SAN MATEO APPRENTICESHIP HEALTH PLAN

SUMMARY PLAN DESCRIPTION

Please note: This Summary Plan Description is in process of being updated; as such, some information contained herein may not be current.

March 9, 2009

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ALERT

The Benefits provided under this Plan may be changed at any time. The Board of Trustees may reduce or eliminate any benefits and may change or eliminate insurance carriers, HMOs, PPOs, or any other entity to make additional contributions for coverage at any time.

The benefits in this Summary Plan Description are as of the date prepared. Any subsequent amendments will govern the actual benefits payable.

January 1, 2009

Dear Participant:

This booklet known as a Summary Plan Description contains information regarding your Medical Benefits and an explanation of the eligibility provisions. The substance of your medical benefits are covered under the Insurance Agreements. We urge you to familiarize yourself with the provisions and benefit structure of your Plan. Please direct any questions you have to the Administrative Office at (650) 328-3100.

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

For details on your benefit coverage, please refer to the Provider's Evidence of Coverage or the Self-Funded PPO Medical Plan Summary. These documents are the binding documents between the Insurance Plan or the Self-Funded PPO Medical Plan and its participants. You should review the booklets and other documents furnished by the entities providing benefits for the Plan.

The provider has discretion to make any factual determination concerning your plan.

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

Open Enrollment is held each year, from April 16th through May 15th, you may elect to change your benefit plan options selection by completing a new enrollment card through the Administrative Office. Your change, which must be received by the Administrative Office by May 15th and will be effective June 1st of that year. Provider benefit booklets are available at the Administrative Office or at the Local Union Office.

The Board of Trustees has authorized the Administrative Office to respond in writing to your written questions. If you have an important question about your benefits, you should write to the Administrative Office. The Administrative Office is located at:

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

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

Plan rules and benefits may change from time to time. The Plan will provide you with a summary of important material changes. You may also receive replacement pages for this booklet. Please be sure to read all Plan communications and keep your booklet up to date by adding replacement pages as soon as you receive them.

The Board of Trustees

IMPORTANT NOTICES:

FUTURE PLAN AMENDMENTS

Future amendments to the Plan may be made from time to time to comply with new laws passed by Congress, rulings by federal agencies or courts, and other changes deemed necessary or prudent by the Trustees.

LIMITATION UPON RELIANCE ON BOOKLET AND STATEMENTS

This booklet provides a brief, general summary of the Plan rules and is also the Plan document. You should review the Plan to fully determine your rights.

You are not entitled to rely upon oral statements of Employees of the Trust Fund Office, a Trustee, an Employer, any Union representative, or any other person or entity. As a courtesy to you, the Trust Fund Office may respond orally to questions; however, oral information and answers are not binding upon the Plan and cannot be relied upon in any dispute concerning your benefits.

If you would like an interpretation of the Plan, you should address your request in writing to the Board of Trustees at the Trust Fund Office. **To make their decision, the Trustees must be provided with full and accurate information concerning your situation. You should also ensure that you provide accurate facts in all forms and documents submitted to ensure you are not held liable for coverage of ineligible Dependents and/or claims.**

You should further understand that, from time to time, there may be an error in a payment or on other matters which may be corrected upon audit or review. **The Board of Trustees reserves the right to make corrections whenever any error or overpayment is discovered.**

NO VESTED RIGHTS

Benefits under this Plan are NOT vested. The Board of Trustees may amend, reduce, eliminate or otherwise change the Plan at any time and may change, reduce, or discontinue any Plan benefits, in whole or in part, at any time. Moreover, the Board of Trustees may require new or greater co-payments at any time. The Board of Trustees may change the eligibility requirements and any other Plan rules at any time.

USE OF MASCULINE GENDER WORDS

In all situations, whenever any words are used in the Plan in the masculine gender, they should be construed as though they were also used in the feminine gender where they would so apply.

I. ELIGIBILITY REQUIREMENTS

A. Initial Eligibility

You become eligible for coverage under this Plan on the month in which you have accumulated to your credit a minimum total of 300 hours of employment with Participating Employers (known as "Covered Employment").

You remain eligible for this coverage as long as you remain in the Apprentice Program whether you are working or not.

B. Covered Dependents

Your Covered Dependents are your lawful spouse (husband or wife), natural children, legally adopted children and stepchildren.

The rules for a Dependent child shall be:

1. Blood Descendent: A blood descendent of the first degree;
2. Adopted Child: A legally adopted child, including children living with adopting parents during the period of probation and children for whom the adopting parents have assumed and retained a legal obligation to provide total or partial support in anticipation of adoption;
3. Stepchild: A stepchild residing in the employee's household;
4. Related Child or Children: A child residing permanently with the employee, who is head of the household, and who is being solely supported by the employee. Except for children who have been or are being adopted by the employee, the child must be related by blood or marriage to the employee, or the employee must be the child's legal guardian;
5. Adding Dependents: During the period you continue to have coverage, any new eligible dependents you acquire may be added in accord with the dependent's eligibility provisions, and any eligible dependents you decline to insure before your continued health coverage began may be added during any open enrollment period provided by the Plan. Coverage will be immediate for all dependents without any preexisting condition limitations;
6. Age Limit for Children/Students: Covered Dependents are eligible for benefits provided from birth through the age of 18 years, provided such children are unmarried, and dependent upon their parents for support and maintenance, and reside with you in a parent-child relationship. Children also include those from age 19 years up to age 25 years provided they are attending an accredited and state licensed technical school or institution of higher education on a full-time basis, are unmarried and are dependent upon you for support and maintenance; and
7. Student Breaks (Summer Months and Periods of Vacation):
    a. Summer Months: During the Summer months (i.e. quarter/semester), coverage will be extended provided the Dependent child continues to meet all Plan eligibility requirements, was a Full-Time student the semester/quarter immediately preceding the Summer break and has enrolled or intends to enroll

as a Full-Time student the quarter/semester immediately following the Summer months.

b. Periods of Vacation: A Period of Vacation from Full-Time enrollment does not necessarily terminate a Dependent child's coverage and a Dependent child might qualify for coverage during a period of vacation from full-time enrollment. A period of vacation is defined as one quarter/semester in which a Dependent child is enrolled in less than 9 units of study. In order to qualify for coverage during a Period of Vacation from Full-time enrollment a Dependent child must meet ALL of the following:

    (1) The Dependent child must meet all other Dependent eligibility requirements and the Participant would be required to sign a statement under penalty of perjury to this effect; and
    (2) The Dependent child must have been enrolled on a Full-Time basis the semester/quarter immediately preceding this period of vacation (excluding Summer break); and
    (3) The Dependent child must intend on again enrolling on a Full-Time basis the quarter/semester immediately proceeding this period of vacation (excluding Summer months).

    Please be aware that if a Dependent child fails to meet all other plan qualification for Dependent children during a period of vacation, was not enrolled on a Full-Time basis the semester/quarter immediately preceding the period of vacation, or does not intend on enrolling on a Full-Time basis immediately after this period of vacation, the Dependent child would not qualify for coverage during this break from Full-Time enrollment; and

8. Disabled Children: A dependent child also includes a child after his 19th birthday provided the child is both incapable of self-sustaining employment by reasons of mental or physical disability; and chiefly dependent upon you for support and maintenance. Such qualifications will continue coverage for the child beyond his 19th birthday, up to age 25.

   The Administrative Office must receive proof of such incapacity and dependency within 31 days of the child's 19th birthday. **THAT IS YOUR RESPONSIBILITY**. The Plan or Trust may require, at reasonable intervals following the child's 19th birthday, proof of the child's continued disability and dependency.

No dependent can ever be deemed a Covered Dependent unless he or she is a dependent of a Participant.

IMPORTANT NOTICE:
WARNING ABOUT FRAUD AGAINST PLAN

It is the Participant's and Dependent's responsibility to notify the Trust Fund Office immediately when a Dependent's status changes. This includes divorce/final dissolution of marriage, legal separation, death, a Dependent child over 19 who is no longer enrolled as a full-time student, a child over 19 being employed with health coverage, and any other events which would make your Dependent not eligible for future coverage. If claims are paid for, or premiums are paid on behalf of any Dependent and it is later found that the Dependent was not eligible, you and the Dependent will be responsible for reimbursing the Plan for the actual amount paid out in benefits by the Trust plus interest and any costs and attorney's fees incurred to recover the money.

C. Domestic Partners

California law and this Plan do not recognize common law marriage; however, the Plan does cover certain domestic partners (that live together on a regular basis). A Participant's domestic partner will be covered provided the domestic partnership meets the following criteria:

1. Both persons must file a Declaration of the Domestic Partnership with the Secretary of the State of California and provide a copy to the Administrative Office;*[1]

2. Both persons must have a common residence;

3. Neither person may be married to someone else or be a member of another domestic partnership with someone else that has not been terminated;

4. The two persons must not be related by blood in any way that would prevent them from being married to each other;

5. Both persons are at least 18 years old;

6. Both persons must be members of the same sex, or, if opposite sex, one or more persons must be over age 62; and

7. Both persons must be capable of consenting to the domestic partnership.

In addition to the above requirements, both the Covered Participant and the domestic partner agree to inform the Administrative Office of the termination of their domestic partnership as a result of a change in one or more of the above requirements or the death of the domestic partner.

[1] For those Participants who do not live in the State of California and are, therefore, not eligible to file a Declaration of Domestic Partnership with the Secretary of State's Office, the Fund will accept a properly completed Affidavit of Domestic Partnership as proof of the domestic partnership so long as the criteria set forth in 2-7 above is met. The Administrative Office will provide Participants with the Affidavit upon request.

The election by a Participant to add a domestic partner may have certain Federal income tax implications. Under Federal tax law, the fair market value of health coverage provided to a domestic partner is a taxable benefit to the Participant. (Please note that domestic partner benefits are not taxable under California law.) Each year the Fund will calculate the fair market value of the domestic partner coverage and this information will be sent to participating employers. The Participant's employer is then responsible for including the imputed income on the Participant's wages and withholding any FICA, FUTA, Medicare and Federal income taxes as applicable.

D. Automatic Coverage for A Newborn Child – If Plan Notified Within 31 days

A newborn or newly adopted child of any age will automatically be covered for the first 31 days of medical benefits on the date the child becomes a Dependent. However, you are required to apply for Dependent coverage for that child within 31 days of the child's birth or of the adopted child's placement in your home in order to continue that child's coverage beyond the first 31 days. You are urged, however, to enroll the new child immediately. **If you fail to do so, there is no coverage.**

If you are required to contribute toward the cost of insurance and if the child's coverage terminates because you fail to apply (or pay the required contribution) within the 31-day period, no benefits will be payable. The Individual Purchase Rights and the extended Benefits (after termination of coverage) will not apply to the child.

E. Qualified Medical Child Support Orders (QMCSO)

The Participant must timely provide the Trust Fund Office with a copy of any court order that establishes the Participant's legal obligation to maintain coverage on a Dependent Child including a QMCSO.

A QMCSO recognizes an eligible child's right to receive Plan benefits as a beneficiary of an eligible Plan Participant. The child, to be covered for benefits by this Plan, must meet Plan requirements for an eligible Dependent child including age requirements.

The steps that will be followed to establish and determine whether a court order would qualify as a QMCSO are:

1. The Participant must provide the Plan Office with a copy of the court order and/or QMCSO.

2. Within thirty (30) days after receipt of the QMCSO, the Plan Office or the Plan's legal counsel will notify the Participant in writing if the court order and/or QMCSO is acceptable to the Plan.

3. If the Plan determines that the court order and/or QMCSO is not acceptable, or if additional information is required, the Participant will be notified in writing by the Plan or the Plan's legal counsel.

a. **If a QMCSO is denied**. The notice will describe the reasons for denial. There is a right to appeal a denial. A summary of the Plan's appeal procedures will be included in the notice of denial. In most instances however, you will simply be asked to revise the order in such a way that it is a proper QMCSO.

b. **If additional information is required**. The notice will describe what is needed. There will be sixty (60) days to respond. If you do not respond within the sixty (60) days, the request for the QMCSO will be deemed canceled.

The Plan requires that the Participant and all of his eligible Dependents be enrolled under only one Health Plan option. Therefore, a Participant must select and enroll in a Health Plan option that would be available to the Participant, the child(ren) covered under the QMCSO and to the Participant's other eligible Dependents. If a Participant enrolls in a Plan that would not be available to the child(ren) covered under the QMCSO because they reside outside of the Plan's service area, the Participant will be required to enroll in another Health Plan option that would cover the child(ren). The Plan will follow the requirements of the QMCSO even if that requires that the Participant be forced to enroll in a different Plan option.

Please be aware that if a child covered under a QMCSO was enrolled independent of the Participant neither the Participant nor any other Dependents would be considered enrolled in the Plan until such time as the Participant has completed all Enrollment Procedures. In addition, the Participant and any other eligible Dependents would then be limited to enrollment into only that Health Plan option that the child covered under the QMCSO has been enrolled in.

F. Termination of Dependent Eligibility

A Dependent's eligibility terminates when the Participant's coverage terminates or when the individual ceases to meet the Plan qualifications of an eligible Dependent.

If a Participant dies, however, his or her Dependents' coverage may continue through COBRA (see page 13.)

II. TERMINATION OF COVERAGE

A participant and dependents who have been eligible for the benefits of this Plan shall cease to be eligible for the benefits on the earliest date of:

A. Apprentice

1. Termination of Coverage

Participant coverage will terminate on the earlier of:

a. The date the person is no longer eligible under the Plan because he or she has been terminated from the Apprentice Program.

b. The date of termination of the Plan or, if any benefit of the Plan is terminated, on the date of termination of such benefit.

B. Dependent

Your Dependent coverage will terminate on the earlier of:

1. The date the person ceases to be a dependent as defined in the Plan.

2. The date that the person who has Covered Dependents ceases to be eligible under the Plan.

3. The date of termination of the Plan, or if any dependent's benefit of the Plan is terminated, the date of termination of such dependent's benefits.

In addition, under certain conditions, your Dependent's Medical expense coverage may be continued after the date it would terminate. For further information, refer to the COBRA section beginning on page 13.

NOTE: When both Federal and State-required continuation are available to you and/or your Dependents, a choice must be made. Thus, the advantages and disadvantages of Federal vs. sate continuation should be carefully weighed before either is chosen.

III. MILITARY SERVICE RULES

A. Military Service – GENERAL RULES

Any eligible person who enters the military service or military training under the laws of the United States may elect to have coverage suspended. This request must be made in writing to the Board of Trustees and will be effective the first day of the month following receipt of the request.

You should notify the Trustees, in writing, as soon as you are aware that you will resume active work by sending a letter to:

United Administrative Services
1120 S. Bascom Avenue
San Jose, CA 95128

B. Uniformed Services Employments and Reemployment Rights Act (USERRA)

If you enter full-time military service for a period in excess of 30 days, your coverage will terminate immediately. You may purchase coverage for your dependents under the rules included in the COBRA section described beginning on page 13. You should notify the Administrative Office in the event you enter military service for more than 30 days, however, you may elect to waive your rights under federal law. The months of coverage so applied would no longer be available to provide coverage upon you return to covered employment.

Employees who are military reservist once called to active duty need to notify the Administrator. The Administrator will notify the Participant of availability to elect continuation of Medical, Dental, Prescription Drug and Vision coverage by self-paying the premium to the Administrative Office. Coverage may be continued for a period that is the lesser of 18 months, or a period that ends on the day the individual fails to apply for, or return to a position as an active Apprentice of San Mateo Electrical Workers.

NOTE: Participants and their dependents may be eligible for coverage under CHAMPUS. The Participants should review these coverages before making a decision to self-pay.

Participants must notify the Administrative Office of his return from active duty.

IV. MEDICAL BENEFITS

The Trust Fund provides medical through a Self-Funded PPO Medical Plan arrangement. A separate booklet available at the Administrative Office describes this coverage.

For details on your benefits coverage, please refer to the Self-Funded PPO Medical Plan Evidence of Coverage. The Evidence of Coverage is the binding document between the Health Plan and its participants.

V. DENTAL BENEFITS

The Trust Fund provides dental care through an insured arrangement. A separate booklet available at the Administrative Office describes this coverage.

For details on your benefit coverage, please refer to the Insurance Provider's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Dental Plan and its participants.

VI. VISION CARE BENEFITS

The Trust Fund provides vision care benefits through a self-funded arrangement. A separate booklet is available at the Administrative Office with complete benefit coverage, limitations, and exclusions.

For details on your benefit coverage, please refer to the Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Vision Care Plan and its participants.

VII. PRESCRIPTION DRUG BENEFITS

The Trust Fund provides prescription drug benefits through a self-funded prescription drug program. A separate booklet is available at the Administrative Office with complete benefit coverage, limitations, and exclusions.

For details on your benefit coverage, please refer to the Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Prescription Drug Plan and its participants.

VIII. NOTICE TO THOSE ELIGIBLE FOR MEDICARE PART D

Effective January 1, 2006, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 created a new prescription drug benefit referred to as Medicare Part D Prescription Drug Coverage (Medicare Part D coverage or coverage). The coverage is available to all Medicare eligible employees and/or dependents who are age 65 or older or are disabled and are receiving Social Security disability benefits, and those with end stage renal disease. The enrollment period for Medicare Part D is November 15th through December 31st.

A notice containing general information about Medicare Part D coverage and this Plan is required to be provided to you (a Medicare eligible individual) by the Trust Fund prior to each annual Medicare Part D enrollment period beginning November 15, 2005. The notice must also be provided to you prior to your initial enrollment period for Medicare Part D coverage, prior to the effective date of your enrollment in this Plan, whenever the Plan's prescription drug coverage ends or changes so that it is no longer creditable, and upon your request. "Prior to" means within 12 months before the event in question.

The Plan intends to continue to provide a prescription drug benefit that is equivalent on a gross basis to Medicare Part D coverage. Therefore, there is no requirement that you enroll in Medicare Part D. The Plan will notify you if this changes.

IX. COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, requires that the Trust Fund participants (covered employees and dependents) be allowed to continue their medical and dental coverage under the Trust Fund at their own expense following certain qualifying events, which request in a loss of coverage. The premium is 102% of the cost of coverage and administrative expenses.

1. Termination of Employment or Reduction in Hours

If your employment terminates (for any reason other than gross misconduct) your eligible dependents may elect COBRA continuation coverage for up to 18 months from the date your coverage would otherwise have ended.

2. Disability-Extended Coverage

If you or an eligible dependent are determined by Social Security to be disabled within 60 days of the date on which COBRA coverage commenced, the disabled individual is entitled to extend the regular 18-month COBRA continuation coverage to 29 months. Eligible dependents of the individual electing this coverage may also receive additional coverage during this special 11-month extension. The premium for the additional 11 months of extended coverage is 150% of the cost of that coverage.
To be eligible for the special 11-month extension, the disabled individual must notify the Plan within 60 days following the later of the date on which the individual receives the initial COBRA notice following a qualifying event or the date Social Security determines that the individual is disabled and in all events before the end of the initial

18-month period of COBRA continuation coverage.

3. Dependent COBRA Coverage

Children born to you or placed with you for adoption during your continuation coverage are eligible to participate in your COBRA coverage, but there may be an additional premium required for their participation. Should you desire this additional coverage, you must promptly notify the Administrative Office at the time of birth or placement for purposes of adoption.

If you first become entitled to Medicare while on COBRA coverage which was elected following a termination of employment, your eligible dependents may elect to extend their initial 18-month COBRA continuation coverage period to 36 months from the date you initially became covered due to a COBRA election.

If your dependents lose coverage due to your death, your surviving spouse and other covered dependents may elect COBRA continuation coverage lasting for up to 36 months from the date their coverage would otherwise have ended.

If a child ceases to be eligible for benefits due to a loss of dependent status, that former dependent may elect COBRA continuation coverage lasting up to 36 months from the date his or her coverage would otherwise have ended.

If your spouse ceases to be an eligible dependent because of a divorce or legal separation, your former spouse may elect COBRA continuation coverage lasting for up to 36 months from the date your spouse's coverage would otherwise have ended.

A parent electing COBRA continuation coverage may elect to continue coverage for dependent children. An employee electing COBRA continuation coverage may elect to continue coverage for the employee's lawful spouse.

4. Cost of COBRA

If you elect COBRA continuation coverage, you must pay the cost of such coverage. The COBRA continuation coverage premiums are adjusted annually by the Trust and reflect 102% of the cost of coverage as of the date the premiums are set for the coverage. If you are totally disabled and qualify for the special extension of an additional 11 months of coverage, the premium for the 19th through 29th months of the extended coverage will be 150% of the cost of that coverage and administrative expenses.

5. Termination of COBRA Coverage

COBRA continuation coverage terminates on the earliest of the following events:

a. The last day of the period for which COBRA continuation coverage may be elected;

b. The date a required COBRA premium payment is due and not received by the Administrative Office;

c. The date the individual receiving coverage pursuant to COBRA first becomes covered under another group medical plan, which does not contain any exclusion or limitation with respect to any preexisting condition of such person. This date may vary for different employees of the same family;

d. The date the person on COBRA continuation coverage first becomes entitled to Medicare coverage. The right to COBRA continuation coverage terminates only for the person who becomes entitled to Medicare coverage;

e. For individuals who are receiving the special 11-month extended coverage period due to disability, the first day of the month that begins more than 30 days after such a person is no longer disabled;

f. The expiration of the applicable 18-month, 29-month, or 36-month COBRA continuation period.

If your coverage ends because of the termination of employment (for any reason other than gross misconduct) or because of your death, you or your dependents will receive information from the Administrative Office within 60 days of the date of loss of coverage. The Trust Fund will then transmit a notice of COBRA continuation rights and an application related to the coverage.

The materials transmitted by the Plan will explain your available options. The materials transmitted will also explain the application process and the premium rates applicable to coverages elected.

6. Election of COBRA Coverage

You will have at least 60 days in which to elect COBRA continuation coverage. If individuals who have lost coverage and are eligible for COBRA continuation coverage fail to make an election within the 60-day time period, rights to COBRA continuation coverage will be waived.

At the end of the COBRA continuation period elected, you may be allowed to enroll in an individual conversion health plan provided to the Plan by certain service providers (such as an HMO or insurance company). Information related to individual conversion health plans may be obtained from the specified service provider.

In order to assure receipt of COBRA materials and other announcements describing changes in the Plan, you and your dependents should advise the Administrative Office of any and all changes in your address.

Your self-payment for COBRA continuation coverage is payable on a monthly basis. It is your responsibility to pay the self-payment directly to the Administrative Office in a timely fashion. You must make your first payment within 45 days after the date that COBRA continuation coverage is elected. If you fail to timely pay your COBRA premium, you will immediately lose your coverage.

X. FAMILY AND MEDICAL LEAVE ACT

The Federal Family and Medical Leave Act (FMLA) enacted by Congress in 1993 provides that in certain situations certain employers are required to grant leave to employees and that in such situations the employer is required to continue medical coverage for the employees.

Certain employers must continue to pay for your health coverage during any approved leave. In general, you may qualify for up to 12 weeks of unpaid FMLA leave per year if:

1. Your employer has at least 50 employees;

2. You worked for the employer for at least 12 months and for a total of at least 1,250 hours during the most recent 12 months; and

3. You require leave for one of the following reasons:

    a. Birth or placement of a child for adoption or foster care;

    b. To care for your child, spouse or parent with a serious medical condition, or

    c. Your own serious health condition. Details concerning FMLA leave are available from your employer.

Requests for FMLA leave must be directed to your employer; the health plan cannot determine whether or not you qualify. If a dispute arises between you and your employer concerning your eligibility for FMLA leave, you may continue your health coverage by making COBRA self-payments.

If the dispute is resolved in your favor, the health plan may obtain the FMLA-required contributions from your employer and will refund the corresponding COBRA payments to you.

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

It is not the role of the Trustees or Trust Fund to determine whether or not an individual employee is entitled to leave with continuing medical care under the applicable laws or the provisions of a collective bargaining agreement. Disputes as to the entitlement to leave with continuing medical benefits must be resolved by the employer, employee and, where applicable, the local union.

To the extent that participants are entitled to leave with continuing medical coverage pursuant to federal and state law or provisions contained within collective bargaining agreement, the Trust Fund will provide continuing medical coverage so long as required monthly contributions are received from the contributing employer.

XI. RIGHTS OF STATES

Payment of benefits with respect to a participant shall be made in accordance with any assignment of rights made by or on behalf of such participant or beneficiary of a participant as required by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of that Act.

To the extent that payment has been made under a state plan for medical assistance approved under the Title XIX of the Social Security Act in any case in which the Plan has a legal liability to make payments for items or service constituting such assistance, payment for benefits under the Plan shall be made in accordance with any state law which provides that the state has acquired rights with respect to a participant to such payment for such items or services.

XII. FEDERAL NOTICES

A. Newborns' and Mothers' Health Protection Act of 1996

Pursuant to the Newborns' and Mothers' Health Protection Act of 1996, the Medical Plans in which you may enroll may not restrict benefits for any hospital length of stay for the mother or newborn child to less than 48 hours following normal delivery or less than 96 hours following a cesarean section delivery.

In accord with Federal Law, those Plans do not require that a provider obtain preauthorization under those Plans for either of the foregoing lengths of stay. However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or her newborn earlier than the applicable time period.

B. Women's Health and Cancer Rights Act of 1998

Your Plan covers medical and surgical benefits for mastectomies. This coverage includes:

1. Reconstruction of the breast on which the mastectomy was performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; or

3. Prosthesis and physical complications of all stages of mastectomy, including lymphedemas.

The coverage is subject to the Plan's annual deductibles and coinsurance provisions.

C. Privacy of Protected Health Information Under HIPAA

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

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

THE FOLLOWING USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI) AND CORRESPONDING RIGHTS AND DUTIES APPLY TO YOU AND YOUR ELIGIBLE DEPENDENTS:

1. Permitted Uses and Disclosures of PHI

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

2. Required Uses and Disclosures of PHI

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

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

This Plan will disclose PHI to family members, other relatives or close personal friends if the information is directly relevant to the family or friend’s involvement with your health care or

payment for such care and you have either agreed to the disclosure or been given an opportunity to object and have not objected.

4. Allowed Uses and Disclosures of PHI For Which Authorization or Opportunity to Object is Not Required

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

5. Your Individual Rights

HIPAA and the Privacy Rule afford you the following rights:

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

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

- You (or your personal representative) have the right to request access to your PHI contained in a Designated Record Set, for inspection and copying, for as long as this Plan maintains the PHI. A Designated Record Set includes the medical billing records about you maintained by or for a covered health care provider, enrollment, payment, billing, claims adjudication, and case or medical management record systems maintained by or for this Plan or other information used in whole or in part by or for this Plan to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you are not in the Designated Record Set and therefore not subject to access. The right to access does not apply to psychotherapy notes or information compiled in anticipation of litigation. You must complete a request form to access PHI in a Designated Record Set. If access to inspect and copy PHI is granted, the requested information will be provided within 30 days if the information is maintained onsite or

within 60 days if the information is maintained offsite. A single 30-day extension is allowed if this Plan is unable to comply with the deadline. This Plan may charge a reasonable fee for the costs of copying. If access to inspect and copy your PHI is denied, a written denial will be provided setting forth the basis for the denial, a description of how you may have the denial reviewed, if applicable, and a description of how you may file a complaint with this Plan or the HHS or its OCR.

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

- You (or your personal representative) have the right to request an accounting of disclosures of PHI by this Plan. This Plan will provide such an accounting only for the six-year period preceding the date of the request. However, such accounting will not include PHI disclosures made to carry out treatment, payment or health care operations or made to you about your own PHI. Also, this Plan is not required to provide an accounting of disclosures pursuant to an authorization request or disclosures made prior to the compliance date of the Privacy Rule. You will be required to complete a request form to obtain an accounting of PHI disclosures within 60 days of the request. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if you are given a written statement of the reasons for the delay and the date by which the account will be provided. If more than one request for an accounting is made within a 12-month period, this Plan will charge a reasonable, cost-based fee for each subsequent accounting.

6. Access to Personal Representatives To PHI

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

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

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

7. This Plan's Duties

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

This Plan is required by law to provide you with its Notice of Privacy Practices ("Notice") by April 14, 2003, and thereafter, upon request. Also, the Notice must be distributed by this Plan to new employees and dependents upon enrollment. You will be advised at least once every three years of the availability of the Notice and how to obtain a copy of it. This Plan is required to comply with the terms of the Notice as currently written. However, this Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by this Plan prior to the date of the change. This Plan will promptly revise and distribute the Notice within 60 days if there is a material change in its privacy policies and procedures.

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

8. Miscellaneous

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

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

This Plan will not use and/or disclose PHI for purposes of marketing. Marketing is defined as a communication that encourages the purchase or use of a product or service, such as

sending a brochure detailing the benefits of a certain medication that encourages it use or purchase. However, this Plan may use PHI without authorization in certain situations, including but not limited to sending information describing the participating providers in its provider network(s), and the benefits provided under the plan, providing information for the management of treatment, or recommending alternative treatment, providers, or health coverage.

9. Duties of the Board of Trustees With Respect to PHI

This Plan will also disclose PHI to the Board of Trustees for Plan administration purposes. The Trustees have amended this Plan's Trust Agreement and signed a certification agreeing not to use or disclose your PHI other than as permitted by the plan documents, the Privacy Rule, or as required by law. The Trustees' uses and disclosures are more fully described in this Plan's Privacy Policy Statement, Notice of Privacy Practices For Protected Health Information, and Board of Trustees' Certificate. Additional copies of these documents can be obtained from the Administrative Office.

10. Complaints

If you wish to file a complaint with this Plan or have any questions regarding the uses or disclosures of your PHI (i.e., access, amendment or accounting of PHI), you may contact the Privacy Officer at the following address:

Jean Sukovez
United Administrative Services, Inc.
1120 Bascom Avenue
San Jose, CA 95128
Phone (408) 288-4400

A complaint may also be filed with the HHS or its OCR, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, DC 20201.

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

11. Security Standards Under HIPAA

The Board of Trustees will implement reasonable and appropriate safeguards to protect the confidentiality, integrity, and availability of electronic protected health information that the Fund creates, receives, maintains, or transmits on behalf of the Plan. The Trustees will ensure that the adequate separation required by the Privacy Rule is supported by reasonable and appropriate security measures. The Trustees will ensure that any agents, including a sub-contractor, to whom it provides electronic protected health information, agrees to implement appropriate safeguards to protect the information. The Trustees will report to the Plan any security incident of which it becomes aware.

XIII. GENERAL PROVISIONS

A. Rules for Coverage if a Labor Dispute

Notice: Arrangements may be made to continue your coverage if you cease Active Work because of a labor dispute. You may continue your coverage up to six months, but only if certain conditions of the Insured arrangements are met. See your *Participating Employer* to make arrangements for continuing your coverage. Your coverage will be terminated unless you make arrangements within 31 days after you cease Active Work due to a labor dispute.

B. Certification of Creditable Coverage Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides that plans must limit the time for which coverage is not provided for pre-existing conditions. (This Plan has no such exclusion; however, some other plans do.) The law requires that this Plan provide written certification of creditable coverage to you when your coverage ceases (under employer coverage and/or COBRA coverage) or when requested by you if your coverage is still in effect or if requested by you within two years after your coverage ends. The certification will specify the period(s) of creditable coverage under this Fund (including COBRA, if applicable) disregarding periods of coverage before a 63-day break. The 63-day break will not include any days between the loss of coverage and any secondary opportunity date to elect COBRA under the Trade Act of 2002.

If your coverage ends (under employer coverage and/or COBRA coverage), the certificate of creditable coverage will be provided to you automatically within a reasonable period of time after your coverage ceases. If you or someone on your behalf (including another health plan or issuer) wants to request a certificate of creditable coverage, please advise the Trust in writing at the following address:

United Administrative Services, Inc.
1120 Bascom Avenue
San Jose, CA 95128

You (or someone on your behalf) should provide your name and the name(s) of your dependent(s) and an address(es) to which the certificate(s) should be sent. The notice will then be processed and sent on the earliest date that the Fund, acting in a reasonable and prompt fashion, can provide it. If you request, in writing, that the Fund send the certificate to another health plan or issuer and the other plan or issuer agrees, the certificate can be processed by means other than in writing, such as by telephone.

Special Enrollment Rights

There are no special enrollment (or late enrollee) requirements under HIPAA because Participants and/or dependents cannot decline coverage under this Trust and new dependents may be added at any time subject to proof of birth, marriage, etc. One composite employer contribution is paid by the participating employer regardless of whether the employee is single, married, or has dependents.

C. Acts of Third Parties

If a Participant (including an eligible dependent) is injured through the act or omission of another party, Plan benefits are provided only on the following conditions:

1. The Participant or dependent will be required to pay to the Plan or any entity providing benefits immediately any proceeds received by way of judgment, settlement or otherwise (including receipt of proceeds under any uninsured motorists coverage or other insurance) arising out of any claims for damages by the individual or his or her heirs, parents or legal guardians, to the extent of the payments made or to be made by the Plan for which the third party may be responsible;

2. Any Participant or dependent who accepts payments from the Plan agrees that by doing so he or she is making a present assignment of his or her rights against such third party to the extent the payments made by the Plan. These rules are automatic, but the Plan may require that any participant or dependent sign an Agreement to Reimburse and/or Assignment of Recovery in such form or forms as the Plan may require; and

3. Any Participant or dependent who refuses to sign an Agreement to Reimburse and/or Assignment of Recovery in a form satisfactory to the Plan shall not be eligible for Plan benefit payments related to the injury involved. Any participant or dependent who receives benefit payments and later fails to reimburse the Plan as set forth above will be ineligible for any future Plan benefit payments until the Plan has withheld an amount equal to the amount which the participant or dependent has failed to reimburse, including reasonable interest on such unpaid funds.

By accepting benefit payments from the Plan, any participant or dependent agrees that the Plan may intervene in any legal action brought against the third party or any insurance company, including the employee's own carrier for uninsured motorist's coverage. A lien shall exist in favor of the Plan upon all sums of money recovered by the participant or dependent against the third party. The lien may be filed with the third party, the third party's agents, or the court. The participant or dependent shall do nothing to prejudice the Plan's right as described above without the Plan's written consent.

If the participant or dependent settles or compromises a third party liability claim in such a manner that the plan is reimbursed in an amount less than its lien, or which results in a third party or its insurance carrier being relieved of any future liability for medical costs, then the participant or dependent shall receive no further benefits from the Trust Fund in connection with the medical condition forming the basis of the third party liability claim unless the Board of Trustees or its duly authorized representative has previously approved the settlement or compromise, in writing, as one which is not unreasonable from the standpoint of the Trust Fund.

D. Coordination of Benefits

General Coordination of Benefits Rule: If a participant or dependent is entitled to benefits from another plan, insurance companies or other entities likely have rules on which plan is

primary or secondary and who pay first. You should consult with these entities to determine the rule. The benefits provided herein shall be paid in accordance with the standardized coordination of benefits provisions of the National Association of Insurance Commissioners.

You may not reject coverage under another Plan, HMO and/or insurance company and/or not enroll in such other Plan, HMO and/or insurance company and then expect this Plan to be primary with respect to payment of your benefits. The other Plan, HMO and/or insurance company would be primary (or you would be responsible for such claims/payments if they refuse such given your failure to enroll or action of unenrolling).

E. Benefit Continuation

(Amendment and Termination)

It is the intent of the Trustees to continue this plan indefinitely, although they reserve the right to modify or discontinue this coverage at any time. Thus, benefits may be reduced or eliminated entirely. Moreover, participants could be asked to pay a portion or all of the required premium.

F. Exclusion for Fraud

No benefits are paid for fraudulent claims or services or supplies by a participant, eligible dependent or any other person. If a fraudulent claim has been paid by the Plan or by any entity on behalf of the Plan for any person, both the participant and any person on whose behalf a fraudulent claim was submitted or paid is liable to the Plan for repayment of benefits paid and the amount of any premium paid to a, PPO, insurance company or any other entity. This does not preclude the Plan, PPO, insurance company or other entity from bringing a lawsuit against any person who commits fraud to recover improperly paid benefits, services or supplies, including reimbursement for any attorney's fees and costs incurred to recover such amounts.

By way of example, if a participant improperly signs up a person as a dependent who is not lawfully a dependent under the Plan, both the participant and such unlawful dependent will be liable to the Plan and the Plan's providers for any claims paid, any premium paid by the Plan, and any attorneys fees and costs incurred by the Plan and any provider in recovering such improperly paid claims.

G. Claims and Appeal Procedure

Health Plan

Copies of the applicable appeals procedures are available from the pertinent insurance companies or other providers. The Plan's medical provider and other entities have their own appeal procedures set forth in their applicable documents.

It is required that your Health Plan provide you with specific reasons for denial of benefits and that you be given the opportunity for "full and fair review" of the denial from the provider of service (carrier).

1. The denial notice must include the following:

2. The specific reason(s) for the denial;

3. The specific reference to pertinent plan provisions on which a denial is based;

4. A description of any additional material or information is necessary for you to make your claim, and an explanation of why such material or information is necessary, and

5. Information on the steps to be taken if you wish to submit your claim for review.

You have at least 180 days (or longer if your plan agrees) to submit our claim for review.

A decision must be made on your initial request for a plan benefit as follows:

1. Claims for urgently needed care must be ruled on “as soon as possible”, and in no event more than 72 hours after the claim is filed;

2. Claims for pre-approval benefits must be decided upon within 15 days; and

3. Claims for reimbursement when you have already received care must be ruled on within 30 days.

Appeal

If the application for benefits or a claim is denied, you or your authorized representative may petition the Board of Trustees for review of the decision (an appeal). Your appeal must be filed with the Plan within 180 days of your receipt of the denial notification. You may have access to relevant documents, records and other information, including any statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Your appeal of the adverse benefit determination of your disability claim will be decided at the next regularly scheduled meeting the Plan’s Board of Trustees following the Plan’s receipt of your appeal, unless the appeal was received within 30 days of the Board meeting. If that occurs, the appeal must be decided by the following regularly scheduled Board meeting.

Finality of Decision on Claim – Right to File Lawsuit

The denial of an application or claim after the right to review has been waived or the decision of the Trustees on appeal has been issued is final and binding upon all parties, including the claimant.
No lawsuit may be filed without first exhausting the above appeals procedure. No legal action may be commenced or maintained against the Plan or any Trustee or legal fiduciary, person or entity involved in the decision more than two years after a claim has been denied on appeal.

When a Lawsuit may be Started

No Participant, Dependent, Beneficiary or other person shall have any right or claim to benefits under these Rules and Regulations or any right or claim to payments from the Fund, other than as specified herein. A Participant may not start a lawsuit to obtain benefits until after either: (1) the Participant has submitted a Claim pursuant to these Rules and Regulations, requested a review after an Adverse Benefit Determination, and a final decision has been reached on review; or (2) the appropriate time frame described above has elapsed since Participant filed a request for review and Participant has not received a final decision or notice that an extension will be necessary to reach a final decision.

No lawsuit may be filed (started) more that two years after services were provided or benefits partially of totally denied or an otherwise adverse determination was made against you or, if the Claim is for short term disability benefits, more than 2 years after the onset of the disability. The provisions of this Section shall apply to and include any and every claim to benefits from the Fund, and any claim or right asserted under the Plan or against the Fund, regardless of the basis asserted for the claim, and regardless of when the act or omission upon which the claim is based occurred, and regardless of whether or not the claimant is a "Participant" or "Beneficiary" of the Plan with the meaning of those terms as defined in ERISA. Such claim shall be limited to benefits due to him under the terms of the Plan, or to clarify his rights to future benefits under the terms of the Plan, and shall not include any claim or right to damages, either compensatory or punitive.

H. Miscellaneous Provisions

The benefits payable hereunder shall not be subject to any manner of anticipations, alienation, sale or transfer.

Self-funded plan benefits shall be paid only if notice of a claim is made within 90 days from the date on which covered charges were incurred. The claimant must submit properly completed claim forms and itemized statements as authorized by the Board of Trustees. Any exceptions to the submission of the claims later than 90 days are subject to the approval of the Board of Trustees, but in no event may claims be considered for payment later than 15 months from the date on which covered charges were incurred.

In the event the Plan determines that the Covered Person is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Covered Person has not provided the Plan with an address at which they can be located for payment, the Plan may, during the lifetime of the Covered Person pay any amount otherwise payable to the Covered Person, to the spouse, or relative by blood of the Covered Person, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Covered Person before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Covered Person: Lawful spouse, child or children, mother, father, brothers or sisters, or to the Covered Person’s estate, as the Board of Trustees, in its sole discretion, may designate. Any payment in accordance with the provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

No participant, dependent or other beneficiary shall have any right to claim to benefits form the Plan, except as specified. Any dispute as to eligibility, type, amount or duration of the benefits under this Plan or any amendment or modification thereof shall be resolved by the Board of Trustees. The Trustees shall have discretion in any such determination. Participants may seek review of any adverse decision of the Trustees in Federal District Court as prescribed by law.

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

The provisions of the Plan are subject to and controlled by the provisions of the Trust Agreement, if applicable, and in the event of any conflict between the provisions of the Trust Agreement and the provisions of this Plan, the Trust Agreement shall prevail.
Certain benefits are self-funded and any references to "insurance" are inapplicable to Self-Funded benefits.

It is recognized that the self-funded benefits provided by the Plan can be paid only to the extent that the Fund has available adequate resources for such payment. No contributing employer, the Local Union nor any individual trustee or the Board of Trustees has any liability, directly or indirectly to provide the self-funded benefits established hereunder beyond the assets available in the Fund and the obligation of contributing employers to make contributions as stipulated in the collective bargaining unit agreements.

WARNING: BENEFITS CAN BE REDUCED OR ELIMINATED.

The Board of Trustees reserves the right to reduce or modify any and all benefits of the Plan, in part or in whole, and may change or eliminate any or all insurance carriers, HMOs and any other provider or entity. The Board may also require contributions for any increases to the Plan from time to time from the Participants of the Plan. Any such changes are at the discretion of the Board of Trustees.

XIV. POTENTIAL LOSS OF BENEFITS

You and/or your eligible Dependent(s) could lose your benefits and/or have payments delayed in at least the following circumstances:

A. Inadequate or Improper Evidence

The Plan grants the Board of Trustees the power to deny, suspend or discontinue benefits to a Participant who fails to submit at the request of the Trust Fund Office any information or proof of coverage reasonably required to administer the Plan.

B. Prohibited Employment in the Electrical Industry

If you engage in certain kinds of work in the Electrical Industry, known as Prohibited Employment, you will no longer be entitled to Apprentice Health and Welfare benefits.

C. Subrogation Third Party Claims

The Plan does not cover any illness, injury, disease or other condition or claim for which a third party may be liable or legally responsible. See page 23 for Third Party Liability.

D. Coordination of Benefits

If Dependents are covered by more than one Plan, this Plan may not be responsible for many claims. Please refer to page 23 for the rules of Coordination of Benefits.

E. Work-Related Injuries

The Plan is not responsible for paying any claims incurred as a result of a work-related injury. This applies even if you have not filed a claim with workers compensation.

F. Right to Recover Claims Paid or Offset of Future Claims

The Plan has the right to recover any amounts improperly paid. The Plan may offset any amounts owed to the Plan against any claims that you and/or a Dependent incur in the future.

G. Plan Exclusions/Co-Payments

The Plan and the insurance providers contain exclusions and exceptions for coverage. You should be aware of the Plan's and the insurance provider's limitations, exclusions, co-payments and other facets of the Plan in which you may not receive full payment on a claim or reimbursement or for which there is a co-payment.

H. Failure to File Complete Applications

Benefits may not be payable until a completed application and other forms required by the Trust Fund Office are received by the Trust Fund Office.

I. Incomplete Information/False Statements

If you fail to provide requested information or give false information to verify disability, age, beneficiary information, marital status or other vital information, coverage under the Plan or benefits provided may be postponed or cancelled.

If you make a false statement to the Plan or other officials regarding the payment of benefits or other issues related to the Plan, you will be liable to the Plan for any benefits paid in reliance on such false statements or information. This includes but is not limited to costs incurred by the Trust Fund Office, reasonable attorneys' fees, and interest charges. The Plan may deduct any such fees and costs from any benefits otherwise payable to you, your estate or a beneficiary.

J. Plan Termination

If the Plan terminates, benefits will no longer be provided.

XV. GENERAL INFORMATION

(As Required by ERISA)

1. **Name and Address of the Plan**: San Mateo Apprenticeship Health Care Benefits Plan, 1900 El Camino Menlo Park, CA 94025.

2. **Type of Plan**: This is a Health Care Plan, providing the following Health Care Benefits Plan –Hospital, Surgical, Medical, Dental, Prescription Drug, and Vision coverages.

3. **Type of Administration and Method of Fund Benefits**: This Plan is administered by the Joint Board of Trustees. The Plan is funded by employer contributions as provided for in the collective bargaining agreement. Claims not related to HMO and insured providers are processed by a contract administrator.

4. **Sponsoring Organizations**: The Plan is maintained in accordance with collective bargaining agreements between N.E.C.A., San Mateo Chapter and Local 617 of the International Brotherhood of Electrical Workers Union. By writing to the Union, participants and beneficiaries may determine whether a particular employer is a sponsor of the Plan, and if so, the employer's address.

5. **Contributions**: Contributions to provide Plan benefits are paid by the sponsoring employers in accordance with their bargaining agreements "on a cents-per-hour basis".

6. **Appeal Procedure**: The procedure for file appealing denials are set forth on page 25 and in the separate booklets furnished by the insurance companies and other entities.

7. **Fiscal Year**: The fiscal year of the Trust is the twelve-month period ending each January 31st 30th, and the Trust's records are maintained on that basis.

8. **Employer Identification Number**: 72-1543541

9. **Plan Number**: 501

10. **Names and Addresses of the Board of Trustees**:

Employer Trustees:	Union Trustees:
Mr. Bob Gonzales NECA 1900 El Camino Real Menlo Park, CA 94025	Mr. Dominic Nolan IBEW Local 617 1701 Leslie Street San Mateo, CA 94402
Mr. Dennis Agresti NECA 1900 El Camino Real Menlo Park, CA 94025	Mr. Mark Leach IBEW Local 617 1701 Leslie Street San Mateo, CA 94402

11. Name and Address of Contract Administrator:

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

12. Name and Address of Agent for Service of Legal Process:

Neyhart, Anderson, Flynn & Grosboll
Attorneys at Law
44 Montgomery Street
Suite 2080
San Francisco, CA 94104-6702
(415) 677-9440

XVI. HIPAA

In accordance with the new disclosure requirements of the Health Insurance Portability and Accountability Act, we are informing you of the names and addresses of all Heath Providers for the Trust Fund and their roles (i.e., whether they guarantee the payment of benefits or provide administrative services).

List of Providers

United Administrative Services, Inc.
1120 Bascom Avenue
San Jose, CA 95128
Administers the self-funded plans; does not guarantee payment of benefits.

Anthem Blue Cross Prudent Buyer Plan
21555 Oxnard Street
Woodland hills, CA 91367
Administers the PPO contracts, case management and utilization review for the Self-Funded Medical Plan; does not guarantee payment of benefits.

Delta Dental
100 First Street
San Francisco, CA 94105
Provides prepaid dental benefits with guaranteed payment of these benefits.

US Rx Care
20 River Ct. #2908
Jersey City, NJ 07310
Provides self-funded prescription drug benefits; does not guarantee payment of these benefits.

Vision Service Plan
333 Quality Drive
Rancho Cordova, CA 95670
Administers the self-funded vision plan for participants and dependents.

The Act also requires that we inform you of the Department of Labor address in Washington, D.C. If you have any questions about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210. Additional information regarding your ERISA rights may be found in your Summary of Benefits booklet under "Statement of ERISA Rights".

XVII. STATEMENT OF ERISA RIGHTS

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.

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

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report at no cost to the participant.

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

You should be provided a certificate of creditable coverage free of charge, from your group health Plan or health insurance issuer as follows:

- when you leave coverage under that Plan, when you become entitled to elect COBRA continuation coverage;
- when your COBRA continuation coverage ceases;
- if you request it before losing coverage; or
- upon your request up to 24 months after losing coverage.

You may be subject to any pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan participants, ERISA imposes duties upon the individuals who are responsible for the operation of the Employee Benefit Plan. The individuals who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interests 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 benefits under the plan or exercising your rights under ERISA. If your claim for benefits is denied or ignored, in whole or in part, you must receive a written explanation for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA there are steps you can take to enforce the above rights.

For instance, if you request materials 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 $110.00 per 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, which is denied or ignored, in whole or in part, you may file suit in a State or Federal Court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal Court. If it should happen that Plan 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 the 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.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. For single copies of publications, contact the EBSA Brochure Request Line at (866) 444-3272 or contact the EBSA field office nearest you.

You may find answers to your questions and a list of EBSA offices at www.dol.gov/ebsa/welcome.html.