interpretation or determination was arbitrary, capricious, an abuse of discretion and/or unlawful.

Benefits under the Southern California Retiree Health Plan are partially financed through employer contributions that are specifically designated to provide health benefits to retired employees. There is no vested right to receive plan benefits. The Trustees may change, modify, reduce or terminate the Plan of benefits at any time as a result of conditions or events requiring such action.

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Summary Plan Description

General Information

Administrative Office

Southern California IBEW-NECA Health Trust Fund

6023 Garfield Avenue
Commerce, CA 90040
(323) 221-5861
(800) 824-6935 – Nationwide
(323) 726-3520 – Fax

Mailing Address
PO Box 910918
Los Angeles, CA 90091

Office Hours: Monday through Friday, 9:00 a.m. - 5:00 p.m., excluding holidays

Board of Trustees

Labor Trustees

Marvin Kropke, *Chairman*
Joel Barton
Eric Brown
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Legal Counsel

Melissa W. Cook & Associates
Law Offices of Carroll & Scully, Inc.

Consultant

Rael & Letson, Actuaries and Consultants

Assistance

This booklet contains a **summary** of your Plan rights and benefits under the Southern California IBEW-NECA Retiree Health Plan.

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

Southern California IBEW-NECA Health Trust Fund Administrative Office

6023 Garfield Avenue
Commerce, CA 90040
(323) 221-5861
(800) 824-6935 – Toll-free Nationwide
(323) 726-3520 – Fax
www.scibew-neca.org

Office Hours: Monday through Friday, 9:00 a.m. - 5:00 p.m., excluding holidays.

Governing Benefit Documents

The extent of each retired Participant's benefits is governed by the complete terms of the Southern California IBEW-NECA Retiree Health Plan SPD and the Evidence of Coverage, Insurance Contracts, and Agreements issued to the Fund by the Kaiser Foundation Health Plan Inc., Southern California Region, UnitedHealthcare of California, CIGNA Dental, Delta Dental of California, United Concordia, MetLife/Safeguard Dental, Vision Service Plan and the self-funded mandatory generic prescription drug benefit and any rules and regulations for eligibility which the Trustees may adopt from time to time. This booklet describes these benefits in general terms. If there is any difference between this booklet and the Insurance Contracts, the Evidence of Coverage documents, and Agreements issued by any of the above providers, the terms and conditions of the Evidence of Coverage, Insurance Contracts or Agreement shall prevail. The Evidence of Coverage documents are distributed to Participants based upon their enrollment in the Plan. The other Documents are available at the Administrative Office, or on the Trust's website at www.scibew-neca.org.

Keep Your Records Current

Notify the Administrative Office immediately in writing of any change of address or if you have a change in your marital status. **Failure to notify the Administrative Office promptly may result in ineligibility for proper benefits or liability for benefits erroneously paid.**

For example:

- You get married
- You get divorced

- The death of an eligible spouse

Refer to the section entitled, "Eligibility & General Plan Provisions" subtitled "Eligible Spouses," for further information.

Appeals

Please note that all appeals related to eligibility for all claims and appeals related to the Mandatory Generic Prescription Drug Plan (when a retired participant is enrolled in the Medicare Supplement Plan or the Medicare Premium Reimbursement Plan) are handled by the Board of Trustees upon timely written notification to the Administrative Office. Any appeals related to insured benefits received are handled directly by the respective insurance company. Please refer to the insurance vendor's Evidence of Coverage booklet for the claims and appeals procedures pertaining to each benefit plan.

HealthAdvocate

The Trustees have contracted with **HealthAdvocate** to assist you and your eligible spouse with advocacy and assistance services, whereby Personal Health Advocates (PHA's), typically registered nurses, supported by medical directors and benefit specialists will work with you and/or your eligible spouse to:

- find physicians, medical specialists and other providers
- assist in understanding and resolution of billing for medical, dental or other professional services
- facilitate referrals for covered services
- clarify Trust Fund coverage
- transfer medical records
- locate elder care

If you would like to view an internet video demonstration of the services available from **HealthAdvocate**, please go to http://www.healthadvocate.com/member_video.aspx. You may contact **HealthAdvocate** at (866) 695-8622.

HealthAdvocate services will compliment the benefits delivered through your Plan by assisting you and your eligible spouse with health care providers and community-based services, locating the best health care providers within the plan's parameters, and provide assistance with the resolution of insurance claims issues etc.

HealthAdvocate representatives may contact you or your eligible spouse to accomplish the aforementioned tasks. Your cooperation and assistance are greatly appreciated. In addressing a participant issue, **HealthAdvocate** may act as a liaison between you or your eligible spouse and the insurance vendor/provider who contract with the Trust.

HealthAdvocate does not replace health insurance coverage, does not provide medical care or recommended treatment, and does not duplicate key benefit plan provider functions. **HealthAdvocate** helps connect you and your eligible spouse to existing services such as case management, disease management, wellness, EAP and other in-place services.

Southern California IBEW-NECA Retiree Health Plan

Benefits Available To You

Early Retirees Under Age 65 (Not eligible for or enrolled in Medicare) and Disability Retirees of Any Age Prior to Medicare Eligibility.

You may choose one of the following:

- Kaiser Permanente (HMO) and Kaiser Permanente Drug Plan
- UnitedHealthcare HMO Plan and Mandatory Generic Prescription Drug Plan
- Premium Reimbursement Plan and Mandatory Generic Prescription Drug Plan

Retirees Age 65 and Medicare Enrolled in Parts A & B

You may choose one of the following:

- Kaiser Permanente Senior Advantage and Senior Advantage Medicare Prescription Drug (Rx) Plan (MA-PD)
- UnitedHealthcare Secure Horizons and Secure Horizons Drug (Rx) Plan
- Medicare Supplement Plan and Mandatory Generic Prescription Drug Plan
- Premium Reimbursement Plan and Mandatory Generic Prescription Drug Plan

Dental (Disability Retirees Only Under Age 65)

You may choose one of the following:

- CIGNA (DHMO) Plan
- DeltaCare USA (DHMO) Plan
- United Concordia (PPO Plan)
- MetLife/Safeguard (DHMO) Plan
- United Concordia (DHMO) Plan

Vision Care Benefits (Disability Retirees Only Under Age 65)

- Kaiser Permanente Vision Plan – Kaiser Participants
- Vision Service Plan (VSP) – UnitedHealthcare Participants

Definitions

General Plan Definitions

Association

Los Angeles County Chapter of the National Electrical Contractors Association.

Calendar Year

The annual period commencing on the 1st day of January each year and concluding on the 31st day of December next following.

COBRA

The federal law requiring the continuation of group health coverage when eligibility or coverage ends as provided for by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended from time to time and by all applicable regulations.

Collective Bargaining Agreement

Any Agreement between the Association and the Union which requires Contributions to the Southern California IBEW-NECA Health Trust Fund and any other Collective Bargaining Agreement requiring Contributions to the Trust Fund approved by the Board of Trustees.

Contribution

The payment made or to be made to the Southern California IBEW-NECA Health Trust Fund by any individual Employer under the provisions of any of the Collective Bargaining Agreements. The term "Contribution" shall also include a payment made on behalf of an Employee of a Local Union or other contributing Employer pursuant to a Participation Agreement approved by the Board of Trustees.

Co-payments

Any amounts charged to a retiree or spouse by the HMO at the time of service for covered benefits.

Covered Employment

Work at a job for which Contributions are required under a Collective Bargaining Agreement.

Eligible Spouse

An individual meeting the definition in this Summary Plan Description under the heading of "Eligible Spouse".

Eligible Employee

An Employee of an Employer who worked in Covered Employment and satisfied the Plan's rules of eligibility as set forth in the Retiree Summary Plan Description.

Employer

Any individual Employer signatory to any Agreement with the Union and the Association, which requires contributions by the employer into this Health Fund. The term "Employer" also includes the Union, the Southern California IBEW-NECA Trust Funds or other participating employers as specifically permitted to participate pursuant to Agreements accepted by the Board of Trustees.

Family Member

The Retiree or Spouse.

Fund or Health Fund

The Southern California IBEW-NECA Health Trust Fund.

HMO Hospital/Medical Plan

The Kaiser Permanente Foundation Health Plan and Senior Advantage, UnitedHealthcare and Secure Horizons are HMO Plans. An HMO is a group of health care providers who have contracted with the Health Trust Fund to provide medical services at a pre-determined cost. Under these plans, with the exception of certain life-threatening emergency medical services, you must use the hospitals and doctors associated with the individual HMO Plan to receive benefits. The HMO's maintain strict guidelines for emergency medical services. Please refer to the HMO descriptive literature and other documents provided to you by your HMO.

Kaiser Permanente

Kaiser Permanente Foundation Health Plan is a Health Maintenance Organization (HMO) that owns its own clinics and hospitals and certain geographic areas contract with doctors and hospitals. For participants enrolled in Parts A and B of Medicare, coverage is provided by Kaiser Permanente's Senior Advantage program.

Medicare

Title XVIII of the Social Security Act (Federal Health Insurance for the Aged) as it is now enacted or as it may be amended.

Medicare Supplement Plan

This Plan pays the annual Medicare deductibles, and the 20% not covered by Medicare, up to an annual Plan reimbursement of \$2,500. The \$2,500 maximum applies separately to each retiree and an eligible spouse. You are entitled to prescription drug benefits through the Mandatory

Generic Prescription Drug Plan. Refer to the separate section entitled Mandatory Generic Prescription Drug Plan that is listed in the Table of Contents.

Use the claim form provided by the Administrative Office or by Allied Administrators. Follow the instructions on completing the claim form with all the attachments to:

IBEW-NECA Claims Administration
Allied Administrators
2831 Camino del Rio South Suite 311
San Diego California 92108-3829
Telephone: 1-800-736-0401

Upon receipt of a fully completed claim form, Allied will process your claim and issue any reimbursement to which you may be entitled within the time frames established by applicable federal regulations. These timeframes are described on pages 63 – 66 in this Summary Plan Description under the heading “Claims & Appeal Rules”.

Note: Send in no more than one claim form per month with all claims for both retiree and spouse listed on the same claim form.

Participant

The term "Participant" applies to all individuals who are eligible for benefits under this Plan. This includes Retirees and an eligible spouse of such participant.

Premium Reimbursement Plan

The Premium Reimbursement Plan is for those retirees who live outside the HMO service area or retirees who do not wish to elect an HMO under contract with the Health Trust Fund. The Plan provides an option to obtain private or group insurance and receive a limited dollar reimbursement monthly from the Health Trust Fund for the private or group medical insurance as otherwise described in this Plan

The Plan will not reimburse participants for any costs paid for medical insurance by any third parties such as current or former employers. For example, if a current or former employer provides medical insurance that costs \$500 per month and you are required to pay \$100 per month toward the cost of that insurance, the most the plan will reimburse you is \$100 (your actual out of pocket cost) and not \$500 (the cost to your employer to provide the coverage). You are entitled to prescription drug benefits through the Mandatory Generic Prescription Drug Plan. Refer to the separate section entitled Mandatory Generic Prescription Drug Plan that is listed in the Table of Contents.

Use the claim form provided by the Administrative Office or by Allied Administrators. Follow the instructions on completing the claim form with all of the attachments to:

IBEW-NECA Claims Administration
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Upon receipt of a fully completed claim form, Allied will process your claim and issue any reimbursement to which you may be entitled within the time frames established by applicable federal regulations. These timeframes are described on pages 63 – 66 in this Summary Plan Description under the heading “Claims & Appeal Rules”.

Note: Send in no more than one claim form per month with all claims for both retiree and spouse listed on the same claim form.

Qualifying Event

A Qualifying Event for continuation coverage occurs when a qualified beneficiary loses coverage under this Plan. This entitles the qualified beneficiary to elect to continue coverage under the Plan by self-payment, as further described herein.

Retiree or Eligible Retiree

A Retiree who qualifies under the rules of the Southern California IBEW-NECA Retiree Health Plan Summary Plan Description and meets all of the following requirements:

1. Fulfills all of the eligibility rules as listed under the section entitled “Eligibility Requirements”.
2. Authorizes a monthly self-payment to be deducted from the retiree’s monthly pension check from the Southern California IBEW-NECA Pension Plan, or self-pays the monthly premium timely to the Administrative Office.
3. No longer works in “active employment” in the jurisdiction of the Southern California IBEW-NECA Pension Plan, except for maintenance work or work expressly permitted under the rules and regulations as may be promulgated by the Board of Trustees.

Secure Horizons

Secure Horizons is a division of UnitedHealthcare, an HMO. It contracts with hospitals and doctors to provide medical care to those participants enrolled in Parts A and B of Medicare.

Self-Payments

A payment by a Retiree or widow of a Retiree required to maintain Plan coverage. The self-payment is either deducted monthly from the Retiree’s or widow’s Southern California IBEW-NECA pension check OR by monthly health benefit payment made to the Southern California IBEW-NECA Health Plan by the 15th of the month immediately preceding the coverage effective month, (i.e. Coverage month January, payment must be received by December 15th). Amount

varies and is subject to change (usually on an annual basis) upon review by the Board of Trustees.

Summary Plan Description and/or SPD

The document provides you with various information as to eligibility and certain information required by law. The Evidence of Coverage documents and the insurance policies provide you with detailed information as to specific benefits under the benefit options available.

Trust Agreement

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

Trustee and/or Board of Trustees

As defined in the Agreement and Declaration of Trust establishing the Southern California IBEW-NECA Health Trust Fund.

UnitedHealthcare

UnitedHealthcare is a Health Maintenance Organization (HMO) that contracts with hospitals and doctors to provide medical care. For participants enrolled in Parts A and B of Medicare, coverage is provided by UnitedHealthcare's Secure Horizons program.

Union and/or Local Union

The International Brotherhood of Electrical Workers (IBEW), AFL-CIO, Local 11.

Eligibility Requirements and General Plan Provisions

You are eligible for coverage under the Southern California IBEW-NECA Retiree Health Plan, if you are a pensioner who has retired and receives benefits from the Southern California IBEW-NECA Pension Plan, and if you meet the following eligibility requirements as of your original pension effective date.

Important: Enrollment in the Retiree Health Plan is not automatic. You must complete an application, pay the monthly medical premium and enroll in the Plan, provided you meet the eligibility requirements of the Retiree Health Plan.

The requirements as of your original pension effective date are as follows:

1. You are 55 years old or older and have accumulated at least 25 years of credited service under the Southern California IBEW-NECA Pension Plan.

OR

You are 62 years or older and have accumulated at least 10 years of credited service under the Southern California IBEW-NECA Pension Plan.

AND

2. At the time of your retirement, you have accumulated at least 10,500 hours contributed to the Southern California IBEW-NECA Active Health Plan (includes Health hours sent through reciprocity) in 7 of the 10 years immediately preceding the date of your original pension effective date.

OR

3. At the time of your original pension effective date, you have accumulated at least 30,000 hours contributed to the Southern California Active IBEW-NECA Health Plan (includes Health hours sent through reciprocity).

AND

4. You elect coverage, complete an application, pay the monthly medical premium and enroll in the Plan. The monthly medical premium may be deducted from your monthly Southern California IBEW-NECA pension benefit OR monthly self-payments may be made to the Southern California IBEW-NECA Health Trust Fund.

Eligible Spouse

To have your spouse covered by the Plan, you must be legally married on the date the first pension check is issued by the Southern California IBEW-NECA Pension Plan. Effective January 1, 2005, if you subsequently remarry because of the death of your spouse or divorce, your spouse will not be eligible for retiree health coverage unless you enroll a new spouse under

this Plan by the end of the second calendar month following the date of the marriage. Coverage for your new spouse shall commence as of the first month following enrollment.

For example, if a participant marries any time during the month of January, he may enroll his new spouse any time through March 31; coverage would commence on April 1, the first of the month following enrollment.

Any spouse who is also a retired participant in the Southern California IBEW-NECA Retiree Health Plan and eligible for benefits under the Plan cannot also be eligible as a dependent spouse.

An eligible retired employee and eligible spouse must select the same medical plan of benefits offered under the Retiree Health Plan. For example, if the retired employee selects Kaiser Permanente as his choice of medical coverage, then his spouse must also enroll in Kaiser Permanente. If one spouse is eligible for Medicare and the other is not, then the non-Medicare participant will be covered under the retiree Kaiser medical plan and the Medicare eligible participant will be covered under the Kaiser Permanente Medicare plan called Senior Advantage.

There is an exception to the above rule. Disability retirees who live outside of the service area of any of the available HMO's offered through the Trust, who are either on Medicare with a non-Medicare eligible spouse or if the spouse is on Medicare and the retired employee is not eligible for Medicare. For example, the disability retiree could be enrolled in Medicare and select the Medicare Supplement Plan and the non-Medicare spouse could select the Premium Reimbursement Plan.

Please note that the Retiree Health Plan provides that if a retiree was married at the time of his or her initial enrollment in the Retiree Health Plan and declined coverage for his or her spouse under the Retiree Health Plan, the retiree cannot later add the same spouse as an eligible spouse under the Retiree Health Plan (see HIPAA Special Enrollment on page 21 to preserve the enrollment of an eligible spouse).

If you would like to add your spouse under the Retiree Health Plan, please contact the Administrative Office for the necessary forms. You will need to provide documentation that your spouse qualifies as an eligible spouse (marriage certificate, etc).

If you have questions, please contact the Administrative Office at (323) 221-5861, Monday through Friday or toll free at (800) 824-6935 between the hours of 9 and 5 p.m.

Termination of Eligibility for Spouse

Upon divorce, legal separation, or annulment, a spouse ceases to be an eligible spouse. **An eligible spouse enrolled in the Retiree Health Plan may continue his/her coverage under the Retiree Health Plan upon the retiree's death.**

Refer to the section entitled "COBRA" which explains how a former spouse may temporarily continue coverage.

Because you will have to refund any unauthorized benefits, received by an ineligible spouse, you should notify the Administrative Office of the dissolution, divorce, legal separation, or

annulment as soon as possible. Please refer to COBRA provisions as contained in the section entitled Five Federal Laws You Should Know About which sets forth the deadlines for notifying the Administrative Office of a divorce, legal separation or annulment.

Coordination of Benefits – Duplicate Coverage

If upon retirement, a non-Medicare retiree is eligible for more than one retiree health plan, the plan which covered the retiree the longest as a retired employee will be considered the primary medical plan. If the Southern California IBEW-NECA Retiree Health Plan is the secondary Plan, the benefits of the Plan will be paid after the application of the primary plan of benefits, where applicable (duplicate coverage). See also “Special Rule” for Medicare “Double Coverage” Members on page 33.

Disability or Partial Disability Retirees

Totally and permanently disabled retirees need only meet requirements 2, 3 and 4. A Partial Disability retiree must be at least 50 years of age and need only meet requirements 2 or 3 and 4.

Effective October 1, 2004 for coverage on or after the date of timely application, a Pensioner whose early retirement was effective on or after April 1, 1993 and who receives a Social Security Total Disability Award on or after April 1, 2003 and who has had no income from gainful employment on and after the effective date of the early retirement benefit shall be entitled to participate as a Disability Retiree as long as they were at least age 50 on their pension effective date and meet the requirements of items 2, 3 and 4 set forth above.

Crediting Disability Hours for Retiree Eligibility

In the event a retired employee has received a disability award from the Social Security Administration, or has an approved Workers Compensation disability, then such employee shall receive disability credit during the period of such disability, up to a maximum of twenty-six (26) weeks at forty (40) hours per week (1,040 Hours), for the sole purpose of satisfying the eligibility requirements for Retiree Health Plan coverage as provided under this plan.

Effective October 1, 2004 for coverage on and after the date of timely application, a pensioner whose early retirement pension benefit was effective on and after April 1, 1993 and who receives a Social Security Total Disability Award on and after April 1, 2003 and who has had no income from gainful employment on and after the effective date of their early retirement pension benefit shall be entitled to participate as a Disability Retiree if they meet the requirements set forth in the table shown on the following page.

TOTAL DISABILITY RETIREMENT	MAINTENANCE AGREEMENT RETIREMENT (OPTION)	PARTIAL DISABILITY RETIREMENT	EARLY RETIREMENT	NORMAL RETIREMENT
PENSION REQUIREMENT:				
You must be receiving a monthly pension benefit payment from the Southern California IBEW-NECA Pension Plan; AND You must meet the requirements below as of your original pension effective date.				
RETIREE HEALTH PLAN (“RHP”) REQUIREMENTS:				
No Age Requirement	You must be at least age 50 when you retire; AND You must have continuity of employment under the Maintenance Agreement to maintain eligibility for the RHP with no lapse of hours greater than 24 consecutive months.	You must be at least age 50 when you retire.	You must be at least age 55 when you retire, BUT you must retire before reaching age 65; AND You must have at least 25 years of credited service under the SC IBEW-NECA Pension Plan	You must be at least age 62 or older when you retire; AND You must have at least 10 years of credited service under the SC IBEW-NECA Pension Plan.
AGE AND CREDITED SERVICE REQUIREMENTS UNDER THE SOUTHERN CALIFORNIA IBEW-NECA PENSION PLAN: (Note that Age and Credited Service requirements set forth below may change at any time and the following description is believed accurate as of 02/01/2013. Only the Pension Fund is authorized to provide advice as to Age and Credited Service Requirements under the Pension Plan.)				
You may retire at any age prior to age 65; AND You must have accumulated 10 vesting service years or 15,000 hours.	See requirements under “Early Retirement.”	See requirements under “Total Disability Retirement.”	You must be at least age 55 when you retire, BUT you must retire before reaching age 65; AND You must have accumulated 10 vesting service years or 15,000 hours.	You must be at least age 65 when you retire; AND You must have Accumulated 5 vesting service years.
CONTRIBUTED HOURS REQUIREMENT AS OF YOUR ORIGINAL PENSION EFFECTIVE DATE:				
30,000 Health Hours under a Collective Bargaining Agreement requiring a Retiree Trust Fund contribution; OR 10,500 health hours in 7 of the 10 years immediately preceding the date of your retirement under a Collective Bargaining Agreement requiring a Retiree Trust Fund contribution.				
PAYMENT REQUIREMENTS:				
You must make monthly payments or authorize the Trust Fund to deduct the required payment from your monthly pension benefit payment.				

Retirees Working Maintenance

Effective with Pensions beginning on or after July 1, 2000, an employee who retires after age 50, but before age 55, receiving a pension under the Southern California IBEW-NECA Pension Plan will become eligible for the Retiree Health Plan at age 55 or later, when the working retiree ceases Covered Employment under the Maintenance Agreement between IBEW Local 11 and Los Angeles County Chapter NECA, subject to meeting all of the requirements a through c listed below. Please note that for pensions effective on or after September 1, 2003 (if application is received after August 1, 2003) only pension benefits accrued on or after August 1, 2003 shall be suspended while working under the Maintenance Agreement.

- a. Continuity of Employment. An employee working under the Maintenance Agreement, as described above, must have continuity of employment to maintain

eligibility for the Retiree Health Plan. A retired employee working under the Maintenance Agreement who has no maintenance hours reported during any 24 consecutive months, beginning from the effective date of retirement under the Southern California IBEW-NECA Pension Plan, will have a break in employment, and all the entitlement to the Retiree Health Plan will be null and void.

- b. An employee must meet all of the eligibility requirements for coverage under this Retiree Health Plan Summary Plan Description.
- c. Hours worked in covered maintenance employment will be credited toward Retiree Health Plan eligibility to meet either of the following requirements:
 1. At the time of retirement from covered maintenance employment, the employee must have accumulated at least 10,500 hours contributed to the Retiree Health Plan in 7 of the 10 years immediately preceding the date the employee terminates maintenance employment;

OR

2. At the time of retirement from Covered maintenance employment, employee has accumulated at least 30,000 hours contributed to the Retiree Health Plan preceding the date employee terminated employment.

Termination of Coverage for Retiree

Voluntary Termination

At any time, you can terminate your participation in the Retiree Health Plan. To terminate your coverage, you must give the Administrative Office 30 days advance notice, in writing. **Once terminated, you will not be permitted to re-enroll in the Retiree Plan.**

If you terminate your retiree coverage, such action will automatically terminate coverage under this Plan for your spouse.

If you request termination, the coverage will end on the last day of the month following the completion of the 30-day period beginning on the date the Administrative Office received your notice. For example, if they received your letter on May 15th, the 30-day period would end on June 14th, and the coverage would end on June 30th. When your coverage ends, the monthly co-payment will no longer be deducted from your Pension check.

Required Termination

Certain circumstances can require the termination or reduction of your retiree health coverage. For example, the Board of Trustees may end or reduce benefits or your pension benefits may be suspended. Coverage will end or be reduced on the earlier of the following dates:

1. The date benefits under the Retiree Health Plan are terminated or reduced by the Board of Trustees.

2. The last day of the month preceding the month in which any portion of your pension benefit is suspended by the Pension Plan. (For example, if you will no longer receive pension benefits in June, May 31st is the last day of your health coverage).
3. The first day of the next calendar month following the day in which you commence any work in Non-Covered Electrical Employment, as that term is defined under the terms of the Southern California IBEW-NECA Pension Plan. In such event, your eligibility and your spouse's eligibility shall terminate as set forth above and no reinstatement of eligibility shall occur unless otherwise permitted by the Plan. If you and your spouse lose eligibility pursuant to this section, the Trust will offer you non-subsidized COBRA coverage and conversion rights to the extent required by applicable law.

Non-Covered Electrical Employment

If after achieving eligibility under the Active Plan, an individual engages in Non-Covered Electrical Employment, all the rights to coverage under the Retiree Health Plan are lost unless subsequent to the Non-Covered Electrical Employment, the individual earned at least 5 years of Credited Service under the Pension Plan. If after such Credited Service is earned, the individual again engages in Non-Covered Electrical Employment, all rights to retiree health care are permanently lost and cannot be regained.

If subsequent to retirement and enrollment in the Retiree Health Plan, an individual engages in Non-Covered Electrical Employment, all rights to ongoing coverage under the Retiree Health Plan are lost unless the individual returns to Covered Employment and earns the required 5 years of Credited Service under the Pension Plan. If such an individual were then again to retire, enroll in the Retiree Health Plan and again engages in Non-Covered Electrical Employment, all rights to retiree health care coverage would be permanently lost and cannot be regained.

Enrollment Requirements

You Must Enroll and Agree to Make a Monthly Payment

Even though you meet the eligibility requirements described in this Summary Plan Description, you and your eligible spouse are not automatically enrolled in the Retiree Health Plan. You must elect coverage, complete an application, pay the monthly medical premium and enroll in the Plan. The monthly medical premium may be deducted from your monthly Southern California IBEW-NECA pension benefit OR monthly self-payments may be made to the Southern California IBEW-NECA Health Trust Fund.

If you do not elect coverage within the period specified in the Section entitled “Deadline for Enrollment in the Retiree Health Plan and When Coverage Begins”, you will not be permitted to enroll for coverage in the Retiree Health Plan at a later date.

Contact the Administrative Office and request a Retiree Health Plan (“RHP”) application form (Note: Retiree Health Plan coverage is not automatic and is a separate process from applying for your pension.)

Return the completed RHP application form to the Administrative Office, Pension status and health hours history are reviewed and you will be notified if you meet eligibility criteria. If eligible for participation, you will receive an enrollment form.

Complete and return the RHP enrollment form indicating authorization to deduct the cost of RHP participation from your monthly pension benefit OR request monthly self-payment. Self-payments must be received by the 15th of the month immediately preceding the coverage effective month, i.e. if the coverage month is January, payment must be received by December 15th.

If you do not elect coverage at this initial period offering, you will not be permitted to do so at a later date, unless extended by COBRA coverage under the Active Plan. See page 21 of HIPAA Special Enrollment.

The only exceptions to the above are as follows:

1. Return to Covered Employment. If a participant in the Retiree Health Plan returns to Covered Employment, such retired participant can resume coverage under the Retiree Health Plan at a subsequent retirement date. Coverage under this plan must be elected within thirty days of the effective date of subsequent retirement. If not elected, the right to participate in the Plan will terminate. Benefits under the Retiree Health Plan will commence on the first of the month following the last month in which the participant is eligible under the Southern California Active IBEW-NECA Health Plan applicable to Active employees.

To reinstate coverage upon a subsequent retirement under the Retiree Health Plan, you are required on your subsequent retirement to sign a new Enrollment Form and agree to pay the cost of the health benefit each month. These signed forms must be

received in the Administrative Office prior to the effective date of your subsequent pension effective date. If you do not submit these signed forms within the time limit, you will not be allowed to re-enroll in the Retiree Health Plan at a later date.

2. Eligible Spouse. To have your spouse covered by the Retiree Health Plan, you must be legally married on the date the first pension check is issued by the Southern California IBEW-NECA Pension Plan, unless HIPAA special enrollment rights are applicable to your spouse.
3. Effective January 1, 2005, if you subsequently remarry because of the death of your spouse or divorce, your spouse will not be eligible for retiree health coverage unless you enroll your spouse under this Plan by the end of the second calendar month following the date of marriage. Coverage for your new spouse shall commence as of the first of the month following enrollment. (For example, if a participant marries during the month of January, he may enroll his new spouse any time through March 31; coverage shall commence on April 1, the first of the month following enrollment.) If applicable, your monthly self-payment shall be adjusted based on the age of your new spouse.

Application Process for Enrollment in the Retiree Health Plan

Upon request, you will receive a Retiree Health Plan application from the Administrative Office, the Retiree Health Plan application is generally mailed to retirees one month in advance of exhausting your Active Hours Bank Reserve or upon notification of your retirement under the Southern California IBEW-NECA Pension Plan.

The Retiree Health Plan package contains an Enrollment Form and a Selection Form. Both forms must be completed, signed and returned to the Administrative Office within (30) days of the date of the postmark.

If the Enrollment Form and Selection Form are not received within thirty (30) days, as stated above, the Administrative Office will send by certified mail a second request. **If these forms are not received within thirty (30) days of the mailing of the certified letter, you will not be permitted to enroll at a later date.**

If you elect not to participate in the Retiree Health Plan, then you should make an affirmative declaration by checking the box declining coverage. If the Enrollment Form and Selection Form are not received by the Administrative Office within thirty (30) days of the certified letter, then the presumption will be that you declined participation in the Retiree Health Plan.

Retirees Working Maintenance

Upon termination of employment under the Maintenance Agreement, the retiree must make application to the Retiree Health Plan to establish entitlement for benefits. Such retirees will be subject to the enrollment requirements as set forth herein.

Deadline for Enrollment in the Retiree Health Plan and When Coverage Begins

The deadline for enrollment in the Retiree Health Plan by those eligible for enrollment is (30) days after the later of:

1. First meeting the eligibility requirements for retiree coverage;
2. Commencing receipt of benefits from the Pension Fund;
3. Exhausting all Hours Bank Reserve coverage under the Active Plan; and
4. Exhausting all COBRA coverage under the Active Plan.
5. Special enrollment rights under HIPAA.

If a properly completed Enrollment Form and Selection Form are received from you as described above, your benefits will commence on the first day of the month following the month in which the forms are received by the Administrative Office. For example, provided you meet the eligibility requirements and Enrollment and Selection Forms are received in the Administrative Office on January 15, your Retiree Health Plan coverage will commence on February 1. Coverage for your eligible spouse will become effective on the date your coverage becomes effective.

The only exception to the 30 day initial enrollment deadline is the Special Enrollment required under HIPAA. To retain this initial Special Enrollment Right you must advise the Fund in writing that you are declining coverage under the Retiree Health Plan because you have coverage from another source. This signed statement must be received by the Fund prior to the expiration of the 30 day period. A spouse may decline initial enrollment through the same process. If a required statement is not received within the 30 days, all HIPAA Special Enrollment rights are lost. If you have provided timely notice to the Fund you may subsequently enroll within 30 days of loss of your coverage. If you do not enroll within the 30 days of loss of your other coverage all HIPAA Special Enrollment rights are lost. At the time of the HIPAA Special Enrollment you must submit written proof of your other coverage, its duration and the date of loss of coverage. If eligible for HIPAA Special Enrollment coverage, your coverage will commence on the first day of the month following the month the Fund receives your application for enrollment. These Special Enrollment rights only apply during you or your spouse's initial enrollment.

Medicare Enrollment Required

Enrollment in Medicare Parts A and B is required either when the retiree or spouse becomes age 65 or eligible for Medicare at any age.

January 1, 2006 was the effective date of Medicare Part D prescription drug coverage. Retirees enrolled in the Kaiser Senior Advantage or UnitedHealthcare Secure Horizons Plan have drug coverage included in their HMO benefits. The drug coverage is determined by the Plan's consultant/actuary to meet the definition of creditable coverage. Creditable coverage means the benefits are equal to or exceed Medicare Part D prescription drug benefits.

Participants enrolled in the Medicare Supplement Plan or in the Medicare Reimbursement Plan and enrolled in Medicare have prescription drug benefits under this plan as contained in the section entitled "Mandatory Generic Drug Plan".

Medicare Assignment to HMOs

If the retiree or eligible spouse selects one of the HMO medical Plans for health coverage and is eligible for Medicare, he or she must assign the Medicare benefits to the HMO Medicare-risk Plan that the retiree or spouse selects.

WARNING:

Once you have enrolled in one of the group HMOs with Medicare-assignment (Kaiser Permanente Senior Advantage or UnitedHealthcare Secure Horizons), do not sign up for another Medicare-risk plan (an HMO with a Medicare Contract) on your own without first writing to the Administrative Office. Enrolling in another Medicare-risk plan may cause your benefits from this plan to be cancelled.

Third Party Liability

Third-party liability refers to expenses for injury or illness caused by another person (called a third party) for which that person is liable or legally responsible to pay.

If you select an HMO Plan, services are provided if you and your spouse are injured through the actions of someone else (third party), such as an automobile accident. If you collect any amount from the other person or his or her insurance company, the HMO is entitled to obtain reimbursement from you for the value of all hospital and medical services provided by them for the care of your injury. The amount collected from you will never be more than the amount you collect from the other person or the insurance company. If you have any questions, contact the HMO for details.

Annual Open Enrollment Period

Each year during your annual open enrollment period held during the months of August and September, participants in the Retiree Health Plan are permitted to make a change in their choice of plans available to them.

For example, if you are currently enrolled in the Kaiser Permanente Senior Advantage plan, you may change to UnitedHealthcare Secure Horizons.

The open enrollment period is generally held during the months of August and September with plan changes effective October 1. You will be notified each year by the Administrative Office of the annual open enrollment period. You will also receive confirmation in writing by the Administrative Office of the effective date of the new Plan selected.

You may enroll in an HMO Plan, only if you reside in the geographical jurisdiction as defined by the HMO you select. For UnitedHealthcare, you must live within a 30-mile radius of a participating provider (doctor/medical group). For Kaiser, you must live within the Kaiser service area which is defined by ZIP code.

Required Monthly Pension Deduction/Self-Payment

To be covered under the Southern California IBEW-NECA Retiree Health Plan, you must either (1) authorize a deduction from your monthly Southern California IBEW-NECA Pension benefit, **OR** (2) make monthly self-payments by the 15th of the month immediately preceding coverage effective month (i.e. If January is the coverage month; payment must be received by December 15th), regardless of the type of pension you are receiving (Normal, Early or Disability). If you elect deductions from your monthly pension benefit, you authorize the Administrative Office to deduct the required self-payment from the monthly pension benefit you receive from the Pension Plan. The Administrative Office will provide you with an authorization form for you to complete and sign. The deduction will be made automatically for each month of coverage provided that this Plan is in effect, and while you continue to meet the Plan's eligibility rules.

How the Monthly Self-Payment is Computed

The amount of the self-payment is based on your paying a portion of the HMO premium or Plan benefit cost. The percentage that participants pay is adjusted on an annual basis effective October 1st. If an adjustment to the amount of the monthly self-payment is required, you will be notified of the new amount at least 60 days in advance of its effective date. However, the Board of Trustees reserves the right to change the monthly self-payment at any time.

How I Find Out About The Monthly Self-Payments

Upon request, the Administrative Office will provide a retiree with a chart indicating the self-payment cost for all the retiree Plans. Once enrolled in a Retiree Health Plan, Participants will be advised of any change in retiree self-payment usually starting on October 1st of each year.

Five Federal Laws You Should Know About

COBRA

Introduction

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (commonly referred to as “COBRA”), requires that this Trust Fund offer you and your eligible spouse the opportunity to continue health care coverage at group rates when coverage under this Trust Fund would otherwise end due to the occurrence of what are called “qualifying events”. Continued coverage under COBRA applies to the health care benefits (medical, dental, prescription drug and vision benefits) described in this Summary Plan Description.

Your group health benefits under COBRA will be the same as those covering you on the day before you lose coverage under this Trust Fund. You should also keep in mind that each individual entitled to COBRA coverage as the result of a loss of group coverage due to the occurrence of a qualifying event has a separate and independent right to make his or her own election of coverage. For example, your spouse could elect COBRA coverage even if you do not.

IMPORTANT: If you choose to continue your health care coverage as explained below, you will have to make a payment each month to the Administrative Office within the time periods explained below. The Administrative Office does not send bills for COBRA coverage. It is your responsibility to make COBRA payments on time. If you don't make your payment on time, your coverage will end.

Under COBRA, you have sixty (60) days from the date you lose coverage because of the occurrence of certain qualifying events to inform the Administrative Office that you want to elect COBRA continuation coverage. Once you receive the COBRA election notice from the Administrative Office you will then have sixty days to notify the Administrative Office that you are electing COBRA continuation coverage. If you don't elect COBRA within that 60-day period, you will forfeit your rights as a qualified beneficiary to elect COBRA. You must make your first payment for COBRA continuation coverage to the Trust Fund within forty-five (45) days after you first elect COBRA coverage. If you do not make your initial COBRA premium payment in full within the 45-day period, the Trust Fund will terminate your COBRA coverage and you will not be able to reinstate that COBRA coverage.

When you make your first COBRA premium payment, you must pay for all months of coverage which are due through the end of the month in which you make your first payment. Your payment for subsequent months is due on the first of each month. The Trust Fund will terminate your COBRA coverage for non-payment if the Administrative Office does not receive your COBRA premium payment within 45 days after the applicable month's due date. For example, a payment for the coverage month of January is due January 1st. If payment is not received in the Administrative Office by February 15th, the Trust Fund will terminate your COBRA continuation coverage. If this happens, there would be no coverage for the month of January, or any additional months for which COBRA benefits may have been available.

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

At a Glance

Qualifying Events That Entitle You to COBRA

If you Lose Coverage Because of This Reason (a “qualifying event”)	These People Would Be Eligible If Covered Under the Plan On the Day Before the Qualifying Event	For COBRA Coverage Up To (Measured from the date coverage is lost)
You die	Your covered spouse	18 months to a maximum of 36 months
You divorce or legally separate	Your former spouse	18 months to a maximum of 36 months

Notification

A Retiree or an eligible Spouse has the responsibility to inform the Administrative Office of a divorce or legal separation within **60 days of the qualifying event**. If you fail to notify the Administrative Office of a divorce or legal separation within the 60-day period, the affected spouse will lose the right to elect COBRA continuation coverage. A qualifying event means the reason you are losing eligibility under one of the situations described above, such as the death of the Retired Participant. Another example of a qualifying event for a legal spouse would be divorce.

When the Administrative Office is notified that one of these events has happened, the Administrative Office will, in turn, notify you that you have the right to elect COBRA continuation coverage. This notice will also explain the monthly payment you must pay to continue your health coverage. Under COBRA, you have at least 60 days from the date you would lose coverage, because of one of the qualifying events described above, to inform the Administrative Office that you want to elect COBRA continuation coverage.

If you do not elect to continue coverage or if you do not make the required self-payment by the applicable due date, your coverage under this Trust Fund will end. You will not be able to elect COBRA Continuation Coverage at a later date.

Benefits & Length of Coverage

If you choose “Basic” COBRA coverage, it will be the same hospital/medical/prescription drug coverage that you had under the Trust Fund on the day before the occurrence of the qualifying event which resulted in your loss of coverage under this SPD. The initial COBRA period may be extended for up to an additional 11 months, for a total of 29 months if the Social Security Administration finds that a qualified beneficiary (either the Retired Participant or the spouse) is disabled at any time during the first sixty (60) days of COBRA coverage. To implement this special 11 month extension, the disabled qualified beneficiary must notify the Administrative Office within 60 days following the latest of the date on which the individual receives the initial COBRA notice following a qualifying event, the date Social Security determines that the individual is disabled, the date of the qualifying event, or the date on which the qualified beneficiary loses (or would lose) coverage due to the occurrence of the qualifying event. In any event you must provide the notice of disability before the end of the initial 18 month COBRA coverage period arising from the Employee’s termination of employment or reduction in hours of employment. The occurrence of another qualifying event during the initial 18 month (or 29 month) COBRA coverage period may increase the maximum COBRA coverage period to 36 months (maximum).

If another qualifying event (such as a divorce or legal separation or the death of the Retiree) occurs during the 18-month COBRA coverage period (or during the 29 month COBRA coverage period in the case of a disability extension), the spouse may be entitled to an extension of the COBRA coverage period to up to a total of 36 months (the maximum COBRA coverage period under the law). In no case may the total maximum COBRA coverage period arising from an initial or related qualifying event be more than 36 months.

Cancellation of Your COBRA Coverage

Your COBRA coverage will be terminated at the end of the maximum applicable COBRA coverage period or prior to the end of the maximum COBRA coverage period for any of the reasons explained below.

1. The Board of Trustees terminates a particular coverage for all Participants of the Trust Fund. If coverage is changed or eliminated, persons on COBRA only have the right to choose among the options offered to similarly situated non-COBRA beneficiaries;

For example, if the Trustees were to terminate an HMO contract under which you were covered under COBRA, and another HMO was offered to all other Plan participants who were previously enrolled in the canceled HMO, you would be allowed to enroll in the replacement HMO.

2. You request that your COBRA coverage be canceled. If you request termination, the COBRA coverage will generally end on the first day of the month following completion of a 30-day period beginning on the date the Administrative Office received your written request to cancel the COBRA coverage. For example, if the Administrative Office received your letter on May 15, the 30-day period would end on June 15, and the COBRA coverage would end July 1. In this situation, you would be required to pay for the COBRA coverage through the month of June;

3. If your COBRA premium is not paid in a timely manner, your coverage will be canceled. The cancellation will be retroactive to the beginning of the month following the end of the month for which you last made a timely COBRA premium payment. If you have received any benefits or services in the period of time following the cancellation of your COBRA coverage, you may be required to repay to the carrier the amount of the benefits received or the cost of the services rendered;
4. The date on which the qualified beneficiary first becomes, **after the date of election**, covered under any other group Trust Fund(as an employee or otherwise) provided that the other Trust Fund does not contain any exclusion or limitation for any pre-existing condition which affects the coverage of the qualified beneficiary covered under the new Trust Fund. Note that a qualified beneficiary may not be denied the right to elect COBRA coverage because they are covered under another group Trust Fund **at or before the time** they make their COBRA election under this Plan;
5. You become entitled to Medicare benefits **after** COBRA coverage has been elected;
6. You are no longer disabled. If a qualified beneficiary is determined to no longer be disabled under the Social Security Act before the end of the 29-month maximum coverage period, COBRA coverage may be terminated at the beginning of the first month that begins more than 30 days after such determination is made;
7. The signatory Employers to the Plan no longer provide group health coverage benefits to any of their Employees;
8. The Plan is terminated.

Change of Address

Contact the Administrative Office if you change your address.

Health Insurance Portability & Accountability Act (HIPAA)

A federal law called the Health Insurance Portability and Accountability Act (HIPAA) requires this Trust Fund to furnish you with certain information.

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

IMPORTANT: The medical plans (Kaiser or UnitedHealthcare) offered through the Southern California IBEW-NECA Health Trust Fund **do not** contain any pre-existing condition exclusions. You become eligible for benefits under this Plan (as explained in the section titled “Eligibility Requirements & General Plan Provisions”) without regard to any pre-existing medical conditions for which you may or may not have been treated prior to your effective date of coverage under this Trust Fund. Benefits become effective upon eligibility determination and the receipt of completed enrollment documentation.

However, each medical plan does have benefit exclusions and limitations for designated illnesses and conditions. For example, each of the medical plans contains an exclusion for experimental surgery. A detailed list of the exclusions for each of the plans is contained in the respective plan's *Evidence of Coverage* document. Further information can be obtained by contacting the Administrative Office or the HMO benefit provider.

Certificate of Group Trust Fund Coverage (“HIPAA Certificate”)

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

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

HIPAA Privacy Rules

HIPAA also gives you certain rights with respect to your health information, and requires that employee welfare plans, like the Southern California IBEW-NECA Retiree Trust Fund, that provide health benefits, protect the privacy of your personal health information (PHI). A complete description of your rights under HIPAA will be found in the Plan's Notice of Privacy Practices, which was initially distributed to all participants as of April 14, 2003 (or when you enroll in the Plan, if you enrolled after April 14, 2003) and which is posted on the Trust Fund's web site and a copy of which may be obtained by contacting the Administrative Trust Funds Office.

Information You Should Know As Required By HIPAA – Limitations on Benefit Changes in Existing Coverage and Appeals Rights

HIPAA requires that Trust Fund participants be notified of material reductions in Trust Fund coverage within 60 days of the change in benefits. This Summary Plan Description contains a section titled “Plan Amendment Procedures” which explains the notice you will receive if there is a material reduction in benefits. This Trust Fund will provide notice of such changes to Trust Fund participants no less than 60 days prior to the effective date of such changes.

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

Medical Plans –	Kaiser Permanente (HMO)
	UnitedHealthcare (HMO)
	Kaiser Permanente - Senior Advantage (HMO)
	UnitedHealthcare - Secure Horizons (HMO)

Dental Plans – CIGNA (DHMO)
DeltaCare (DHMO)
MetLife/Safeguard (DHMO)
United Concordia (DHMO and PPO)

Vision Insurance – Vision Service Plan

Questions/Assistance – Health*Advocate* Program

Each of the above benefit providers maintains an appeals procedure. This appeals procedure is explained in the *Evidence of Coverage* document provided by each benefit provider. An example of an appeal under an HMO may be where you received emergency care outside the HMO network and the claim was denied by the HMO because they did not deem it an emergency. You can contact the benefit provider directly for information on their appeals procedure. Of course, the representative at the Health*Advocate* Program will also assist you if you have questions or need information. You can contact the Health*Advocate* Program representative at (866)695-8622.

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

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

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

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

Health plans are required to provide coverage for a minimum of a 48-hour stay for the mother and newborn following a vaginal delivery and for at least a 96-hour maternity stay following a delivery by cesarean section. Under this law, a mother and newborn can leave prior to the end of the required minimum stay, provided there is a mutual agreement between the mother and doctor. The HMO medical plans under this Plan administer maternity benefits in accordance with the requirements of this Act.

If you have any questions, contact your HMO directly, or call Health*Advocate* for assistance.

Women's Health & Cancer Rights Act (WHCRA)

The Women's Health & Cancer Rights Act (WHCRA) is a federal law requiring group health plans (HMOs and other insurers) providing coverage for mastectomies to also cover reconstructive surgery after a mastectomy in a manner determined in consultation with the attending physician and the patient. Prior to this law, the HMO plans generally already covered the services now mandated by this law. The purpose of this section is to remind you and your covered spouse of the following:

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

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

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that are consistent with those established for other benefits under the plan or coverage.

If you have any questions, contact your HMO plan directly, or call *HealthAdvocate* for assistance.

The Mental Health Parity and Equity Addiction Act (MHPAEA)

The Mental Health Parity and Equity Addiction Act of 2008 (MPHAEA) expanded the requirements initially provided under the Mental Health Parity Act (MPHA) that group Trust Funds and insurers provide equivalent benefits for mental health and substance disorder benefits.

For this Trust Fund the effective date of the MHPAEA is July 1, 2011. It is the intention of the Board of Trustees of the Southern California IBEW-NECA Health Trust Fund and the contracted insurers (Kaiser Permanente and UnitedHealthcare) that the Trust Fund's benefits be provided in full compliance with requirements of the MPHAEA as of July 1, 2011.

Please refer to the *Evidence of Coverage* documents provided to you by Kaiser Permanente or by UnitedHealthcare for a complete description of the mental health and substance disorder benefits available to you under the terms of the Trust Fund through these respective insurers. If you need further assistance or have questions you can always contact the Southern California IBEW-NECA Health Trust Fund Administrative Office or the website at www.scibew-neca.org, or contact *HealthAdvocate* for assistance.

Plan Amendment Procedures

Changing, Enhancing, Reducing, or Eliminating Benefits

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

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

Notification of Plan Changes to Participants

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

Such action by the Trustees will be accomplished by a Plan Amendment, which details in writing the changes made.

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

Termination or Reduction of Coverage

Termination of Coverage for Retiree

Voluntary Termination

At any time, you can terminate your participation in the Retiree Health Plan. To terminate your coverage, you must give the Administrative Office 30 days advance written notice. **Once terminated, however, you will not be permitted to subsequently re-enroll in the Retiree Health Plan. (See HIPAA Special Enrollment Rights, and Medicare Dual Coverage of persons or benefits as described below.)**

If you terminate your retiree coverage, such action will also automatically terminate coverage under this Plan for your eligible spouse.

If you request termination, the coverage will end on the last day of the month following completion of a 30-day period beginning on the date the Administrative Office received your notice. For example, if they received your letter on May 15, the 30-day period would end on June 14, and the coverage would end at midnight on June 30. When your coverage ends, the monthly co-payment will no longer be deducted from your pension check.

Required Termination

Certain circumstances can require the termination or reduction of your retiree health coverage. For example, the Board of Trustees may end or reduce benefits or your pension benefits may be withheld or suspended. Coverage will end or be reduced on the earlier of the following dates.

1. The date benefits under this Retiree Health Plan are terminated or reduced by the Board of Trustees.
2. A retiree will have his retiree coverage cancelled commencing with the first day of the month following the month in which the Administrative Office issues the written suspension notice to the retiree when pension benefits are withheld or suspended, in whole or in part, by the Southern California IBEW-NECA Pension Plan.

If your pension benefits are suspended and later reinstated, you will be advised of your Retiree Health Plan status when your pension benefits are reinstated.

3. The date the spouse no longer meets the Plan's eligibility rules for being a spouse because of annulment, legal separation or divorce. Remember, you must notify the Administrative Office of a divorce, annulment or legal separation. Refer to the section entitled COBRA to see how legally separated or divorced spouses may temporarily continue coverage.

Special Rule for Medicare “Double Coverage” Members

Commencing August 1, 2008, Medicare advised the HMOs that a Medicare eligible retiree and/or spouse could not be enrolled in two Health Plans. This most frequently occurs when a retiree and spouse both receive retiree coverage from different health Plans due to prior employment and each is enrolled in the other’s Plan as a dependent. Medicare is applying this restriction even when all enrollment is in a single HMO. Retirees and/or spouses who are in such “double coverage” situations will be advised by their HMO or Medicare they must terminate coverage under one Health Plan and elect coverage under the other Health Plan. If the Retiree and/or spouse fail to make the election, the HMO will terminate their coverage under one Health Plan. The special rule is adopted due to Medicare’s actions. It provides an exception to this general eligibility rule that termination of participation in the retiree Plan prohibits any later re-enrollment. All of the following seven conditions must be met in order to be eligible for re-enrollment in the Retiree Health Plan.

1. The Medicare Retiree and/or Spouse must have been enrolled in this Retiree Health Plan.
2. The Medicare Retiree and/or Spouse must have received a “Double Coverage” notice from their HMO or Medicare.
3. The Medicare retiree and/or Spouse must have, in response to the Notice, elected to terminate coverage under this Retiree Health Plan or had such coverage terminated by their HMO or Medicare.
4. The Medicare Retiree and/or Spouse must have continued coverage under the other Health Plan.
5. The Medicare Retiree and/or Spouse must have subsequently lost coverage under the other Health Plan.
6. The Medicare Retiree and/or Spouse within 30 days of loss of coverage under the other Health Plan re-enrolls in this Retiree Plan.
7. The Medicare Retiree and/or Spouse must submit with their re-enrollment application written proof of conditions (1) through (6) set forth above.

Return to Covered Employment

If your pension is suspended, in whole or in part, because you return to Covered Employment, you may elect retiree non-subsidized COBRA coverage. If you select retiree non-subsidized COBRA coverage you can retain your retiree health benefits during the period of time necessary to establish health benefits under the Active Plan, subject to the maximum time limits under COBRA. To do this, you must make a COBRA payment each month, beginning the first month that your pension is suspended. Contact the Administrative Office for full details and the amount you will be required to pay.

Unless you establish eligibility under the Active Health Plan, your eligibility for retiree health coverage resumes in the month the Pension Fund next issues a full pension check(s). If you establish eligibility under the Active Health Plan and then cease suspendible employment, your eligibility for retiree health coverage resumes the next month the Pension Fund issues a full pension check(s) or the month following the last month in which you were eligible under the Active Health Plan.

Suspension of Benefits for Other Than Return to Covered Employment

A retiree who has his monthly pension benefit withheld or suspended, in whole or in part, by the Southern California IBEW-NECA Pension Plan, will have his retiree coverage cancelled commencing with the first day of the month following the month in which the Administrative Office issues the written suspension notice to the retiree.

Unless otherwise provided in the Plan, your eligibility for retiree health coverage resumes in the month the Pension Fund next issues you a pension check(s).

Termination of Coverage for Spouse

Voluntary Termination

At any time, you and your spouse can terminate your spouse's participation in the Retiree Health Plan. To terminate your spouse's coverage, you must give the Administrative Office 30 days advance notice, by letter, signed by you and your spouse. This letter must have both the retiree and spouse's signatures notarized. Once terminated, however, a spouse will not be permitted to re-enroll in the Retiree Health Plan, except HIPAA Special Enrollment Rights or Dual Medicare coverage when the Retiree and the Spouse are permitted to re-enroll in the Retiree Health Plan.

If you and your spouse request termination of coverage for your spouse, your spouse's coverage will end on the last day of the month following the completion of a thirty-day period beginning on the date the Administrative Office received your notice. For example, if the Administrative Office received your letter on May 15, the thirty-day period would end on June 14, and coverage would end on midnight June 30 at midnight.

Required Termination

Your spouse's coverage under the Retiree Health Plan can be terminated or reduced for the same reasons as your own. In addition, spouse coverage will end upon annulment, divorce or legal separation. You must notify the Administrative Office of the occurrence of any of these events within the periods specified under the COBRA provisions of the Plan. The coverage will end or be reduced on the earlier of the following dates:

1. The date these benefits are terminated or reduced by the Board of Trustees.
2. A retiree and their eligible spouse will have their retiree coverage cancelled commencing with the first day of the month following the month in which the Administrative Office issues the written suspension notice to the retiree that pension benefits were withheld or suspended, in whole or in part, by the Southern California IBEW-NECA Pension Plan.

If your pension benefits are suspended and later reinstated, you will be advised of your Retiree Health Plan status when your pension benefits are reinstated.

3. The date the spouse no longer meets the Plan's eligibility rules for being a spouse because of annulment, legal separation or divorce. Remember, you must notify the Administrative Office of a divorce, annulment or legal separation. Refer to the section entitled COBRA to see how legally separated or divorced spouses may temporarily continue coverage.

If there is a divorce, legal separation or annulment, your spouse's coverage ends on the first day of the month following the date of divorce, annulment or legal separation.

Brief Summary Comparison of Retiree Health Plan Benefits

Early Retirees

HMO	Office Visit	Hospital	Prescription Drugs- <i>Mandatory Generic Drug Plan</i>
Kaiser	\$5	100%	\$0 Generic/\$10 Brand – 30 day-supply
UnitedHealthcare	\$5	100%	\$0 Generic/\$10 Brand 30 day-supply

Secure Horizons & Senior Advantage Retirees

HMO	Office Visit	Hospital	Prescription Drugs- <i>Mandatory Generic Drug Plan</i>
Kaiser - Senior Advantage	\$15	100%	MA-PD Rx Drug Plan \$5 Generic/\$15 Brand – 30 day-supply
UnitedHealthcare Secure Horizons	\$15	100%	MA-PD Rx Drug Plan \$5 Generic/\$15 Brand 30 day-supply

Medicare Supplement Plan

An alternative in choosing one of the HMO Plans above is a supplement plan for Parts A and B of Medicare.

Annual Maximum per Person \$2,500

Prescription Drugs - <i>Mandatory Generic Prescription Drug Plan</i>	Retail 30-day supply –
	Mail Order 90-day supply –
	\$0 Generic/\$20 Brand
	\$0 Generic/\$10 Brand

Premium Reimbursement Plan

Individuals who live outside the HMO service area or do not wish to elect an HMO under contract with the Trust Fund are eligible to participate in the Premium Reimbursement Plan. The

Plan provides an option to obtain private medical health insurance (including long-term care insurance) and receive a limited dollar reimbursement from the Retiree Health Plan for the cost of health insurance. There are two benefits:

1. Quarterly reimbursement in an amount equal to the lesser of the cost of private insurance or a specified maximum, based on the lowest cost early retiree HMO premium available under the Plan. This monthly maximum is generally adjusted each October 1st.
2. Prescription drugs through the Mandatory Generic Prescription Drug Plan – 30-day Walk-in \$0 Generic/\$10 Brand and Mail Order 100-day - \$0 Generic/\$10 Brand.

Choosing Between the Two HMO Plans, Premium Reimbursement or Medicare Supplement Plans

General Discussion – Choosing a Medical Plan That Best Suits Your Needs

As a participant in the Retiree Health Plan, you may select to enroll in either of the two Health Maintenance Organizations (HMOs), the Premium Reimbursement Plan, or the Medicare Supplement Plan. The two HMO plans are Kaiser and UnitedHealthcare.

This section is intended to help you become acquainted and familiar with the medical Plans available to you. Beginning on page 41 you will find a summary comparison of the two HMO plans in greater detail. For detailed and specific information about the benefits, exclusions and limitations of either of the two HMO plans (Kaiser and UnitedHealthcare) please refer to the specific *Evidence of Coverage* document provided by either Kaiser or UnitedHealthcare. Copies of Kaiser's and UnitedHealthcare's *Evidence of Coverage* documents are available from the Administrative Offices at no charge, or on the Trust Fund website.

Note: Refer to the section entitled "Mandatory Generic Prescription Drug Plan" for an explanation of your prescription drug coverage unless you are a spouse of a participant enrolled in Secure Horizons. Spouses of Secure Horizons participants are covered under the Secure Horizons Prescription Drug Plan. Refer to the Secure Horizons Plan.

Both Kaiser Senior Advantage and UnitedHealthcare Secure Horizons provide their own prescription drug program. Prescription drug coverage provided under both plans is considered creditable coverage. This means that the actual value of the HMO coverage is equal to or exceeds the actuarial value of standard prescription drug coverage under Medicare Part D. Therefore, do not enroll in Medicare Part D

HMO Medical Plans

In most cases, if you reside within the jurisdiction of the Southern California IBEW-NECA Health Trust Fund's Retiree Health Plan, you can select among a choice of HMO Plans. You have an opportunity to make a choice of health plans for medical benefits once each year. If you are enrolled in Medicare Parts A and B, you can choose Kaiser Permanente Senior Advantage or UnitedHealthcare Secure Horizons.

In order to enroll in an HMO, you must live within that HMO's service area. For Kaiser, the ZIP code of your home must be within Kaiser's service area which is defined by Kaiser's ZIP code listing. For UnitedHealthcare, you must live within a 30-mile radius of the Medical Group to which your selected primary care physician belongs.

Under the HMO Plans, covered services are generally provided without charge, or for a fixed copayment.

In this Summary Plan Description, you have been provided with General information for each of the two HMO's under contract with the Trust. However, this information is only a summary, included here for easy reference. For complete information on either of the HMO plans, you should contact the HMO directly or the Administrative Office and request that they send you the HMO's *Evidence of Coverage* document and other descriptive literature for the HMO in which you are interested or enrolled. Copies of these documents are also available on the Trust Fund's website.

A Health Maintenance Organization consists of a network of health care providers and facilities. In the case of Kaiser, the physicians are employees of Kaiser and Kaiser typically owns the facilities. In the case of UnitedHealthcare, the physicians are independent practitioners who contract with UnitedHealthcare to provide medical services to eligible participants. UnitedHealthcare also contracts with hospitals and other facilities to provide services to eligible participants. Each HMO provides an *Evidence of Coverage* document, which explains in detail the services and benefits provided, as well as the limitations and exclusions of their respective plans.

The HMO you select (Kaiser or UnitedHealthcare) will provide you with an *Evidence of Coverage* document and other descriptive literature after you enroll, including an identification card. The medical facilities you must use are listed in the HMO packet you will receive. Importantly, you must use the physicians, hospitals and other medical providers associated with the HMO you select.

Retirees and their eligible spouses, who use an HMO and are age 65 or eligible for Medicare Parts A and B, must enroll in Medicare. Medicare pays the HMO a fixed fee each month to provide you with all Medicare approved benefits. The benefits of the HMO are generally greater than that provided by private Medicare insurance.

There are two ways to find out if you live within either the UnitedHealthcare or Kaiser service area. For UnitedHealthcare, you can either call Member Services at (800) 624-8822, or you can log on to the UnitedHealthcare website at www.uhcwest.com. For Kaiser, you can either call Member Services at (800) 464-4000, or you can log on to the Kaiser website at www.kp.org.

Medicare Supplement Plan for Retirees/Spouses

Instead of selecting an HMO, you may elect the Medicare Supplement Plan which provides a supplement to the benefits you are entitled to under the Federal Medicare Program. When you become age 65 or eligible for Medicare, you must enroll in the Federal Medicare Program. Your spouse must enroll as soon as eligible.

The Medicare Supplement Plan then provides reimbursement to the benefits you are entitled to under Medicare, subject to a maximum payment of \$2,500 per person (employee or spouse) per year. The Medicare Supplement Plan also provides prescription drug coverage under the "Mandatory Generic Prescription Drug Plan", which includes a prescription drug benefit provided you are not enrolled in Medicare Part D. Again, you must be enrolled in Medicare Part A and Part B of the Federal Medicare Program to enroll in this Plan. The prescription drug benefits under the Mandatory Generic Prescription Drug Plan have been certified (notice of creditable coverage) by an actuary as equal to or greater than Medicare Part D benefits.

Premium Reimbursement Plan

The Premium Reimbursement Plan is for those retirees who live outside of the HMO service area; or retirees who do not wish to elect an HMO under contract with the Trust Fund or do not wish to elect the Medicare Supplement Plan. The Premium Reimbursement Plan provides an option to obtain private insurance on your own and receive a limited dollar reimbursement from the Retiree Health Plan for your private medical insurance. The Premium Reimbursement Plan also provides prescription drug benefits under the “Mandatory Generic Prescription Drug Program”. It offers retirees participating in the Retiree Health Plan the following three benefits:

- **Prescription Drug Plan**
You and your spouse, if covered, have prescription drug benefits under the Mandatory Generic Drug Plan. Refer to the section entitled “Mandatory Generic Prescription Drug Plan”.
- **Quarterly Reimbursement**
You receive reimbursement, on a quarterly basis. Reimbursement is based on the lesser of:
 1. Lowest Trust Fund Early Retiree HMO Plan cost per person; or
 2. The cost of your private insurance.
- **Future HMO Enrollment if Outside Service Area of HMOs.** If you remain a participant in the voluntary Retiree Health Plan, you would later be eligible to enroll in one of the Health Maintenance Organizations (HMOs) offered (Kaiser Permanente Senior Advantage, UnitedHealthcare Secure Horizons) if you move to the service area of either of the HMO Plans. Also, when you (and your eligible spouse) receive Medicare benefits, either by reaching age 65 or from Social Security Disability Benefits, you would become eligible to participate in the Medicare Supplement Plan, which is available regardless of where you live in the United States. The Plan reimburses you for the annual Medicare deductible and the 20% of covered charges not paid by Medicare, up to a maximum annual payment of \$2,500 for you and \$2,500 for your spouse (if eligible).

Comparison of Kaiser HMO & UnitedHealthcare

HMO Medical Plans

- The benefits chart on the following page is only a representative summary of the coverage and benefits available under the two HMO plans, Kaiser and UnitedHealthcare. It does not fully describe your coverage and benefits under either of the HMO plans. For details on your coverage and benefits, please refer to the respective HMO's *Evidence of Coverage* document. The *Evidence of Coverage* document is the legal document that describes the benefits, limitations, exclusions, and other coverage provisions provided by either HMO to its members. The current *Evidence of Coverage* document is available directly from the HMO (Kaiser or UnitedHealthcare), as well as from the Administrative Office upon request.
- An HMO physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat your medical condition. The services and supplies must be provided, prescribed, authorized, or directed by an HMO physician. You must receive the services and supplies at an HMO facility inside the HMO's service area, except where specifically noted to the contrary in the respective HMO's *Evidence of Coverage* document.
- For details on the benefit and claim review and adjudication procedures for either HMO, please refer to the respective HMO's *Evidence of Coverage* document or contact the HMOs Membership Services Department at:

Kaiser: 1-800-464-4000

UnitedHealthcare: 1-800-624-8822

You may also contact HealthAdvocate at 1-866-695-8622.

Southern California IBEW-NECA Health Trust Fund		
Comparison of Medical Plan Offerings – Early Retirees		
Vendor	Kaiser HMO (In Network Only)	UnitedHealthcare (In Network Only)
<p>This is only a summary of the benefits available to you under the Kaiser and UnitedHealthcare HMO Plans. For a complete description of the respective HMO's benefits, please refer to the carrier's EVIDENCE OF COVERAGE AND DISCLOSURE DOCUMENT. The EVIDENCE OF COVERAGE AND DISCLOSURE DOCUMENT is the legal document that describes the benefits, exclusions and limitations and other coverage provisions including claims appeals, claims review and adjudication procedures.</p>		
Member Customer Service Number	800-464-4000	800-624-8822
Website	www.kp.org	www.uhcwest.com
<u>General Features</u>		
Calendar Year Deductible	None	None
Maximum Benefits	Unlimited	Unlimited
Annual Co-payment Maximum	\$1500 per Individual, \$3,000 per family	\$1000 per Individual, \$3,000 per family
Hospital Benefits	No Charge	No Charge
Emergency Services <i>Co-pay waived if admitted</i>	\$5 co-payment	\$50 co-payment
Urgently Needed Services <i>Medically Necessary services required outside geographic service area by Primary Medical Group</i>	\$5 co-payment	\$50 co-payment
Preexisting Conditions	Not Applicable. All conditions are covered provided the service is a covered benefit.	
<u>Benefits Available While Hospitalized as an Inpatient</u>		
Alcohol, Drug or Other Substance Abuse Detoxification	No Charge	No Charge
Mental Health Services <i>As required by law, coverage includes treatment for Severe Mental Illness (SMI) of adults and the treatment of Serious Emotional Disturbance (SED).</i>	No Charge	No Charge
Newborn Care	No Charge	No Charge
Physician Care	No Charge	No Charge
Reconstructive Surgery	No Charge	No Charge
Rehabilitative Care <i>Including physical, occupational and speech therapy</i>	No Charge	No Charge

Southern California IBEW-NECA Health Trust Fund		
Comparison of Medical Plan Offerings – Early Retirees		
Vendor	Kaiser HMO (In Network Only)	UnitedHealthcare (In Network Only)
Skilled Nursing Facility <i>Up to 100 Consecutive Days from the first treatment per disability</i>	No Charge	No Charge
<u>Benefits Available on an Outpatient Basis</u>		
Alcohol, Drug or Other Substance Abuse Detoxification	\$5 Per Visit	No Charge
Ambulance	No Charge	No Charge
Durable Medical Equipment	No Charge	No Charge
Voluntary Termination of Pregnancy <i>Medical, medication, surgical</i>		
1st Trimester	\$5 Co-payment	\$75 Co-payment
2nd Trimester (12 – 20 weeks)	\$5 Co-payment	\$150 Co-payment
After 20 weeks <i>Not covered unless mother's life is in jeopardy or fetus is not viable.</i>		Not covered unless Medically Necessary, such as the mother's life is in jeopardy or fetus is not viable.
Laboratory Services <i>When available through or authorized by PCP</i>	No Charge	No Charge
Maternity Care, Tests Procedures	No Charge	No Charge
Mental Health Services <i>As required by law, coverage includes treatment for Severe Mental Illness (SMI) of adults and the treatment of Serious Emotional Disturbance (SED)</i>	\$5 Office Visit Co-payment	\$5 Office Visit Co-payment
Oral Surgery Services <i>No dental</i>	No Charge	No Charge
Outpatient Medical Rehabilitation Therapy <i>At Participating Free Standing or Outpatient Surgery Facility</i>	\$5 Office Visit Co-payment	\$5 Office Visit Co-payment
Outpatient Surgery <i>At Participating Free Standing or Outpatient Surgery Facility</i>	\$5 Co-payment	No Charge
Periodic Health Evaluations <i>Physician, laboratory, radiology and related services as recommended by the American Academy of Pediatrics (AAP). Advisory Committee on Immunization Practices (ACIP) and U.S. Preventive Services Task Force and authorized through PCP</i>	\$5 Office Visit Co-payment	\$5 Office Visit Co-payment
Physician Office Visit	\$5 Office Visit Co-payment	\$5 Office Visit Co-payment

Southern California IBEW-NECA Health Trust Fund

Comparison of Medical Plan Offerings – Early Retirees

Vendor	Kaiser HMO (In Network Only)	UnitedHealthcare (In Network Only)
<i>Well-Woman Care, Includes PAP smear By PCP or an OB/GYN in PMG and a referral by the PMG for screening mammography as recommended by the U.S. Preventive Services Task Force</i>	\$5 Office Visit Co-payment	No Charge

Southern California IBEW-NECA Health Trust Fund		
Comparison of Medical Plan Offerings - Medicare Retirees		
Vendor	(Kaiser) Senior Advantage	(UnitedHealthcare) Secure Horizons
<p>This is only a summary of the benefits available to you under the Kaiser and UnitedHealthcare HMO Plans. For a complete description of the respective HMO's benefits, please refer to the carrier's EVIDENCE OF COVERAGE AND DISCLOSURE DOCUMENT. The EVIDENCE OF COVERAGE AND DISCLOSURE DOCUMENT is the legal document that describes the benefits, exclusions and limitations and other coverage provisions including claims appeals, claims review and adjudication procedures.</p>		
Member Service Number	<u>800-464-4000</u>	<u>800-457-8506</u>
Website	<u>www.kp.org</u>	<u>www.uhretiree.com</u>
<u>General Features</u>		
Calendar Year Deductible	None	None
Maximum Benefits	Unlimited	Unlimited
Annual Co-payment Maximum	\$1,500 per Individual, \$3,000 per family	\$6,700
Hospital Benefits	No Charge	No Charge
Emergency Services <i>Co-pay waived if admitted</i>	\$5 co-payment	\$20 co-payment
Urgently Needed Services <i>Medically Necessary services required outside geographic area service by Primary Medical Group</i>	\$5 co-payment	\$15 co-payment
Pre-existing Conditions	Not Applicable. All conditions are covered provided they are a covered benefit.	
<u>Benefits Available While Hospitalized as an Inpatient</u>		
Alcohol, Drug or Other Substance Abuse Detoxification	No Charge	No Charge
Mental Health Services <i>As required by law, coverage includes treatment for Severe Mental Illness (SMI) of adults and the treatment of Serious Emotional Disturbance (SED)</i>	No Charge	No Charge
Physician Care	No Charge	No Charge
Reconstructive Surgery	No Charge	No Charge
Rehabilitative Care Including physical, occupational and speech therapy)	No Charge	No Charge
Skilled Nursing Facility <i>Up to 100 Consecutive Days from the first treatment per disability</i>	No Charge	No Charge
<u>Benefits Available on an Outpatient Basis</u>		

Southern California IBEW-NECA Health Trust Fund		
Comparison of Medical Plan Offerings - Medicare Retirees		
Vendor	(Kaiser) Senior Advantage	(UnitedHealthcare) Secure Horizons
Alcohol, Drug or Other Substance Abuse Detoxification	\$5 Per Individual Visit, \$2 Per Group Visit	\$5 Co-payment
Ambulance	No Charge	No Charge
Durable Medical Equipment	No Charge	No Charge
Mental Health Services <i>As required by law, coverage includes treatment for Severe Mental Illness (SMI) of adults and the treatment of Serious Emotional Disturbance (SED)</i>	\$5 Per Individual Visit, \$2 Per Group Visit	\$5 Office Visit Co-payment
Oral Surgery Services <i>No dental</i>	No Charge	No Charge
Outpatient Medical Rehabilitation Therapy <i>At Participating Free Standing or Outpatient Surgery Facility</i>	\$5 Office Visit Co-payment	\$5 Office Visit Co-payment
Outpatient Surgery <i>At Participating Free Standing or Outpatient Surgery Facility</i>	\$5 Office Visit Co-payment	No Charge
Periodic Health Evaluations <i>Physician, laboratory, radiology and related services as recommended by the American Academy of Pediatrics (AAP) Advisory Committee on Immunization Practices (ACIP) and U.S. Preventive Services Task Force and authorized through the PCP</i>	\$5 Office Visit Co-payment	No Charge
Physician Office Visit	\$5 Office Visit Co-payment	\$5 Office Visit Co-payment
Prescription Drugs		
RETAIL		
Generic	\$5 copayment, up to a 100 day supply	\$5 copayment, up to a 30 day supply
Brand	\$15 copayment, up to a 100 day supply	\$15 copayment, up to a 30 day supply
MAIL ORDER		
Generic	\$5 copayment, up to a 100 day supply	\$10 copayment, up to a 30 day supply
Brand	\$15 copayment, up to a 100 day supply	\$30 copayment, up to a 30 day supply
Well-Woman Care, Includes PAP smear <i>Group by PCP or an OB/GYN in Primary Medical Group and a referral by the Primary Medical Group for screening mammography as recommended by the U.S. Preventive Services Task Force</i>	\$5 Office Visit Co-payment	No Charge

Online Internet Website – Kaiser Permanente

www.members.kp.org

Kaiser maintains Kaiser Permanente Online, a confidential interactive Web site offering convenient services, instant information, and personal advice from health care professionals. Some of the services available to you online are as follows:

- Schedule an appointment
- Consult with a pharmacist
- Join an online discussion
- Locate Kaiser facilities
- Research health education classes
- Get your own customized health assessment

Online Internet Website – UnitedHealthcare

www.UnitedHealthcare.com

United \Healthcare maintains a web site, which can provide you with valuable assistance about many topics. Some of the information available to you online is as follows:

- Provider directories
- Customer services information and answers to your health care questions
- Health tip of the day
- Online magazines with information on specific health issues
- Childcare and pregnancy information for mothers and mothers-to-be and “Healthy Baby” with UnitedHealthcare
- Send UnitedHealthcare an e-mail with questions about your health plan and you will receive a response either by phone or e-mail.

Death Benefit for Retirees

IMPORTANT: FILE A BENEFICIARY FORM

A self-funded benefit is provided to eligible retirees who retired under the Southern California IBEW-NECA Pension Plan on or after June 1, 1981 as outlined below:

Amount of Coverage

The amount shown is the maximum amount payable by the Trust.

Retiree Only Death Benefit - \$1,000

Manner of Payment

The death benefit will be paid in a lump sum.

Beneficiary

“Beneficiary” means the person(s) named by the retiree to receive the death benefit proceeds upon his or her death.

A retiree may name or change the person(s) named by the retiree at any time by filing a beneficiary form, which is available from the Administrative Office. You should also remember to change your beneficiary form if there is a change in your marital status.

If any death benefit payment has been made before any change in beneficiary is received by the Administrative Office, the Plan does not have to pay this amount again.

If more than one beneficiary is named, they shall share equally unless otherwise stated.

When a beneficiary dies before the retiree, payment shall be made to any remaining beneficiary(ies) in the same ratio that proceeds were made payable among other beneficiaries unless otherwise stated.

If no beneficiary is named or no beneficiary survives the retiree, proceeds shall be made in the following order;

1. The surviving spouse;
2. The surviving children, equally;
3. Mother and father equally or to the surviving parent;
4. The executors or administrators.

Mandatory Generic Prescription Drug Plan

If you are eligible for health benefits provided by the Southern California IBEW-NECA Health Trust Fund (Kaiser HMO or UnitedHealthcare HMO), then you and your eligible spouse are entitled to prescription drug benefits, as described herein.

The Mandatory Generic Prescription Drug Plan is designed to help you meet the cost of prescription drugs prescribed by your doctor, for you or your eligible spouse, for the treatment of illness or injury.

You must use a generic drug substitute whenever it is available. If you or your doctor requests a brand-name drug instead of a generic equivalent, you will be charged the difference in cost between the brand-name drug and the generic, in addition to the copayment applicable to the quantity and type of drug prescribed. The copayments, which vary depending on the type of drug prescribed and the quantity dispensed, are shown on the following page.

To fill your prescription, you can use any of the following:

- Walk-In Pharmacy Plan (contracted network of pharmacies)
- Mail Service Pharmacy Plan
- The participant may contact the Administrative Office to request a direct member reimbursement form for purchasing prescriptions out of network, or may download the form from the Trust's website at www.scibew-neca.org.

Each Plan is described in greater detail in the following sections.

Walk-In Pharmacy Plan

Mandatory Generic Prescription Drug Plan

Generic Drug: \$0 Copayment per Prescription for up to a 30-day supply

Brand-Name Drug: \$10 Copayment per Prescription for up to a 30-day supply

Maintenance Medications as described below:

Generic Drug: \$0 Copayment per Prescription for up to a 100-day supply

Brand-Name Drug: \$20 Copayment per Prescription for up to a 100-day supply

To obtain a prescription as outlined in this section for a fixed co-payment, you must use a network pharmacy. The pharmacy network is extensive and includes most major chains and many independent pharmacies. A listing of the California network pharmacy chains is included at the end of this section.

You simply pay directly to the pharmacy a copayment for each prescription. The Plan allows up to a 30-day supply, or up to a 100-day supply if a maintenance drug is prescribed by your doctor. As a cost-containment feature, the Plan requires that you use a generic drug substitute when it is available.

It is important to note, however, that if the prescription calls for a brand name, the pharmacist will dispense the generic drug whenever a generic equivalent is in stock and may legally be substituted for the prescribed brand name.

If you or your doctor requests a brand-name drug instead of a generic equivalent, you will be charged the difference in cost between the brand-name drug and the generic, in addition to the copayment applicable to the quantity and type of drug prescribed. The copayments, which vary depending on the type of drug prescribed and the quantity dispensed, are shown above on this page.

Mail Service Prescription Drug Plan **(For Maintenance Medications Only)**

Generic Drug: \$0 Copayment per Prescription for up to a 100-day supply

Brand-Name Drug: \$20 Copayment per Prescription for up to a 100-day supply

A Mail Service Prescription Drug Plan is available for maintenance medications. Maintenance medications are prescribed for such conditions as high blood pressure, diabetes, heart disease, ulcers, arthritis and other chronic conditions. You may obtain up to a 100-day supply of a maintenance medication drug for your \$0 Generic or \$20 Brand-Name copayment (when there is no generic equivalent for the brand-name drug). Maintenance prescription drugs will be mailed directly to your home. Your prescription should arrive within seven working days after your order is received at the Mail Service Pharmacy. The Prescription Benefit Manager pays all mailing expense for standard deliveries.

Your copayment can be paid by check, money order, or credit card. Your prescription can be sent in a pre-printed envelope supplied by the Prescription Benefit Manager and your medication will be delivered to your home within seven working days after your order is received. You can order refills over the Internet or by phone. You can contact Citizens Rx at 1-888-545-1120 or at <http://www.citizensrx.com>.

Non-Participating Pharmacy Reimbursement Plan

Generic Drug: \$5 Copayment per Prescription – for up to a 30 day supply

Brand-Name Drug: \$15 Copayment per Prescription – for up to a 30 day supply

In addition, Limits on Drug Claim Reimbursement

You may go to any non-network pharmacy of your choice. Under this Trust Fund you must contact the Administrative Office to request a direct member reimbursement form for purchasing prescriptions from non-participating pharmacies. You will be reimbursed for the prescription based on a limited formula, less a copayment of \$5 for each generic drug prescribed or \$15 for each brand-name drug prescribed, up to a 30-day supply.

Under this Trust Fund you may be responsible for most of the drug cost; therefore you are encouraged to use the participating Walk-In Pharmacy or Mail Service Prescription Drug Plan whenever possible. This Plan is intended for emergency purposes (for example traveling away from home) or other emergency situations.

How to File a Claim

Claim forms may be obtained from the Administrative Office or from the website at www.scibew-neca.org. One portion of the claim form is to be completed by you, the other by the pharmacy. Claim forms must be filed within 15 months of the date of the drug charge to be eligible for reimbursement. Contact the Administrative Office for information as to where the completed claim form may be mailed.

Claim Payments

Claims will generally be processed within 30 days from the date the claim is received by the Pharmacy Benefit Manager.

Covered Benefits

The Mandatory Generic Prescription Drug Plan covers the following services and materials:

- Federal Legend Drugs: Any medicinal substance which bears the legend, “*Caution: Federal law prohibits dispensing without a prescription.*”
- State Restricted Drugs: Any medicinal substance, which may be dispensed by prescription only according to state law.
- Federal Legend Oral Contraceptives/Birth control pills
- Contraceptive products, including, but not limited to Diaphragms, Cervical Caps, Depo-Provera Injection and Ortho-Evra Patches.
- Inhaler extender devices and bags (Aerochamber™, Aerochamber™, w/ mask, Easivent™, Inspirsease™, EZ-Spacer™, Optichamber™, Optihaler™, Ellipse, etc.) are part of the pharmacy benefit.
- Anaphylaxis prevention kits, including but not limited to Epi-Pen®/Epi-Pen Jr.®, Ana-Kits®, Ana-Kit Jr.®, Glucagon, Glucagon Emergency Kit, and Ana-Guard®.
- Compounds with at least one federal legend or state restricted ingredient.
- Normal saline for inhalation and irrigation
- Prescription prenatal vitamins
- Injectables (see also Exclusions for exceptions)

The following non-prescription items are also covered when prescribed in writing by a physician and dispensed by a licensed pharmacist:

- Insulin, insulin syringes and needles
- Blood glucose test strips
- Urine glucose test strips
- Sterile lancets
- Novolin Pen, Humulin Pen, Prefilled pens, Penneedles; cartridges

Limitations

The following items are a covered benefit subject to the limitations as stated below:

- Drugs to treat erectile dysfunction (including but not limited to Viagra, Cialis and Levitra) – coverage will be for prescriptions limited to a maximum of eight (8) pills for a 30-day supply.
- Smoking deterrents when prescribed in writing, by a physician, subject to the following limitations: up to 90 days supply per year; lifetime maximum benefit, 180 days supply. This limitation applies to smoking deterrents received from both retail and mail pharmacy outlets. It is recommended you discuss a treatment plan with your physician. There are many products to assist you in smoking Cessation. These include the following:
 - Nicotine Patches
 - Nicotine Gum
 - Nicotine Nasal Spray (Rx Required)
 - Nicotine Inhalers (Rx Required)
 - Nicotine Lozenges
 - Zyban (Bupropion) (Rx Required)
- Morning after pills & kits (i.e., Preven, Plan B) - (limited to 2 total per person per 365 days)

Exclusions

The following items are not covered:

- If enrolled in an HMO (Kaiser or UnitedHealthcare), all injectables, except insulin, which are included as part of your medical benefit to be administered in a doctor's office, and are an exclusion, Mandatory Generic Drug Plan, and out-of-network plans.
- Drugs for which no charges are made, of which are provided under any Workers' Compensation or similar benefit or for which reimbursement is provided by any federal, state, or other governmental agency.
- Medications available without a prescription (over-the-counter) or prescription medications for which there is a non-prescription equivalent available, even if ordered by a physician via a prescription, except as listed under Covered Drugs
- Infertility drugs.
- Anorexiant/appetite suppression weight loss drugs.
- Medications for the treatment of sexual dysfunction (except drugs to treat erectile dysfunction, such as Viagra, Cialis and Levitra).
- Medications to be taken or administered to the eligible member while he is a patient in a hospital, nursing home (skilled nursing care only), rest home, sanitarium, etc.
- Medications used for cosmetic purposes (For example: Renova, Rogaine, Vaniqa, Penlac, Pigmenting & Depigmenting agents).
- Medical devices, therapeutic devices or appliances including hypodermic needle syringes, (except insulin syringes) support garments and other non-medicinal substances (unless listed as covered).
- Drugs or medicines purchased and received prior to the member's effective date or subsequent to the member's termination.

- Drugs or medicines delivered or administered to the member by a prescriber or prescriber's staff. For example, drugs administered, injected, or dispensed by a physician.
- Medications prescribed for experimental or non-FDA approved indications unless prescribed in a manner consistent with a specific indication in Drug Information for the Health Care Professional, published by the United States Pharmacopoeial Convention, or in the American Hospital Formulary Services edition of Drug Information; medications limited to investigational use by law.
- All homeopathic medications.
- Unit dose drugs (unless only available as unit dose).
- Vitamins (other than prescription prenatal vitamins).
- Dental related products (prescription oral & topical fluoride, Peridex, Atridox, Periostat).
- Drug claims submitted after 15 months of the date the drug was dispensed.
- Biological sera.
- Blood and Blood plasma.

Pharmacy Benefit Manager California Pharmacy Chains

The Pharmacy Benefit Manager maintains a web site which can provide you with valuable assistance, including the most up-to-date list of nationwide pharmacies. The website address is <https://www.citizensrx.com>. You can also call them at 1-888-545-1120.

The following is a list of retail prescription vendors in the State of California that are contracted with the Prescription Benefit Manager as of the date of printing of this Summary Plan Description:

Albertsons
Big "A" Drug Stores
Costco
CVS
Gemmel Pharmacy
Horton and Converse
K-Mart Pharmacies
Longs
Medicine Shoppe
Pavilions Pharmacies
Raley's Super Stores
Ralphs
Rite Aid
Safeway Pharmacy
Save Mart Supermarkets
Sav-On Drugs
Scolari's Food & Drug
Shopko Stores
Target
Vons/ Pavilions Pharmacies
Walgreens

Dental Plans Available to Disability Pensioners on Medicare Parts A and B Under Age 65

You get a choice of one of the following:

- United Concordia Plan (PPO)
- CIGNA Dental Plan (DHMO)
- DeltaCare USA Dental Plan (DHMO)
- MetLife/Safeguard Dental Plan (DHMO)
- United Concordia Dental Plan (DHMO)

The Trust Fund offers five dental plans from which to choose: a dental Preferred Provider Organization (PPO) plan and four Dental Health Maintenance Organizations (DHMO) plans. The dental PPO plan is provided by United Concordia. The four DHMO plans are CIGNA, DeltaCare USA (also known as Delta Dental), MetLife/Safeguard, and United Concordia. We suggest that you carefully review all of the Plans, and discuss these different Plan options with your eligible spouse. A brief overview of the United Concordia PPO Plan and the four DHMO plans (CIGNA, DeltaCare USA, MetLife/Safeguard and United Concordia) begins on page 56. Please refer to your *Evidence of Coverage* document for a complete description of your dental benefits, including the exclusions and limitations.

**Comparison of Dental Benefits Available to Disability Pensioners
on Medicare Parts A and B Under Age 65**

This summary of the DHMOs' benefits, exclusions, limitations, and other provisions affecting dental benefits is not intended to take the place of the respective DHMO's *Evidence of Coverage* document or Schedule of Benefits. Please refer to your Evidence of Coverage and Disclosure Document for a complete description of your dental benefits, including the exclusions and limitations. In the event of any conflict between the information summarized in this section and the DHMO's Certificate of Insurance document or Schedule of Benefits, the DHMO's Certificate of Insurance document or Schedule of Benefits shall govern.

Dental Provider Name	United Concordia (PPO) In-Network/ Out-of-Network	CIGNA (DHMO) In-Network Only	DeltaCare (DHMO) In-Network Only	MetLife (DHMO) In-Network Only	United Concordia (DHMO) In-Network Only
Member Service Number	800-332-0366	800-CIGNA-24	800-422-4234	800-880-1800	866-357-3304
Website Address	unitedconcordia.com	cigna.com	deltadentalins.com	metlife.com/mybenefits	unitedconcordia.com
Claims Filing Address <i>Applies to PPO Plan Only</i>	P.O. Box 69421 Harrisburg, PA 17106-9422				
Member Copayment					
Annual Deductible					
Per Individual	\$0/\$25	N/A	N/A	N/A	N/A
Per Family	\$0/\$75	N/A	N/A	N/A	N/A
Annual Maximum <i>Waived for Diagnostic and Preventive</i>					
Per Individual	\$2,500/ \$2,000	N/A	N/A	N/A	N/A
Per Family	N/A	N/A	N/A	N/A	N/A
Diagnostic/Preventive (X-rays, Exams, Cleanings)	0%/0%, Plus Balance Billing	\$0	\$0	\$0	\$0 (Copay for white filings)
Basic <i>Fillings, Sealants, Oral Surgery, Root Canals</i>	5%/20% Plus Balance Billing	\$0 - \$25	\$0 - \$220	\$0 - \$130	\$0
Major <i>Crowns & Casts, Dentures, Bridges and Implants</i>	25%/50% Plus Balance Billing	\$22 - \$340	\$0 - \$195 – Implants not covered	\$0 - \$75	\$0 (Cost for metal crowns and bridges)
EMERGENCY SERVICES					
Emergency Exam	25%/50% Plus Balance Billing	\$0	\$5	\$0	\$0

Vision Benefits Available For Disability Pensioners On Medicare Parts A and B Under Age 65

Vision Benefits

Vision Service Plan (VSP) or Kaiser Vision Plan

If you are enrolled for health benefits under the **UnitedHealthcare HMO Plan** provided by the Southern California IBEW-NECA Health Trust Fund, then you are entitled to vision benefits as described herein.

If you are enrolled in the **Kaiser HMO Plan**, you are provided separate vision benefits through Kaiser and are not eligible for the Vision Service Plan coverage as described below.

Benefits

Vision Examination. A complete analysis of the eyes and related structures to determine the presence of vision problems, or other abnormalities.

Lenses. The VSP Providers will order the proper lenses (only if needed). The program provides the finest quality lenses fabricated to exacting standards. The doctor also verifies the accuracy of the finished lenses.

Frames. The Plan offers a wide selection of frames. However, if you select a frame that costs more than the amount allowed by the Plan, there will be an additional charge. If you order frames through a VSP doctor, you will receive a 20% reduction in the amount of the cost of the frames which exceeds VSP's allowance.

Contact Lenses. Contact lenses are in lieu of frames and lenses for your eligibility period.

Cosmetic contact lenses, when chosen by patients will have an allowance made toward their cost by VSP.

Copayments and Schedule of Benefits for Disability Pensioners on Medicare Parts A and B Under Age 65

UnitedHealthcare Plan Participants				
Benefit	Frequency (Based on service year)	Copayment	Coverage from a VSP Doctor	Out-of-Network Reimbursement
Exam	12 months	\$5	Covered in full after the copayment.	Up to \$45 allowance
Prescription Eyewear – If you choose contact lenses you will be eligible for frame 12 months from the date the contact lenses were obtained.				
Lenses	12 months	\$10 (lenses and/or frame)	Single vision, lined bifocal and lined trifocal lenses are covered in full after the copayment.	Single vision up to \$45 allowance Lined bifocal up to \$65 allowance Lined trifocal up to \$85 allowance
Frame – As Provided by VSP	24 months	\$10 (lenses and/or frame)	Covered up to \$120 allowance	Up to \$47 allowance
Contact Lenses*	12 months		Covered up to \$105 allowance	Up to \$105 allowance

**Your allowance applies to the cost of your contact lens exam and your contact lenses. You'll receive a 15 percent savings off the cost of your contact lens exam from a VSP doctor. Your contact lens exam is in addition to your routine eye exam to check for eye health risks associated with improper wearing or fitting of contacts.*

You may get regular glasses (frames and lenses) twelve months after you get contact lenses.

Kaiser Vision Plan	
Vision Benefit	Co-pay/Allowance
Eye refraction exams to determine the need for vision correction and to provide a prescription for eyeglasses	\$5 per visit
Regular plastic eyeglass lenses every 24 months	\$100 Allowance*
An eyeglass frame every 24 months	
Medically necessary contact lenses	No charge

**An allowance is the total expenses of an item that is covered. If the cost of the item you select exceeds the allowance, you must pay the difference*

Using the Plan

To obtain vision care from the Vision Service Plan, do the following:

- 1) Contact the membership services department at the Administrative Office for a VSP brochure, or call your VSP doctor. If you need to locate a VSP doctor, call VSP at (800) 877-7195 or visit their web site at www.vsp.com. If you would like a list of VSP doctors (optometrists and ophthalmologists) near where you live, a list will be sent to you.
- 2) When making an appointment, identify yourself as a VSP member. The VSP doctor will also need the covered member's identification number (usually the member's Social Security Number), and the covered member's group name. The VSP doctor will contact VSP to verify your eligibility and Plan coverage. The VSP doctor will also obtain authorization for services and materials. If you are not eligible, the VSP doctor will notify you.
- 3) At your appointment, the VSP doctor will conduct an eye examination and determine if corrective eyewear is necessary. If so, the VSP doctor will submit your prescription to a VSP-approved, contract laboratory. The VSP doctor will itemize any non-covered charges and have you sign a form to document that you received the services. VSP will pay the VSP doctor directly, according to their contract agreement, less any copayments you may be required to pay as set forth above.
- 4) Selecting a doctor from the VSP list assures direct payment to the doctor and a guarantee of quality and cost control. However, if you seek the services of a provider who is not a VSP doctor, you should pay the provider his/her full fee at the time of service and submit your receipts to VSP. VSP will reimburse you directly in accordance with the schedule of allowances. VSP will not reimburse the non-VSP provider.

There is no assurance that this schedule will be sufficient to pay for the examination or the glasses. When you obtain service from a provider who is not a VSP doctor, and/or glasses from a dispensing optician, be sure to mail your itemized statement of charges to VSP so VSP can reimburse you directly. All claims must be submitted within six months of the date services are completed.

Non-Panel Providers

If you do not wish to seek services from a doctor who is a member of the VSP network, you may go to any other licensed vision provider, pay the provider his/her full fee, and be reimbursed by VSP in accordance with the reimbursement schedule listed in the "Schedule of Benefits" shown above. To receive reimbursement you need to send your itemized receipt to VSP within six months from your date of service. You should include the covered member's name, phone number, address, member ID, the name of the group, the patient's name, date of birth, phone number and address, and the patient's relationship to the covered member (spouse.) along with your itemized receipt.

Please keep a copy of the information for your records and send the originals to the following address: VSP, OON Claims, P.O. Box 997105, Sacramento, CA 95899-7105.

Limitations

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

- A) Blended lenses;
- B) Contact lenses (except as noted elsewhere herein);
- C) Oversize lenses;
- D) Progressive multifocal lenses;
- E) Photochromic lenses or tinted lenses other than Pink #1 or #2;
- F) Coated lenses;
- G) Laminated Lenses;
- H) A frame that costs more than the Plan allowance;
- I) Certain limitations on low vision care;
- J) Cosmetic lenses;
- K) Optional cosmetic processes; or
- L) UV protected lenses.

Not Covered. There is no benefit for professional services or materials connected with:

- A) Orthoptics or vision training and any associated supplemental testing.
- B) Plano lenses (non-prescription).
- C) Two pair of glasses in lieu of bifocals.
- D) Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.
- E) Medical or surgical treatment of the eyes.
- F) Any eye examination, or any corrective eyewear, required by an Employer as a condition of employment.
- G) Corrective vision services, treatments, and materials of an experimental nature.

Complaints

If you have a complaint regarding VSP's service or claim payment, you should send a complaint to VSP by using the complaint form which is available in all VSP doctor offices as well as from the Administrative Office. You should send the complaint form to:

Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670-7985

You may also call VSP's toll-free Customer Care Division at (800) 877-7195, Monday through Friday, 5:00 a.m. to 7:00 p.m., Pacific Standard Time.

Disclosure Information

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

1) Name and type of administration of the Plan:

The name of the Plan is the Southern California IBEW-NECA Health Trust Fund. The Plan is administered by the Board of Trustees of the Southern California IBEW-NECA Health Trust Fund, a collectively bargained, jointly-trusted labor-management Trust Fund.

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

Joanne Keller, Administrator
6023 Garfield Avenue
Commerce, CA 90040
(Service of legal process may also be made upon any Trustee)

3) Administrative Office of the Plan Administrator:

6023 Garfield Avenue
Commerce, CA 90040
Administrator: Joanne Keller
Executive Director: George Wallace

4) Names, titles, and addresses of the Trustees:

Labor Trustees (IBEW Local #11)

Marvin Kropke, Chairman
c/o Administrative Office
6023 Garfield Avenue
Commerce, CA 90040

Joel Barton
c/o Administrative Office
6023 Garfield Avenue
Commerce, CA 90040

Eric Brown
c/o Administrative Office
6023 Garfield Avenue
Commerce, CA 90040

Management Trustees (NECA)

James M. Willson, Secretary
c/o Administrative Office
6023 Garfield Avenue
Commerce, CA 90040

Steve Watts
c/o Administrative Office
6023 Garfield Avenue
Commerce, CA 90040

Cathy O'Bryant
c/o Administrative Office
6023 Garfield Avenue
Commerce, CA 90040

Dean Todd, Alternate
c/o Administrative Office
6023 Garfield Avenue
Commerce, CA 90040

Dick Reed, Alternate
c/o Administrative Office
6023 Garfield Avenue
Commerce, CA 90040

5) Source of financing of the Plan and identity of any of the organizations through which benefits are provided:

Payments are made to the Trust by individual Employers under the provision of the applicable Collective Bargaining Agreements and self-payments are required for participation in the Retiree Health Plan.

The Trustees provide a choice of hospital/medical programs.

The following organizations provide benefits by virtue of contracts with the Board of Trustees as follows:

Kaiser Foundation Health Plan, Inc. – *HMO Hospital/Medical Benefits*

UnitedHealthcare of California – *HMO Hospital/Medical Benefits*

Citizen's Rx – *Self-Funded Prescription Drug Benefits*

CIGNA – *DHMO Dental Benefits*

Delta Dental (DeltaCare USA) - *DHMO Dental Benefits*

MetLife/Safeguard Dental – *DHMO Dental Benefits*

United Concordia – *PPO AND DHMO Dental Benefits*

Vision Service Plan – *Vision Benefits*

HealthAdvocate – *Advocacy and Assistance Services*

6) Date of the end of the Plan Year: June 30

7) Internal Revenue Service Plan Identification Number: No. 95-6140101

8) A description of the relevant provisions of any applicable collective bargaining agreement:

The Plan is maintained pursuant to Collective Bargaining Agreements between Local #11 of the International Brotherhood of Electrical Workers, AFL-CIO and the L.A. County Chapter of the National Electrical Contractors Association. Copies of Collective Bargaining Agreements may be obtained by Plan participants from the Union or Administrative Office without charge upon written request. Additionally, Collective Bargaining Agreements may be examined by Plan participants at the Administrative Office of the Trust Fund during regular business hours.

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

Claims & Appeal Rules

Introduction

The Claims & Appeal Rules described in this section ***do not apply*** to the following plans:

1. Kaiser HMO Medical Plan (including the Kaiser vision benefit)
2. UnitedHealthcare HMO Medical Plan
3. United Concordia PPO Plan
4. CIGNA DHMO Dental Plan
5. Delta Dental DHMO Plan
6. United Concordia DHMO Dental Plan
7. MetLife/Safeguard DHMO Dental Plan

Benefits provided to eligible Participant and spouse by the above Health Maintenance Organizations (HMO's), Dental Health Maintenance Organizations (DHMO's) and Dental PPO Plan are subject to the claims and appeal rules established by each of the above providers. You should review the program's Evidence of Coverage document and contact the provider directly for its claims review or grievance procedure. The Administrative Office can provide you with information on where to write.

On or after July 1, 2002 the following rules have been adopted by the Trustees regarding all eligibility appeals and claims appeals for those enrolled in the Mandatory Generic Prescription Drug Plan, the Medicare Supplement Plan and the Premium Reimbursement Plan.:

It is the intent and desire of the Trustees that these rules be consistent and comply with applicable regulations, including but not limited to 29 CFR 2560. et. seq. These rules shall be construed in accord with that intent. Those regulations are incorporated here as though set forth in full. The regulations shall be construed in accord with Department of Labor guidance issued subsequent to issuance of the regulations.

Pre-Service Claims

Pre-service claims are for benefits that require pre-authorization before you receive medical care.

There is no pre-certification requirement for prescription drug coverage.

Your eligibility appeal involving any Pre-Service Claim with your medical provider will be dealt with by the Trustees within 72 hours. All eligibility appeals involving post-service claims will be considered by the Board of Trustees at their next regularly scheduled meeting so long as your appeal is received by the Administrative Office at least 30 days in advance of a regularly scheduled meeting of the Board of Trustees.

Post-Service Claims: Prescription Drug Benefits

Prescription drug benefits are administered by the Pharmacy Benefit Manager. Your prescription drug benefit is a so-called card-based system, and your claim is deemed made when you present the prescription and your OptumRx identification card to a participating pharmacist.

Within 30 days of filing a post service claim, to the extent that any portion of your claim is denied, you will receive a notice of denial that identifies the specific Plan provision upon which the denial is based. For example, a claim or a portion thereof may not be payable because the annual deductible has not been met.

The 30-day period described above may be extended as permitted by federal regulations if additional information is required to process your post-service claim. You will be notified in writing what additional information is required in order to process your claim.

If your appeal is received in the Administrative Office at least 30 days in advance of a Board of Trustees Meeting, your appeal will be considered at that meeting. Generally, the Trustees meet no less frequently than quarterly.

To the extent permitted by federal regulations, consideration of your appeal may be put over to the next meeting of the Board if additional information is required to consider your appeal.

To assure timely consideration of appeals the Board has established an Appeals Committee comprised of one Union Trustee and one Employer Trustee. This committee is empowered to make final decisions if required to timely deal with appeals. The Appeals Committee would meet, for example, when a regular Board meeting is cancelled.

When the Appeals Committee or the Board of Trustees makes a final determination on your appeal, the Administrative Office will advise you in writing within five days of the decision.

Eligibility Issues

Eligibility for plan coverage is explained in the "Summary Plan Description" under the section entitled "Eligibility & General Plan Provisions" of the Summary Plan Description.

The Administrative Office is responsible for maintaining eligibility. Each month the Administrative Office provides a listing of eligible participants to the benefit providers (Kaiser, and UnitedHealthcare).

There may be instances where a Trust Fund Participant has a claim denied because he or she has not met the plan rules to be eligible for benefits under the Trust Fund. There are many reasons why this can happen.

Most eligibility issues are resolved quickly with a call or a letter to the Administrative Office. The Administrative Office is there to assist you and provide you with exact information on the status of your eligibility and entitlement to benefits under the various plans.

If you have a claim denied because you do not meet the eligibility requirements of the Trust Fund you have the right to appeal this denial. Your appeal should be in writing, and be sent to the Administrative Office. You should state in your appeal why you believe you meet the eligibility requirements (refer to “Eligibility & General Plan Provisions” of the Summary Plan Description), and provide any factual information you believe is important in having your appeal reviewed.

Your appeal will be considered within the appropriate time parameter described in the sections above entitled “Pre-Service Claims” and “Post Service Claims”.

Generally, the Board meets no less frequently than quarterly.

Exhaustion of the Appeal Process

Under a Federal Law known as ERISA a Participant or beneficiary whose claim for benefits has been denied may file suit against the Trust Fund seeking the denied benefit. However, prior to filing such a suit the appeal process under the Trust Fund described above must be pursued and exhausted. Thus, following any initial denial of benefits, if you disagree it is important you file a timely appeal. In all cases your appeal must be filed no later than 180 days after the initial denial of your claim was received by you. If you do not file an appeal within the required time frame you will have failed to exhaust your appeal rights. The Trustees may extend the 180 day limit upon your showing good cause for the delay, but to protect your rights you should file any appeal promptly after your receipt of the initial denial.

Following the Trustees’ decision, the Participant or spouse shall have the right to bring a civil action under Section 502.

Some Questions Common to all Claims and Appeals

Question: Who may file an appeal if my claim is denied?

Answer: You may file the appeal yourself or you may authorize a representative (i.e., doctor, spouse, etc.) to file an appeal on your behalf. Except in pre-service claim appeals where your doctor is acting as your representative, any representative acting on your behalf must have received written authorization from you to act on your behalf and that written authorization must be filed immediately with the Administrative Office as part of your appeal. If you are physically

or mentally incapacitated the Trustees will waive this written authorization requirement. It is extremely important to understand that an assignment of benefits to the provider of services does not constitute an authorization for the provider to act as your representative.

Question: If my claim is denied will the Trust Fund, upon request, supply me or my representative with all documents relevant to my claim?

Answer: Yes. You should be supplied copies of all documents and opinions relevant to your claim in accord with federal regulations.

Question: May I seek prior approval from the Trust Fund for medical care that is not governed by pre-service provisions of the Plan and appeal any adverse determination under Pre-Service Rules?

Answer: No. Only claims for which pre-authorization is required under the Trust Fund are subject to the expedited decision and appeal provisions pertaining Pre-Service Claims.

Question: If my pre-service claim is denied and I receive the medical care despite the denial and then file a claim for the medical expense incurred, will this claim for medical expense be handled under the expedited provisions of Part B of these rules?

Answer: No. Once medical care has been provided the only issue is what, if any, portion of the bill will be paid and the provisions of post-service claims apply to the claim for medical expenses.

Question: May the Trust Fund and I mutually agree to extend the time frames contained in the pre-service and post-service claim rules.

Answer: Yes.

Question: Whom should I contact if I have questions about these claims and appeal rules?

Answer: You should contact the Administrative Office.

Question: Do any provisions of these rules change the deductibles, co-payments, exclusions or limitations contained in any of the plans?

Answer: No.

Your Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)

As a Participant in the Southern California IBEW-NECA Health Trust Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Administrative Office and at other specified locations, such as work locations and union halls, all documents governing the Plan, including summary plan descriptions, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series).
- Obtain, upon written request to the Administrative Office, copies of documents governing the operation of the Plan, including collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Trustees are required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health coverage for yourself or your spouse if there is a loss of coverage under the Plan as a result of a "qualifying event." You or your spouse 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.

Certificate of Creditable Coverage

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or 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 new coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a health benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits that is denied or ignored in whole or in part, and you have exhausted the claim review and appeal procedures available to you under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W., Suite N-5623
Washington D.C, 20210.
Telephone: (202) 693-8680

The nearest office of the Employee Benefits Security Administration is located at:

Los Angeles Regional Office
1055 E. Colorado Blvd, Suite 200
Pasadena, CA 91106.
Telephone: (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.

Notice to Participants

Providers Regulated by the State Department of Managed Health Care or California Department of Insurance:

Kaiser
United Healthcare
CIGNA Dental Plan
Delta Dental Plan (DeltaCare USA)
MetLife/Safeguard Dental Plan
United Concordia
Vision Service Plan

AMENDMENT NO. 1
TO THE
SUMMARY PLAN DESCRIPTION
OF THE
SOUTHERN CALIFORNIA IBEW-NECA HEALTH TRUST FUND
RETIREE HEALTH PLAN
RESTATED AS OF FEBRUARY 1, 2013

This Amendment to the Southern California IBEW-NECA Health Trust Fund Retiree Health Plan Summary Plan Description (“SPD”) is made by the Board of Trustees of the Southern California IBEW-NECA Health Trust Fund (“Board of Trustees”) with reference to the following facts and circumstances:

A. The Board of Trustees wishes to amend the SPD to reflect the change of Prescription Benefit Manager (“PBM”) and to eliminate the 50% co-payment for sexual dysfunction drugs.

B. The Board of Trustees has reserved to themselves the ability to amend the SPD from time to time.

NOW THEREFORE, effective February 1, 2013, the SPD is amended as follows:

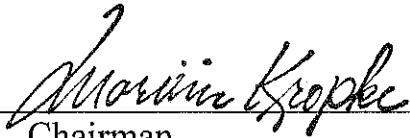
1. Citizens Rx shall replace Optum Rx (formerly “Prescription Solutions”) as the Plan’s PBM. All references in the SPD and elsewhere in the SPD to “Optum Rx” (formerly “Prescription Solutions”) shall be changed to “Citizens Rx” wherever those terms appear.

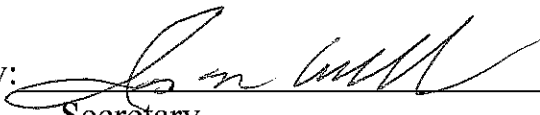
2. The 50% co-payment for sexual dysfunction drugs for both males and females shall be eliminated. The co-payment for sexual dysfunction drugs will be the same as any other covered drug, limited to a maximum of eight (8) pills for a 30-day supply.

3. All other terms and conditions of the Plan shall remain in full force and effect.

Executed this 31st day of January, at Commerce, California.

BOARD OF TRUSTEES
SOUTHERN CALIFORNIA IBEW-NECA
HEALTH TRUST FUND

By: 
Chairman

By: 
Secretary

AMENDMENT NO. 2
TO THE
RETIREE HEALTH SUMMARY PLAN DESCRIPTION
OF THE
SOUTHERN CALIFORNIA IBEW-NECA HEALTH TRUST FUND

RESTATED AS OF FEBRUARY 1, 2013

This Amendment to the Southern California IBEW-NECA Health Trust Fund's Retiree Health Summary Plan Description restated as of February 1, 2013 ("SPD") executed this 29th day of August is made by the Board of Trustees of the Southern California IBEW-NECA Health Trust Fund ("Board of Trustees") with reference to the following facts and circumstances:

A. The Board of Trustees wishes to amend the SPD to memorialize the long established practice of the Fund Offices to specify the documentation that a participant must provide as proof of payment under the Premium Reimbursement Plan and to outline the process for filing claims for the Premium Reimbursement Plan and the Medicare Supplement Plan.

B. The Board of Trustees has reserved to themselves the ability to amend the SPD from time to time.

NOW THEREFORE, effective October 1, 2013, the SPD is amended as follows:

1. The address listed under the Definition of "Medicare Supplement Plan" on pages 9-10 is revised as follows:

IBEW-NECA Claims Administration
Allied Administrators
P. O. Box 2500
San Francisco, CA 94126
Telephone: (800) 736-0401

2. The address listed under the Definition of "Premium Reimbursement Plan" on pages 10-11 is revised as follows:

IBEW-NECA Claims Administration
Allied Administrators
P. O. Box 2500
San Francisco, CA 94126
Telephone: (800) 736-0401

3. The following shall be added to the end of the Section entitled "Medicare Supplement Plan for Retirees/Spouses (page 39):"

"How to File a Claim

When sending a Claim to the Administrative Office, follow these steps:

1. Obtain a Medicare Supplement Claim Form from the Administrative Office, the Trust Funds' website, or Allied Administrators.
2. Use the Medicare Supplement Claim Form when submitting bills and claims for payment.
3. Complete Parts One and Two of the Medicare Supplement Claim Form.
4. Attach all Explanation of Medicare Benefit ("EOB") forms to the Claim Form.
5. Date and sign the Claim Form. Keep a copy of the Claim Form for your own personal records.
6. Claim Forms should be mailed to the following:

IBEW-NECA Claims Administration
Allied Administrators
P. O. Box 2500
San Francisco, CA 94126
Telephone: (800) 736-0401

Benefits (reimbursement of eligible Medicare out-of-pocket expense) are generally paid within 30 days from the date of receipt of all required information by Allied Administrators.

Note: Send in only one Claim Form per calendar month, with all claims for both retiree and spouse listed on the same Claim Form."

4. The “Quarterly Reimbursement” bullet point of the “Premium Reimbursement Plan” Section of the SPD (page 40) is changed to the “Monthly Reimbursement” bullet point and the following is added to the existing sentence under such bullet point:

“How to File a Claim for Premium Reimbursement

When sending a Claim to the Administrative Office or Allied Administrators, follow these steps:

1. Obtain a Premium Reimbursement Claim Form from the Administrative Office, the Trust Funds’ website, or Allied Administrators.
2. Complete the Premium Reimbursement Claim Form entirely.
3. Submit one or more of the following as proof of premium payment:
 1. Cancelled Check (front and back)
 2. Bank Statement (online statement acceptable)
 3. Credit Card Statement
 4. Payroll Stub with deduction indicated or
 5. Other proof of premium payment.
4. Date and sign the Premium Reimbursement Claim Form. Keep a copy of the Claim Form for your own personal records.
5. Claim Forms should be submitted to:

IBEW-NECA Claims Administration
Allied Administrators
P. O. Box 2500
San Francisco, CA 94126
Telephone: (800) 736-0401

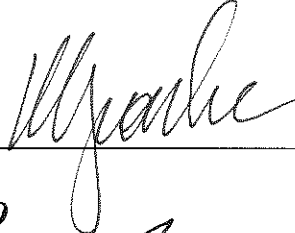
Benefits (premium reimbursement) are generally paid within 30 days from the date of receipt of all required information by Allied Administrators.

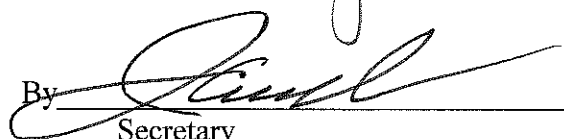
Note: Send in only one Claim Form per calendar month, with all claims for both retiree and spouse listed on the same Claim Form.”

5. All other terms and conditions of the Plan shall remain in full force and effect.

Executed this 29th day of August, at Commerce, California.

Board of Trustees
Southern California IBEW-NECA
Health Trust Fund

By 
Chairman

By 
Secretary

AMENDMENT NO. 3
TO THE
RETIREE HEALTH SUMMARY PLAN DESCRIPTION
OF THE
SOUTHERN CALIFORNIA IBEW-NECA HEALTH TRUST FUND
RESTATED AS OF FEBRUARY 1, 2013

This Amendment to the Southern California IBEW-NECA Health Trust Fund's Retiree Health Summary Plan Description restated as of February 1, 2013 ("SPD") executed this 19th day of November, 2013 is made by the Board of Trustees of the Southern California IBEW-NECA Health Trust Fund ("Board of Trustees") with reference to the following facts and circumstances:

A. The Board of Trustees wishes to amend the SPD to clarify that the injectable prescription drugs are covered prescriptions under the Mandatory Generic Prescription Drug Plan.

B. The Board of Trustees has reserved to themselves the ability to amend the SPD from time to time.

NOW THEREFORE, the SPD is amended as follows:

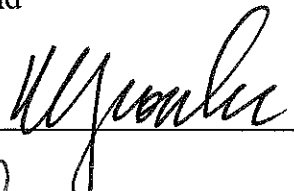
1. Under the "Mandatory Generic Prescription Drug Plan" Section of the Plan, the eleventh bullet point on the list of "Exclusions" is revised to provide as follows: "Drug or medicines purchased or administered to the participant by a prescriber or prescriber's staff. For example, drugs administered, injected or dispensed by a physician. However, injectables obtained at a pharmacy shall be covered."

2. All other terms and conditions of the SPD shall remain in full force and effect.

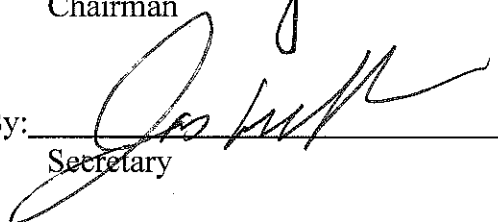
Executed this 19th day of November, 2013 at Commerce, California.

Board of Trustees
Southern California IBEW-NECA
Health Trust Fund

By: _____
Chairman



By: _____
Secretary



AMENDMENT NO. 4
TO THE
RETIREE HEALTH SUMMARY PLAN DESCRIPTION
OF THE
SOUTHERN CALIFORNIA IBEW-NECA HEALTH TRUST FUND
RESTATED AS OF FEBRUARY 1, 2013

This Amendment to the Southern California IBEW-NECA Health Trust Fund's Retiree Health Summary Plan Description restated as of February 1, 2013 ("SPD") executed this 19th day of November, 2013 is made by the Board of Trustees of the Southern California IBEW-NECA Health Trust Fund ("Board of Trustees") with reference to the following facts and circumstances:

A. The Board of Trustees wishes to amend the SPD to include the cost of a participant's long term care insurance policy where such costs are incurred and paid on or after October 1, 2008 as eligible for reimbursement under the Premium Reimbursement Plan provisions of the SPD.

B. The Board of Trustees has reserved to themselves the ability to amend the SPD from time to time.

NOW THEREFORE, the SPD is amended as follows:

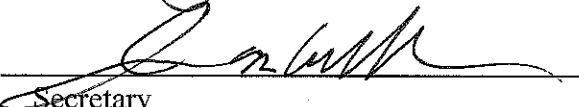
1. The first paragraph under Premium Reimbursement Plan is amended by adding the following sentence after the second full sentence: "In addition, the cost to a retiree and/or spouse of a long term care insurance policy where such costs are incurred and paid on and after October 1, 2008 are eligible for reimbursement under the Premium Reimbursement Plan."

2. All other terms and conditions of the SPD shall remain in full force and effect.

Executed this 19th day of November, 2013 at Commerce, California.

Board of Trustees
Southern California IBEW-NECA
Health Trust Fund

By: 
Chairman

By: 
Secretary

**AMENDMENT NO. 5
TO THE
RETIREE HEALTH SUMMARY PLAN DESCRIPTION
OF THE
SOUTHERN CALIFORNIA IBEW-NECA HEALTH TRUST FUND
RESTATED AS OF FEBRUARY 1, 2013**

This Amendment to the Southern California IBEW-NECA Health Trust Fund's Retiree Health Summary Plan Description restated as of February 1, 2013 ("SPD") executed this 27th day of May, 2014 is made by the Board of Trustees of the Southern California IBEW-NECA Health Trust Fund ("Board of Trustees") with reference to the following facts and circumstances:

A. The Board of Trustees wishes to amend the SPD to eliminate the Premium Reimbursement Plan in order to comply with recent regulations issued by the U.S. Government under the Affordable Care Act which have affected the existing Premium Reimbursement Plan in a manner so as to require the Board of Trustees to consider an alternative arrangement in order to maintain coverage for those retirees who do not live in the HMO service areas that cover the Southern California IBEW-NECA Health Trust Fund. As a result, the Board of Trustees has replaced the existing Premium Reimbursement Plan with a new insured program for retirees who reside outside of the health Plan's HMO Service Areas.

B. The Board of Trustees has reserved to themselves the ability to amend the SPD from time to time.

NOW THEREFORE, effective April 1, 2014, the SPD is amended to remove the Premium Reimbursement Plan and to replace it with the Out of Area Retiree Plan as follows:

1. Out of Area Retiree Plan

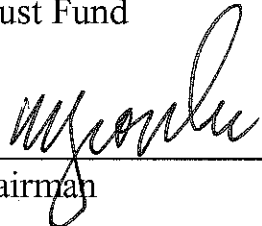
Early Retirees and Medicare Eligible Retirees and their eligible spouses who reside outside of the HMO Service Areas can receive coverage through an insured arrangement provided by UnitedHealthcare. To participate in the Out of Area Retiree Plan, you must enroll in the Out of Area

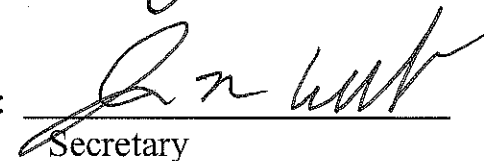
Retiree Plan and make monthly premium payments to the Fund. Payment of the monthly premium is explained in the Summary Plan Description under the section entitled "Required Monthly Pension Deduction/Self-Payment."

2. All other terms and conditions of the Plan shall remain in full force and effect.

Executed this 27th day of May, 2014 at Commerce, California.

Board of Trustees
Southern California IBEW-NECA
Health Trust Fund

By: 
Chairman

By: 
Secretary

**AMENDMENT NO. 6
TO THE
SUMMARY PLAN DESCRIPTION
OF THE
SOUTHERN CALIFORNIA IBEW-NECA HEALTH TRUST FUND
RETIREE HEALTH PLAN
RESTATED AS OF FEBRUARY 1, 2013**

This Amendment to the Southern California IBEW-NECA Health Trust Fund Retiree Health Plan Summary Plan Description restated as of February 1, 2013 (“SPD”) executed this 27th day of May, 2014 is made by the Board of Trustees of the Southern California IBEW-NECA Health Trust Fund (“Board of Trustees”) with reference to the following facts and circumstances:

A. The Board of Trustees wishes to amend the SPD to change the open enrollment period.

B. The Board of Trustees has reserved to themselves the ability to amend the SPD from time to time.


NOW THEREFORE, effective May 1, 2014, the first three sentences in the Annual Open Enrollment Period Section of the SPD found at page 22 are amended in their entirety as follows:

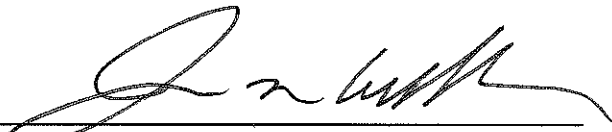
1. Each year during your annual open enrollment period held during the months of November and December, participants in the Retiree Health Plan are permitted to make a change in their choice of plans available to them. For example, if you are currently enrolled in the Kaiser Permanente Senior Advantage plan, you may change to United Healthcare Secure Horizons by completing the necessary documentation and submitting it to the Fund Office before the expiration of the open enrollment period. The open enrollment period is generally held during the months of November and December with plan changes effective January 1.

2. All other terms and conditions of the Plan shall remain in full force and effect.

Executed this 27th day of May, 2014, at Commerce, California.

Board of Trustees
Southern California IBEW-NECA
Health Trust Fund

By: 
Chairman

By: 
Secretary

**AMENDMENT NO. 7
TO THE
RETIREE HEALTH SUMMARY PLAN DESCRIPTION
OF THE
SOUTHERN CALIFORNIA IBEW-NECA HEALTH TRUST FUND
RESTATED AS OF FEBRUARY 1, 2013**

This Amendment to the Retiree Health Summary Plan Description of the Southern California IBEW-NECA Health Trust Fund restated as of February 1, 2013 ("SPD"), executed this 13th day of November, 2014, is made by the Board of Trustees of the Southern California IBEW-NECA Health Trust Fund ("Board of Trustees") with reference to the following facts and circumstances:

A. The Board of Trustees wishes to amend the SPD to specify that assignment of Medicare Parts A and B is required for participation in an HMO or the Out of Area Retiree Plan.

B. The Board of Trustees has reserved to themselves the ability to amend the SPD from time to time.

NOW THEREFORE, effective April 1, 2014, the SPD is amended as follows:

1. The following language shall replace the first two paragraphs on the top of page 22 of the SPD.

"Medicare Assignment.

If the retiree or eligible spouse selects one of the HMO medical Plans or the Out of Area Plan for health coverage and is eligible for Medicare, he or she must assign Parts A and B of his or her Medicare benefits to the Medicare-risk Plan that the retiree or spouse selects.

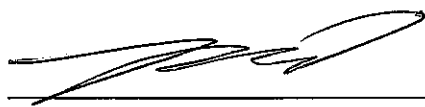
WARNING:

Once you have enrolled in one of the groups with Medicare-assignment (Kaiser Permanente Senior Advantage, UnitedHealthcare Medicare Advantage, or Out of Area Plan), do not sign up for another Medicare-risk plan on your own without first writing to the Administrative Office. Enrolling in another Medicare-risk plan may cause your benefits from this plan to be cancelled."

2. All other terms and conditions of the Plan shall remain in full force and effect.

Executed this 13th day of November, 2014 at Commerce, California.

Board of Trustees
Southern California IBEW-NECA
Health Trust Fund

By: 
Chairman

By: 
Secretary

**AMENDMENT NO. 8
TO THE
RETIREE HEALTH PLAN SUMMARY PLAN DESCRIPTION
OF THE
SOUTHERN CALIFORNIA IBEW-NECA HEALTH TRUST FUND
RESTATED AS OF FEBRUARY 1, 2013**

This Amendment to the Retiree Health Plan Summary Plan Description of the Southern California IBEW-NECA Health Trust Fund restated as of February 1, 2013 (“SPD”), executed this 12th day of February, 2015, is made by the Board of Trustees of the Southern California IBEW-NECA Health Trust Fund (“Board of Trustees”) with reference to the following facts and circumstances:

A. The Board of Trustees wishes to amend the SPD to reflect that HealthAdvocate has been replaced by MedExpert to assist participants and their eligible spouses.

B. The Board of Trustees has reserved to themselves the ability to amend the SPD from time to time.

NOW THEREFORE, effective March 1, 2015, the Retiree Health Plan Summary Plan Description is amended as follows:

1. 1. The Section on page 6 entitled “HealthAdvocate” is amended by replacing the existing language with the following:

“MedExpert

The Trustees have contracted with MedExpert to assist you and your eligible spouse with advocacy and assistance services, whereby Personal Health Advocates (PHA’s), typically registered nurses, supported by medical directors and benefit specialists will work with you and /or your eligible spouses to:

- Find physicians, medical specialists and other providers.
- Assist in understanding and resolution of billing for medical, dental or other professional services.

- Facilitate referrals for covered services.
- Clarify Trust Fund coverage.
- Transfer medical records.
- Locate elder care.

You may contact MedExpert at 1-800-999-1999.

MedExpert services will compliment the benefits delivered through your Plan by assisting you and your eligible spouse with health care providers and community-based services, locating the best health care providers within the Plan's parameters, and provide assistance with the resolution of insurance claims issues, etc.

MedExpert representatives may contact you or your eligible spouse to accomplish the aforementioned tasks. Your cooperation and assistance are greatly appreciated. In addressing a participant issue, MedExpert may act as a liaison between you or your eligible spouse and the insurance vendor/provider who contracts with the Trust.

MedExpert does not replace health insurance coverage, does not provide medical care or recommended treatment, and does not duplicate key benefit plan provider functions. MedExpert helps connect you and your eligible spouse to existing services such as case management, disease management, wellness, EAP and other in-place services."

2. The "Questions/Assistance" Section on page 29 is amended by replacing "HealthAdvocate Program" with "MedExpert Program".

3. The final two sentences of the first full paragraph on page 29 are amended by replacing the existing language with the following:

"Of course, the representative at the MedExpert Program will also assist you if you have questions or need

information. You can contact the MedExpert Program representative at 1-800-999-1999.”

4. The last sentence on page 29 is amended by replacing “HealthAdvocate” with “MedExpert.”

5. The last sentences of the Sections entitled “Women’s Health & Cancer Rights Act (WHCRA)” and the “Mental Health Parity and Equity Addiction Act (MHPAEA)” on page 30 are amended by replacing “HealthAdvocate” with “MedExpert”.

6. The last sentence on page 41 is amended by replacing the existing language with the following:

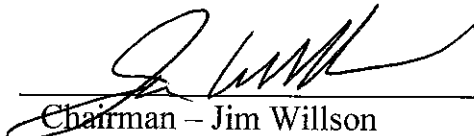
“You may also contact MedExpert at 1-800-999-1999.”

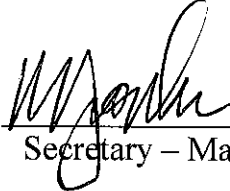
7. Section 5 on page 62 is amended by replacing “HealthAdvocate” with “MedExpert”.

8. All other terms and conditions of the SPD shall remain in full force and effect.

Executed this 12th day of February, 2015 at Commerce, California.

Board of Trustees
Southern California IBEW-NECA Health Trust Fund

By: 
Chairman – Jim Willson

By: 
Secretary – Marvin Kropke

**AMENDMENT NO. 9
TO THE
RETIREE HEALTH PLAN SUMMARY PLAN DESCRIPTION
OF THE
SOUTHERN CALIFORNIA IBEW-NECA HEALTH TRUST FUND
Restated as of February 1, 2013**

This Amendment to the Retiree Health Plan Summary Plan Description of the Southern California IBEW-NECA Health Trust Fund restated as of February 1, 2013 (“SPD”), executed this 12th day of February, 2015, is made by the Board of Trustees of the Southern California IBEW-NECA Health Trust Fund (“Board of Trustees”) with reference to the following facts and circumstances:

A. The Board of Trustees wishes to amend the SPD to reflect that the MetLife/Safeguard (DHMO) Dental Plan is no longer provided under the SPD effective January 1, 2015.

B. The Board of Trustees has reserved to themselves the ability to amend the SPD from time to time.

NOW THEREFORE, effective January 1, 2015, the Retiree Health Plan SPD is amended as follows:

1. Page 5 is amended by removing “MetLife/Safeguard Dental” from the Section entitled “Governing Plan Documents”.

2. Page 7 is amended by removing “MetLife/Safeguard (DHMO) Plan” under the Section entitled “Dental (Disability Retirees Only Under Age 65)”.

3. Page 29 is amended by removing “MetLife/Safeguard (DHMO)” under the Section entitled “HIPAA Privacy Rules”.

4. Page 55 is amended by replacing the existing language with the following:

You get a choice of one of the following:

- United Concordia Plan (PPO)
- CIGNA Dental Plan (DHMO)
- DeltaCare USA Dental Plan (DHMO)
- United Concordia Dental Plan (DHMO)

The Trust Fund offers four dental plans from which to choose: a dental Preferred Provider Organization (PPO) plan and three Dental Health Maintenance Organizations (DHMO) plans. The dental PPO plan is provided by United Concordia. The three DHMO plans are CIGNA, DeltaCare USA (also known as Delta Dental), and United Concordia. We suggest that you carefully review all of the Plans, and discuss these different Plan options with your eligible spouse. A brief overview of the United Concordia PPO Plan and the three DHMO plans (CIGNA, DeltaCare USA, and United Concordia) begins on page 56. Please refer to your *Evidence of Coverage* document for a complete description of your dental benefits, including the exclusions and limitations.

5. Page 56 is amended by removing “MetLife (DHMO)” from the table of Dental Providers.

6. Page 62 is amended by removing “MetLife/Safeguard Dental - DHMO Dental Benefits” from Section 5.

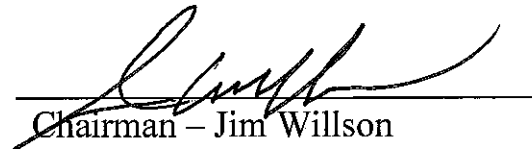
7. Page 63 is amended by removing “MetLife/Safeguard DHMO Dental Plan” from the section entitled “Claims & Appeal Rules”.

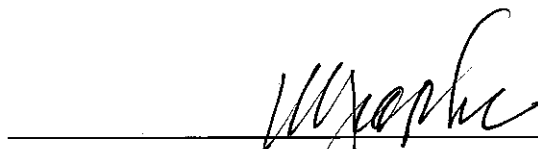
8. Page 69 is amended by removing “MetLife/Safeguard Dental Plan” from the section entitled “Notice to Participants”.

9. All other terms and conditions shall remain in full force and effect.

Executed this 12th day of February, 2015 at Commerce, California.

Board of Trustees
Southern California IBEW-NECA Health Trust Fund

By: 
Chairman – Jim Willson

By: 
Secretary – Marvin Kropke

**AMENDMENT NO. 10
TO THE
RETIREE HEALTH PLAN SUMMARY PLAN DESCRIPTION
OF THE
SOUTHERN CALIFORNIA IBEW-NECA HEALTH TRUST FUND
Restated as of February 1, 2013**

This Amendment to the Retiree Health Plan Summary Plan Description of the Southern California IBEW-NECA Health Trust Fund restated as of February 1, 2013 (“SPD”), executed this 13th day of August, 2015, is made by the Board of Trustees of the Southern California IBEW-NECA Health Trust Fund (“Board of Trustees”) with reference to the following facts and circumstances:

A. The Board of Trustees wishes to amend the SPD to reflect that effective January 1, 2016, the Medicare Supplement Plan will no longer be available to retirees and their eligible spouses who are enrolled in one of the RHP options other than the Medicare Supplement Plan, or for retirees and their eligible spouses who first enroll in the Retiree Health Plan after that date.

B. The Board of Trustees has reserved to themselves the ability to amend the SPD from time to time.

NOW THEREFORE, effective January 1, 2016, the Retiree Health Plan SPD is amended as follows:

1. Page 7 is amended in the Section entitled “Retirees Age 65 and Medicare Enrolled in Parts A and B” by adding the following language to the third bullet which refers to the “Medicare Supplement Plan and Mandatory Generic Prescription Drug Plan:”

Please note that effective January 1, 2016, the Medicare Supplement Plan is not an option for retirees and their eligible spouses who are enrolled in one of the Retiree Health Plan options other than the Medicare Supplement Plan or who first become covered under the Retiree Health Plan on or after that date.

2. Page 10 is amended by replacing the address for IBEW-NECA claims administration as follows:

IBEW-NECA Claims Administration
Allied Fund Administrators, an ATPA Company
P. O. Box 24160
Oakland, California 94623-2416

3. Pages 9-10 are amended by adding the following language to the end of the Section entitled "Medicare Supplement Plan."

Please note that effective January 1, 2016, the Medicare Supplement Plan is not an option for retirees and their eligible spouses who are enrolled in one of the Retiree Health Plan options other than the Medicare Supplement Plan or who first become covered under the Retiree Health Plan on or after that date.

4. Page 14 is amended by adding the following language to the end of the fourth full paragraph:

Please note that effective January 1, 2016, the Medicare Supplement Plan is not an option for retirees and their eligible spouses who are enrolled in one of the Retiree Health Plan options other than the Medicare Supplement Plan or who first become covered under the Retiree Health Plan on or after that date.

5. Page 21 is amended by adding the following language to the end of the last paragraph under the Section entitled "Medical Enrollment Required" with the following:

Please note that effective January 1, 2016, the Medicare Supplement Plan is not an option for retirees and their eligible spouses who are enrolled in one of the Retiree Health Plan options other than the Medicare Supplement

Plan or who first become covered under the Retiree Health Plan on or after that date.

6. Page 36 is amended by adding the following language after “Medicare Supplement Program” under the Section entitled “Brief Summary Comparison of Retiree Health Plan Benefits”.

Please note that effective January 1, 2016, the Medicare Supplement Plan is not an option for retirees and their eligible spouses who are enrolled in one of the Retiree Health Plan options other than the Medicare Supplement Plan or who first become covered under the Retiree Health Plan on or after that date.

7. Page 38 is amended by adding the following new language after the first sentence of the Section entitled “General Discussion - Choosing a Medical Plan That Best Suits Your Needs” as follows:

Please note that effective January 1, 2016, the Medicare Supplement Plan is not an option for retirees and their eligible spouses who are enrolled in one of the Retiree Health Plan options other than the Medicare Supplement Plan or who first become covered under the Retiree Health Plan on or after that date.

8. Page 39 is amended by inserting the following sentence after the second sentence in the last paragraph on that page.

Do not enroll in Medicare Part D. Enrollment in Medicare Part D will cause termination of coverage under this Plan. Once terminated, the retiree or spouse will not be permitted to subsequently re-enroll in the Retiree Health Plan.

9. Page 39 is amended by adding the following new language to the end of the Section entitled “Medicare Supplement Plan for Retirees/Spouses.”

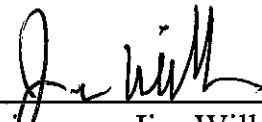
Please note that effective January 1, 2016, the Medicare Supplement Plan is not an option for retirees and their eligible spouses who are enrolled in one of the Retiree Health Plan options other than the Medicare Supplement Plan or who first become covered under the Retiree Health Plan on or after that date.

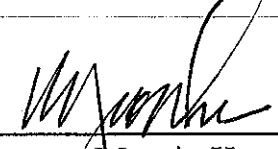
10. Page 63 is amended by adding the following language after the end of the penultimate paragraph on that page:

Please note that effective January 1, 2016, the Medicare Supplement Plan is not an option for retirees and their eligible spouses who are enrolled in one of the Retiree Health Plan options other than the Medicare Supplement Plan or who first become covered under the Retiree Health Plan on or after that date.

Executed this 13th day of August, 2015 at Commerce, California.

Board of Trustees
Southern California IBEW-NECA Health
Trust Fund

By: 
Chairman – Jim Willson

By: 
Secretary – Marvin Kropke

AMENDMENT NO. 11
TO THE
SUMMARY PLAN DESCRIPTION
OF THE
SOUTHERN CALIFORNIA IBEW-NECA HEALTH TRUST FUND
RETIREE HEALTH PLAN

This Amendment to the Southern California IBEW-NECA Health Trust Fund Retiree Health Plan Summary Plan Description ("SPD") is made by the Board of Trustees of the Southern California IBEW-NECA Health Trust Fund ("Board of Trustees") with reference to the following facts and circumstances:

A. The Board of Trustees wishes to amend the SPD to reflect a change in the eligibility rules to permit a surviving spouse of a deceased participant, who elected to remain on the Active Plan through COBRA, to enroll in the Retiree Health Plan.

B. The Board of Trustees has reserved to themselves the ability to amend the SPD from time to time.

NOW THEREFORE, effective April 1, 2015, the SPD is amended as follows:

1. The Eligible Spouse section is restated in its entirety as follows:

Eligible Spouse

To have your spouse covered by the Plan, you must be legally married on the date the first pension check is issued by the Southern California IBEW-NECA Pension Plan. Effective January 1, 2005, if you subsequently remarry because of the death of your spouse or divorce, your spouse will not be eligible for retiree health coverage unless you enroll a new spouse under this Plan by the end of the second calendar month following the date of the marriage. Coverage for your new spouse shall commence as of the first month following enrollment.

For example, if a participant marries any time during the month of January, he may enroll his new spouse any time through March 31; coverage would commence on April 1, the first of the month following enrollment.

Any spouse who is also a retired participant in the Southern California IBEW-NECA Retiree Health Plan and eligible for benefits under the Plan cannot also be eligible as a dependent spouse.

An eligible retired employee and eligible spouse must select the same medical plan of benefits offered under the Retiree Health Plan. For example, if the retired employee selects Kaiser Permanente as his choice of medical coverage, then his spouse must also enroll in Kaiser Permanente. If one spouse is eligible for Medicare and the other is not, then the non-Medicare

participant will be covered under the retiree Kaiser medical plan and the Medicare eligible participant will be covered under the Kaiser Permanente Medicare plan called Senior Advantage.

An eligible spouse enrolled in the Retiree Health Plan may continue his/her coverage under the Retiree Health Plan upon the Retiree's death. An individual who has retired under the Southern California IBEW-NECA Pension Plan and meets all of the eligibility requirements under this Retiree Health Plan may delay enrollment in this retiree Health Plan until the later of exhaustion of Hour Bank Coverage and/or COBRA coverage under the Active Plan. If during this permitted delay in enrollment such an individual shall die, his or her otherwise eligible spouse may enroll in this Retiree Health Plan no later than the exhaustion of Hour Bank Coverage and/or COBRA coverage under the Active Plan.

Please note that the Retiree Health Plan provides that if a retiree was married at the time of his or her initial enrollment in the Retiree Health Plan and declined coverage for his or her spouse under the Retiree Health Plan, the retiree cannot later add the same spouse as an eligible spouse under the Retiree Health Plan (see HIPAA Special Enrollment on page 21 to preserve the enrollment of an eligible spouse).

If you would like to add your spouse under the Retiree Health Plan, please contact the Administrative Office for the necessary forms. You will need to provide documentation that your spouse qualifies as an eligible spouse (marriage certificate, etc).

If you have questions, please contact the Administrative Office at (323) 221-5861, Monday through Friday or toll free at (800) 824-6935 between the hours of 8:30-5:30 p.m.

2. All other terms and conditions of the Plan shall remain in full force and effect.

Executed this 28th day of July 2016, at Commerce, California.

BOARD OF TRUSTEES
SOUTHERN CALIFORNIA IBEW-NECA HEALTH
TRUST FUND

By: _____
Chairman – Jim Willson

By: _____
Secretary – Marvin Kropke

**AMENDMENT NO. 12 TO THE
SUMMARY PLAN DESCRIPTION OF THE
SOUTHERN CALIFORNIA IBEW-NECA HEALTH TRUST FUND
RETIREE HEALTH PLAN**

This Amendment to the Southern California IBEW-NECA Health trust Fund Retiree Health Plan *Summary Plan Description* ("SPD") is made by the Board of Trustees of the Southern California IBEW-NECA Health Trust Fund ("Board of Trustees") with reference to the following facts and circumstances:

- A. The Board of Trustees wishes to amend the SPD to reflect a change in the eligibility rules.
- B. The Board of Trustees has reserved to themselves the ability to amend the SPD from time to time.

NOW THEREFORE, effective April 1, 2017, the SPD beginning at page 13, is amended as follows:

- C. Effective with Retiree Health Plan initial enrollments for pensions commencing on or after April 1, 2017, the requirements are as follows:

1. Age/Pension and Service Requirements:

Early Retirees who have attained age 56 and are awarded an unreduced early retirement benefit from the Southern California IBEW-NECA Defined Benefit Plan, have had at least 44,500 hours worked under a collective bargaining agreement requiring retiree health Plan contributions to this Plan (includes Health hours credited through reciprocity), and of those hours 10,500 hours must have been worked in 7 of the 10 years prior to retirement.

Normal Retirees retiring on and after age 62 under the Southern California IBEW-NECA Pension Trust Fund, retiree health plan eligibility is limited to such individuals who have at least 10 years of credited service under the Pension Plan and have had 10,500 health hours under a Collective Bargaining Agreement requiring Retiree Health Plan contributions (includes Health hours credited through reciprocity) in 7 of the 10 years immediately preceding the date of retirement.

2. Timely Application and Payments

In addition to each of the requirements stated above, you must request and complete an application, enroll by no later than the later of the date your first pension check was issued or your loss of eligibility under the Active Health Plan, and pay the monthly medical premium. The monthly medical premium may be deducted from your monthly Southern California IBEW-NECA Pension Plan benefit **OR** monthly self-payments may be made to the Southern California IBEW-NECA Health Trust Fund.

3. Delayed Enrollments

An individual who has retired under the Southern California IBEW-NECA Pension Plan and meets all of the eligibility requirements under this Retiree Health Plan may delay enrollment in this Retiree Health Plan until the later of the exhaustion of the Hours Bank Reserve and/or COBRA coverage under the Active Plan. If during this permitted delay in enrollment such an individual shall die, his or her spouse may enroll in this Retiree Health Plan no later than the exhaustion of the Hours Bank Reserve and/or COBRA coverage under the Active Plan.

4. Total Disability and/or Partial Disability Benefits and Crediting of Disability Hours for Retiree Health Plan eligibility are not available to individuals retiring on or after April 1, 2017. Initial eligibility for Retiree Health Plan benefits through the Maintenance Agreement after retirement will no longer be available effective April 1, 2017.

NOTE: Nothing in the eligibility requirements set forth above impacts those individuals who meet the Retiree Health Plan's eligibility rules and commence to receive a benefit from the Southern California IBEW-NECA Pension Plan on or before March 31, 2017.

D. All other terms and conditions of the Plan, including the HIPAA Special Enrollment rights, shall remain in full force and effect.

Executed this 21st day of December 2016 at Commerce, California.

**BOARD OF TRUSTEES
SOUTHERN CALIFORNIA IBEW-NECA
HEALTH TRUST FUND**

By: _____
Chairman

By: _____
Secretary

AMENDMENT NO. 13
TO THE
SUMMARY PLAN DESCRIPTION
OF THE
SOUTHERN CALIFORNIA IBEW-NECA HEALTH TRUST FUND
RETIREE HEALTH PLAN
RESTATED AS OF FEBRUARY 1, 2013

This Amendment to the Southern California IBEW-NECA Health Trust Fund Retiree Health Plan Summary Plan Description (“SPD”) is made by the Board of Trustees of the Southern California IBEW-NECA Health Trust Fund (“Board of Trustees”) with reference to the following facts and circumstances:

A. The Board of Trustees wishes to amend the SPD to reflect the change of Claims Administrator for the Medicare Supplement Plan for retirees who enrolled in the Medicare Supplement Plan on or before January 1, 2016.

B. The Board of Trustees has reserved to themselves the ability to amend the SPD from time to time.

NOW THEREFORE, effective February 1, 2017, the SPD is amended as follows:

1. Coast Benefits, Inc. shall replace Allied Administrators as the Plan’s claims administrator. References in the SPD appearing on pages 10, 11 and elsewhere in the SPD to “Allied Administrators” shall be changed to “Coast Benefits, Inc.” wherever those terms appear.

2. Page 10 and 11 are amended by replacing the address for IBEW-NECA claims administration as follows:

Coast Benefits, Inc.
IBEW-NECA Claims Administration
3444 Camino Del Rio North, Suite 100
San Diego, CA 92108
Phone: (800) 886-7559 or (619) 280-2009
Fax: (619) 280-4304

3. All other terms and conditions of the Plan shall remain in full force and effect.

Executed this 26th day of January 2017, at Commerce, California.

BOARD OF TRUSTEES
SOUTHERN CALIFORNIA IBEW-NECA
HEALTH TRUST FUND

By: _____
Chairman – Marvin Kropke

By: _____
Secretary – Jim Willson

AMENDMENT NO. 2
TO THE
SUMMARY PLAN DESCRIPTION
OF THE
SOUTHERN CALIFORNIA IBEW-NECA HEALTH TRUST FUND
RETIREE HEALTH PLAN

This Amendment to the Southern California IBEW-NECA Health Trust Fund Retiree Health Plan Summary Plan Description (“SPD”) is made by the Board of Trustees of the Southern California IBEW-NECA Health Trust Fund (“Board of Trustees”) with reference to the following facts and circumstances:

- A. The Board of Trustees wishes to amend the SPD to reflect the addition of the same orthotic benefit currently offered to Active participants.
- B. The Board of Trustees has reserved to themselves the ability to amend the SPD from time to time.

NOW THEREFORE, effective January 1, 2019, Section **6.4, Specialized Footwear** is added to **Article 6: Additional Benefits** as follows:

6.4 Specialized Footwear Benefit

The Plan provides benefits for specialized footwear, sometimes known as “orthotics.” The annual benefit of \$400 may be used to defray the costs of consulting with a certified orthotist or other provider certified by the American Board for Certification in Orthotics, Prosthetics and Pedorthics and the cost of fabricating and fitting the specialized footwear. Specialized footwear includes orthopedic shoes and custom-made, rigid plastic or polypropylene inserts for the shoe. This benefit is available to all eligible retirees and spouses enrolled for medical benefits under the Plan.

Eligible expenses subject to reimbursement shall include expenses for the professional services provided by an orthotist, prosthetist, pedorthist or other provider certified by the American Board for Certification in Orthotics, Prosthetics and Pedorthics when professional services are in connection with the treatment of foot disfigurement. For purposes of this benefit, foot disfigurement means foot disfigurement resulting from cerebral palsy, arthritis, polio, spinal bifida, diabetes, accidental injury or abnormal condition.

6.4.1 Specialized Footwear

Eligible services for specialized footwear shall include the cost of fabricating custom-made rigid (plastic or polypropylene) foot orthotics (shoe inserts) and/or custom-made standard orthopedic shoes.

6.4.2 Maximum Annual Benefit

The maximum annual benefit payable per eligible individual for eligible expenses incurred for the procurement of specialized footwear shall be \$400.

6.4.3 Submission of Claims

Claims for eligible expense reimbursement under this provision shall be submitted to Coast Benefits, Inc. at:

**Coast Benefits, Inc.
3444 Camino del Rio North, Suite 101
San Diego, CA 92108**

Claims must include the name and address of the provider, the date services are rendered, the diagnosis or condition being treated, and an itemized listing of services rendered. Reimbursement shall be made directly to the Participant and not to the provider.

6.4.4 Exclusions

No benefits shall be provided under the terms of this provision for:

- Dress shoes;
- Casual shoes (e.g., tennis shoes or deck shoes);
- Shoe inserts (except as provided above);
- Foot pads;
- Foot orthotics that are fabricated from soft plastic, cork or leather;
 - a. Socks or any supplies that are not custom-made or of which the equivalent can be purchased without prescription; or
 - b. Services provided to Participants that do not suffer from foot disfigurement as defined above under "Eligible Expenses.

All other terms and conditions of the Plan shall remain in full force and effect.

Executed this 30th day of January 2019, at Commerce, California.

BOARD OF TRUSTEES
SOUTHERN CALIFORNIA IBEW-NECA
HEALTH TRUST FUND

By: _____
Chairman – Joël Barton

By: _____
Secretary – Jim Willson

AMENDMENT NO. 3
TO THE
SUMMARY PLAN DESCRIPTION
OF THE
SOUTHERN CALIFORNIA IBEW-NECA HEALTH TRUST FUND
RETIREE HEALTH PLAN

This Amendment to the Southern California IBEW-NECA Health Trust Fund Retiree Health Plan Summary Plan Description (“SPD”) is made by the Board of Trustees of the Southern California IBEW-NECA Health Trust Fund (“Board of Trustees”) with reference to the following facts and circumstances:

- A. The Board of Trustees wishes to amend the SPD to reflect an increase to the frame and lenses allowances under Kaiser Permanente Vision Plan benefits for Disabled Retirees who commenced retirement prior to April 1, 2017. The Kaiser Permanente Vision Plan allowance was increased from \$100 on frames to \$150.
- B. The Board of Trustees has reserved to themselves the ability to amend the SPD from time to time.

NOW THEREFORE, effective March 1, 2019, Article 8, Benefits for Disabled Retirees who commenced retirement prior to April 1, 2017, sub-section 8.4, Vision Co-Payments and Schedule of Benefits, is amended as follows:

8.4 Vision Co-Payments and Schedule of Benefits:

UnitedHealthcare Plan Participants				
Benefit	Frequency (Based on service year)	Copayment	Coverage from a VSP Doctor	Out-of-Network Reimbursement
Exam	12 months	\$5	Covered in full after the copayment.	Up to \$45 allowance
Prescription Eyewear – If you choose contact lenses you will be eligible for frame 12 months from the date the contact lenses were obtained.				
Lenses	12 months	\$10 (lenses and/or frame)	Single vision, lined bifocal and lined trifocal lenses are covered in full after the copayment.	Single vision up to \$45 allowance. Lined bifocal up to \$65 allowance. Lined trifocal up to \$85 allowance
Frame – As Provided by VSP	24 months	\$10 (lenses and/or frame)	Covered up to \$150 allowance	Up to \$47 allowance
Contact Lenses*	12 months		Covered in full for medically necessary allowance, \$130 allowance for Elective Contact lenses	Up to \$210 allowance for medically necessary and \$105 for Elective Contact lenses

**Your allowance applies to the cost of your contact lens exam and your contact lenses. You'll receive a 15 percent savings off the cost of your contact lens exam from a VSP doctor. Your contact lens exam is in addition to your routine eye exam to check for eye health risks associated with improper wearing or fitting of contacts. You may get regular glasses (frames and lenses) twelve months after you get contact lenses.*

Kaiser Vision Plan	
Vision Benefit	Co-pay/Allowance
Eye refraction exams to determine the need for vision correction and to provide a prescription for eyeglasses	\$5 per visit
Regular plastic eyeglass lenses every 24 months	\$150 Allowance*
An eyeglass frames every 24 months	
Medically necessary contact lenses	No charge

**An allowance is the total expenses of an item that is covered. If the cost of the item you select exceeds the allowance, you must pay the difference.*

All other terms and conditions of the Plan shall remain in full force and effect.

Executed this 30th day of January 2019, at Commerce, California.

BOARD OF TRUSTEES
SOUTHERN CALIFORNIA IBEW-NECA
HEALTH TRUST FUND

By: _____
Chairman – Joël Barton

By: _____
Secretary – Jim Willson