

**SANTA BARBARA COUNTY ELECTRICAL
WORKERS HEALTH TRUST**

SUMMARY PLAN DESCRIPTION

JANUARY 1, 2011

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It is anticipated that the Plan is permanent and will continually be in operation. It is, however, legally necessary to consider the possibility of termination of the Plan. The parties to the Collective Bargaining Agreements between IBEW Local 413, NECA, Central Coast California Chapter, may terminate the Plan in whole or in part. Although there is no intent to terminate the Plan, there is no guarantee that the Plan will last forever.....	48
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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, 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, 2011

Dear Participant:

This booklet, which is both the Plan Document and Summary Plan Description, contains general information regarding your Insurance Benefits and an explanation of the eligibility provisions. We urge you to familiarize yourself with the provisions and benefit structure of your Plan. Please direct any questions you have to the Trust Office at (408) 288-4400. In the event of any dispute, the official language of the group insurance policy, or other master agreements, will prevail.

For details on your medical coverage, please refer to the Anthem Blue Cross Evidence of Coverage. This document is the binding document between the Anthem Blue Cross and its participants. You should review the booklet and other documents furnished by Anthem Blue Cross.

The full Board of Trustees is authorized to interpret this Plan document. 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. Anthem Blue Cross retains the authority to interpret its Evidence of Coverage document and other internal documents.

Open Enrollment is held annually for the purpose of enrolling your dependents that were not previously enrolled when you first qualified for coverage, or within 30 days of their becoming an eligible dependent. Enrollment must be received within the allocated time frame and will be effective the first day of the month following receipt of the required documents.

If a dependent is not enrolled timely, they can be enrolled during the following year's Open Enrollment period.

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

Santa Barbara County Electrical Workers Health Trust
c/o United Administrative Services
1120 S. Bascom Avenue
San Jose, California 95128
(408) 288-4400

Plan rules and benefits may change from time to time. The Plan will provide you with a summary of important material changes.

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 and signed into law, 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 summarizes 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 RULES

The eligibility rules described in this booklet apply to all the benefits provided by the Trust Fund to Participants and their dependents, including coverage through Health Maintenance Organizations (HMOs) and Insurance Companies. Note that the timely filing of an application (enrollment form(s)) for benefits is one of the conditions of eligibility for benefits.

A. Eligibility for Active Participants

To be eligible for benefits provided by the Trust Fund, you must be a Participant.

Participant means any person who is:

1. (a) Employed in Covered Employment by a Contributing Employer;
(b) Has accumulated a minimum of 300 hours of Covered Employment within a continuous 12 month period; and
(c) Meets the eligibility requirements below.

Covered Employment is employment covered by a Collective Bargaining Agreement between IBEW 413 and the California Central Coast Chapter of NECA.

2. A Non-Bargaining Unit employee pursuant to the terms of a recognized Collective Bargaining Agreement as defined in the Trust Agreement, a Letter of Assent to such an Agreement, or a Subscription Agreement.

B. Eligibility for Dependents

Dependent means a:

1. Participant's spouse;
2. Participant's child (including stepchild or legally adopted child) whether live birth or placement for adoption until the end of the month in which the child attains age 26.

The right of a child under age 26 to participate in the Plan terminates if he or she is eligible for coverage through his or her own employment (or the child has coverage through his or her spouse's employment).

Covered Dependents

Your Covered Dependents are your lawful spouse (husband or wife), natural children, legally adopted children and stepchildren. Dependents must be listed on the health Plan beneficiary form covered by the participant in order to be covered under the Plan.

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 (process for adopting has started and is proceeding), 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 all benefits provided from birth up to the age of 26 years (end of the month the child attains age 26) assuming the child has no other health care coverage through his or her own employment or through the employment of the child's spouse.
7. Disabled Children: A dependent child also includes a child after his 26th 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.

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 child being eligible for health coverage through his or her employment (or his or her spouse's employment), 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 funds.

The Trustees may require evidence of Dependent status such as a marriage license, birth certificate, and other such evidence as the Trustees determine is reasonable.

Adding New Eligible Dependents

During the period you continue to have coverage, any new eligible Dependents you acquire may be added in accordance with the Eligibility for Dependents provisions, and any eligible Dependents you decline to enroll for coverage under the Plan may be added during any open enrollment period provided by the Plan. Coverage will begin immediately upon the date that open enrollment coverage commences for all Dependents without any preexisting condition limitations.

No New Dependents Added After Retirement

Dependents acquired after the Participant's date of retirement shall not be eligible for benefits under this Plan. This rule will apply even if the Participant returns to covered employment after such retirement.

C. ELIGIBILITY FOR RETIREES

1. Retiree means a Participant who:

Has been eligible under this Plan or the predecessor Plan (Electrical Workers Area Health and Welfare Plan) as an active employee (Excluding Coverage Under COBRA) for 120 months out of the last 180 months and 24 months out of the last 60 months immediately preceding age 62 or a subsequent age (whichever is earlier for purposes of establishing eligibility); or

Has attained age 62 and has less than 10 years of coverage under this Plan or the predecessor Plan, but has had continuous coverage under this Plan or coverage under either Plan since his/her inception date of work experience in the electrical industry and has coverage at his/her retirement date.

2. Dependent Eligibility:

The Retiree and his/her Dependents shall be eligible to participate in the Retiree Health and Welfare benefits then in effect, if any. The Retiree's working dependent spouse has the option to delay enrollment until retirement or, if earlier, once becoming entitled to Medicare.

3. Enrollment in Medicare – Parts A & B Required:

If a Retiree is eligible for Medicare, the Retiree must enroll in both Part A (Hospital Insurance) and Part B (Medical Insurance) of Medicare. If a Retiree's spouse is eligible for Medicare, he or she also must enroll in both Part A and Part B of Medicare.

Please note the Board of Trustees reserves the right to modify, amend, or delete any benefits or eligibility for benefits, including Retiree benefits, at any time, and may increase the amount of self-payment required of the Retiree.

4. Retiree Self-Payments

A Retiree must make a monthly payment to the Trust to help cover the cost of the benefits provided. The amount of such payment is established by the Board of Trustees and may be changed at any time.

5. Disabled Retiree means a participant who:

- Becomes totally disabled as defined below, prior to age 62, and has been eligible under this Plan or the predecessor Plan for 10 out of the last 15 years and two out of the last five years immediately prior to disability retirement or, for those with less than 10 years of Plan participation, he or she:
- Has participated in this Plan or the Area Health and Welfare Plan since inception of work experience in the electrical industry; or
- Has coverage at his or her retirement date.

6. Early Retirement Direct Payment

If you have retired after reaching age 55 and prior to age 62, pursuant to the provisions of the Central California IBEW-NECA Pension Trust Fund, and have been eligible under this Plan or the Area Plan for 10 of the last 15 years and two of the last five years (24 months out of the last 60 months) immediately preceding retirement and have coverage at your (120 months out of the last 180 months) retirement date, you may be permitted to make direct payment in order to maintain continuation of coverage. The amount of such payment is set by the Board of Trustees and can be changed at any time.

D. ELIGIBILITY AND HOUR BANK SYSTEM

The Trust Office, in addition to maintaining a separate record for each Participant, will keep an hour bank showing an accumulation of hours worked as reported from each Contributing Employer.

1. Initial Eligibility

As a Participant you must have accumulated to your credit a minimum of 300 hours in your hour bank within a continuous 12-month period for which contributions have been made pursuant to a recognized Collective Bargaining Agreement as defined in the Trust Agreement. **Coverage is to be effective on the first day of the second month after the month in which these eligibility requirements are satisfied.** As an example, if you begin working in January and accumulate 300 hours by the end of March, your coverage will be effective May 1st.

2. Subsequent Eligibility

In order to maintain your eligibility as a Participant you must have a minimum of 125 hours of hour bank available each month. The 125 hours can come from contributions made on your behalf by a Contributing Employer, or from hour bank reserves, or, if eligible, under the direct payment or Short-Term Disability provisions set forth below. They cannot, however, be made up of a combination of direct payment and hours worked or direct payment and hour bank.

3. Monthly Hours Charged for Coverage

The charge for coverage shall be 125 hours per month against the individual Participant's hour bank until insufficient hours remain in your hour bank. Hours worked in one month shall not apply toward coverage in the next month, but in the second following month.

4. Maximum Hour Bank- 750 Hours

You can build up your hour bank to the maximum of 750 hours. You shall have no claim for hours or contributions reported in excess of said 750 hours. The hour bank is not a vested benefit and may be modified or eliminated by the Trustees at any time.

5. Loss of Hour Bank Credits

In any situation in which you have not had eligibility under the Plan for a period of 12 consecutive months or more, any remaining hours in your hour bank shall no longer be shown to your credit, and thereafter, should you again perform work covered by the collective bargaining agreement, you shall have to establish eligibility as provided above.

Employees also have their hour bank hours cancelled by immediately engaging in any employment in the electrical industry that would be covered employment if the Employer had a Collective Bargaining Agreement with IBEW 413.

E. RETURN TO WORK POLICY (Active and Retiree)

A person who has retired under the Plan who returns to Covered Employment under a Return to Work Policy approved by the Board of Trustees as evidenced by a motion approved at a Board of Trustees meeting will, upon earning sufficient hours of eligibility, be covered under the rules as if he or she were an Active Employee. His or her dependents will then be treated in the same manner.

With respect to the premium to be paid by a Retiree, if a Retiree returns to Covered Employment under a Return to Work Policy approved by the Board of Trustees and works 100 or more hours of Covered Employment in a month, a subsidy for that Retiree will not be provided. Thus, the full premium established by the Board shall apply. If the retiree works under 100 hours of Covered Employment in a month, a subsidy will be provided by the Plan

F. ELIGIBILITY AND BENEFITS IN THE EVENT OF DISABILITY

If you are or become disabled, you may qualify for extended eligibility and certain benefits under limited circumstances as provided below.

1. Definition of Disability

The term "Disability" means: Subject to number 2 below, a licensed medical doctor has certified on a form or in a manner approved by the Trust Fund that you are temporarily or permanently unable to perform the duties of your job. The Plan is not required to rely upon an opinion of a doctor selected by the Participant.

For the purpose of determining disability, you will be considered disabled, if in the opinion of a competent medical professional(s), you are unable to satisfy any one of five physical requirements or suffer from a condition which would make the performance of tasks inherent in the duties of an electrician particularly dangerous to the Participant as a result of such medical condition. The five physical requirements are the following:

- Can you lift, push and pull loads of at least 20 pounds?
- Can you work from ladders, scaffolds, ditches and uneven ground?
- Can you lie down and retrieve objects from the ground floor?
- Do you have use of both arms and legs and have dexterity in the fingers and hands?
- Can you read normal printed material (with corrected lenses if required)?

"Total Disability" shall be evidenced by a current Social Security Disability Award; however, in the event a Social Security Disability Award is denied, disability benefits may be granted if you are determined to be totally and permanently disabled by the Trust Fund.

2. Proof of Disability

The Trustees reserve the right to require proof of any disability from a doctor of their choice at the expense of the Trust Fund.

3. Short-Term Disability Coverage

If you become temporarily disabled while coverage is in force due to Employer contributions, hour bank or direct payments to the Trust Fund (excluding coverage through COBRA Payments) and your disability continues for a period of at least 30 consecutive days, you may submit to the Board of Trustees, in writing, proof of such disability on a form approved by the Trust Fund, along with a request that you be placed on the Temporarily Disabled list.

The Trust will provide for up to 18 months free coverage. This is a lifetime maximum.

Participants have the option to freeze their hour bank after 125 hours have been used prior to receiving the 18 months of lifetime benefits.

If you recover within the 18-month period and have registered for immediate employment in order to re-qualify for eligibility under this Plan by virtue of such employment, your temporary disability coverage shall continue for up to three months, provided such eligibility does not exceed the above maximum of 18 months.

4. Permanent Disability Coverage

In the event a disability qualifies as "Total Disability" as defined above, you are eligible to participate in the Retiree Health and Welfare benefits then in effect, if any, by paying the required monthly premium as established by the Board of Trustees.

5. Direct Payment by a Participant

A Participant already having coverage under this Plan whose hour bank hours have fallen below 125 hours may, in order to maintain continuous coverage, make payment directly to the Trust Fund under the following conditions:

The amount of such payment as set by the Board of Trustees;

In no event will hour bank residuals (less than 125 hours) be used to offset the amount required to maintain one month of Covered Employment.

There may not be a break in payments, and the Trust Office must receive all payments prior to the 20th of the month for which coverage is to be effective or the date established by the Trustees, whichever is earlier.

In order to qualify for direct payments you must be registered on your Union's out of workbook. There are two exceptions:

The Board of Trustees or the Board's delegate has the right to designate that a medical opinion of your disability be determined by a physician selected by the Board, or

If you obtain written approval from the Board of Trustees to make direct payments during an extended leave of absence, subject to the time limits outlined below.

So long as you continue to qualify for direct payments, such payments may continue up to a maximum of 18 consecutive months provided that, if at any time during the 18 month period you are disabled and unable to work and present proof of such disability on a form provided by and to the satisfaction of the Trust Fund, you may qualify for up to 18 months of temporary disability coverage as described in the "Temporary Disability Coverage" section above. However, in no event may the combination of direct self-payments and/or temporary disability benefits exceed a total of 30 months for any "Single Disability" as defined above. The Board of Trustees has absolute discretion to determine whether a disability is a "Single Disability".

G. Industry Reciprocity

In order to re-establish or preserve continuity of coverage in the Plan, you may apply for the transfer of contributions from a Reciprocal Fund in accordance with the Electrical Industry Health and Welfare Reciprocal Agreement by completing an Employee's Reciprocal Authorization and Release form. You may designate a Local Trust as your Home Fund if:

- You are a member of the Local Union participating in that fund and have been eligible for Plan benefits through the Local Trust within the six-year (72 months) period preceding application for reciprocity, or
- You are eligible for Plan coverage through that Local Trust at the time you apply for transfer of contributions, and intend to return to work under the jurisdiction of the Local union, which participates in that Trust as soon as work is available.

Upon approval of the application based on the foregoing rules, the lesser of (1) contributions in an amount provided in the current Collective Bargaining Agreement of the Home Fund, or (2) contributions in an amount provided in the current Collective Bargaining Agreement of the Reciprocal Fund in which you are working, will be transferred. If the contribution rate in the Home Fund is greater than that in effect in the Reciprocal Fund, the Trust Office shall, on behalf of the Home Fund, prorate the hours reported based on the relationship of the Home Fund rate to the Reciprocal Fund rate.

The effective date of transfer shall be the first of the month in which the appropriate application is signed and shall remain in effect until you have not worked in the jurisdiction of the Reciprocal Fund for twelve consecutive months or until the end of the month written notice is given to the Reciprocal Fund to cancel the authorization to transfer contributions. Retroactive Reciprocity transfers will not be made. Thus, timely submittal of the form is important.

The terms of the Electrical Industry Health and Welfare Reciprocal Agreement may be changed or amended from time to time by vote of the participating Trusts throughout the

United States. To determine whether changes have occurred in the Reciprocal Agreement since the printing of this booklet contact the Trust Office.

H. Effective Date for Initial Coverage

You must request initial coverage under the Plan by completing and returning the appropriate application and any other forms provided by the Trust Office. If you are not required to contribute toward the cost of your coverage, your benefits will be in force on the date you are eligible.

I. 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 enroll the child within 31 days, there is no coverage.**

J. 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, known as a Qualified Medical Child Support Order (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 Trust Office with a copy of the court order and/or QMCSO.
2. Within thirty (30) days after receipt of the QMCSO, the Trust 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.

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.

Coverage If 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 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 beginning on page 27.

II. TERMINATION OF COVERAGE

Your coverage will cease on the earliest of:

- The date the Plan's Group Insurance Policy terminates; or
- The beginning of the month in which you cease to maintain eligibility for which benefits are provided; or
- The end of the calendar month in which you have less than 125 hours in your hour bank account.

If you cease Active Work because of sickness or injury, your Plan provides for limited continuation coverage. If you are covered by the Collective Bargaining Agreement and you cease Active Work because of a lay-off or leave of absence, coverage may be continued until your bank is exhausted.

Your coverage may also be continued or reinstated in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA) described below.

If you are interested in continuing your coverage beyond the date it would normally terminate, you should consult with the Trust Office *before* your coverage terminates.

NOTE: When both Federally 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. State continuation should be carefully weighed before either is chosen.

1. Leaving Covered Employment

Upon leaving Covered Employment, if you have at least 125 hours in your hour bank in the Plan, you will have the option of:

- Running out your hour bank by using the hours to provide coverage for one or more months, or
- Serving notice to the Trust Fund within 30 days of leaving Covered Employment of your desire to freeze your hour bank for a period not to exceed one year.
 - The freezing of your hour bank will become effective on the first day of the calendar month after the date of serving said notice, provided said notice is received by the Trust Office prior to the 15th of the month. If notice is received after the 15th of the month, the freezing will become effective on the 1st day of the second following calendar month.
 - Upon re-entry into Covered Employment within the one-year period from the date of serving the above notice, you shall be allowed 30 days within which to file notice of your intention to unfreeze your hour bank. “Covered Employment” as used in this section is defined as the first day Employer Contributions are made, or should have been made, on a person’s behalf.
 - No one is eligible to freeze his/her hour bank unless there are 125 or more hours in the bank; and
 - When unfreezing hours, unfrozen hours of less than 250 will allow coverage to begin on the 1st of the month following the month the returning Participant accumulates 125 new contribution hours; and
 - A returning Participant unfreezing 250 or more hours will have coverage effective the 1st of the month he/she resumes Covered Employment; and
 - Failure to return within one year results in cancellation of the Participant’s hour bank; and
 - A Participant’s hour bank will be canceled if he/she engages in work of the type covered by the Collective Bargaining Agreement for a non-contributing employer.

III. CONTINUATION OF COVERAGE

A. Military Service

Any eligible person who enters the military service or military training under the laws of the United States may elect to have coverage suspended by freezing his or her reserve hours. 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. See address below.

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

Santa Barbara County Electrical Workers Health Trust
c/o United Administrative Services
1120 S. Bascom Avenue
San Jose, California 95128
(408) 288-4400

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

If you enter full-time military service for a period in excess of 30 days, your coverage under the Plan will terminate immediately. You may purchase coverage for your dependents under the rules included in the COBRA section. You should notify the Trust Office in the event you enter military service for more than 30 days. .

The following procedures are to be followed for participants who are military reservist once called to active duty:

1. Upon notification that a Participant has been called to active duty, a Participant's hours will be frozen from the first day of the month following the date the employee begins active duty. Exception: If the Participant begins active duty on the first of any month, the Participant's hours will be frozen as of the first of that month.
2. The Trust Fund will notify the Participant of availability to elect continuation of Medical, Dental, Disability, AD&D, and Life coverage by self-paying the premium to the Trust 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 Participant of Electrical Workers Health and Welfare Trust Fund of Santa Barbara.

NOTE: Participants and their dependents may be eligible for coverage under CHAMPUS, a federal health care program. Participants should review your coverage options before making a decision to self-pay.

Participants must notify the Trust Office of his/her return from active duty. The Trust Office will restore the Participant's frozen hours, and the Participant will once again be eligible for all benefits that he/she would normally have been eligible for had he/she not been called to active duty.

However, you may elect to waive your rights under federal law. In that case, your Reserve Account may be applied to provide coverage for your dependents at the applicable rate for active members. The months of coverage so applied would no longer be available to provide coverage upon your return to covered employment.

IV. MEDICAL BENEFITS

The Trust Fund provides prepaid medical benefits through Anthem Blue Cross HMO or Anthem Blue Cross PPO. Separate booklets available at the Trust Office describe this coverage.

For details on your benefit coverage, please refer to Anthem Blue Cross's HMO or Anthem Blue Cross's PPO Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between Anthem Blue Cross and its Participants.

V. RETIREE MEDICAL BENEFITS

The Trust Fund provides prepaid retiree medical benefits through United HealthCare Secure Horizons and a Senior Supplement Plan. Separate booklets available at the Trust Office describe this coverage.

For details on your benefit coverage, please refer to United HealthCare's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between United HealthCare and its Participants.

VI. DENTAL BENEFITS

The Trust Fund provides prepaid dental benefits through Delta Dental. Separate booklets available at the Trust Office describe this coverage.

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

VII. LIFE INSURANCE BENEFIT & ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Trust provides active participants with Life/AD&D benefits through Prudential Insurance. Separate booklets available at the Trust Office describe this coverage.

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

VIII. HEALTH REIMBURSEMENT ACCOUNTS

Effective as of April 1, 2011, each active Participant for whom contributions are made under a collective bargaining agreement for the purpose of a Health Reimbursement Account ("HRA") will receive credit for that contribution. During 2010 and each year thereafter, the Board of Trustees will decide on the hours of breakage and will determine the dollar amount to be allocated to the HRA's. The breakage and allocation amounts will be reviewed in the manner and time period determined by the Board of Trustees but usually annually. Funds will be credited as of April 1, 2011. The Board of Trustees has the power and discretion to allocate funds retroactively for prior periods. These Accounts will be separate from, and in addition to, the amounts credited to each active Participant for the purposes of determining current coverage and accruing an Hours Bank. Notwithstanding the above:

If a Participant working under a collective bargaining agreement of IBEW Local 413 has reciprocity in effect, he or she shall not have an HRA in this Plan.

If a Participant of IBEW Local 413 is working under a collective bargaining agreement of another IBEW Local Union which has contributions dedicated to an HRA, credit for such dedicated contributions are reciprocated to this Plan, unless otherwise requested by the Participant. Any other amounts received by the Health and Welfare Plan are credited towards the Participant's hour bank.

1. No Vested Right to HRA Account

HRA Accounts may be used for any of the purposes allowed under the Plan rules below, and only for such purposes. No provision in these HRA rules shall be construed as making such Accounts vested at any time or subject to use in any manner except as provided in these rules. There is no vested right to an HRA balance.

2. Allocate Earnings or Losses/Statements

HRA Accounts that have a year-end balance may be credited (or charged) an amount reflecting the income (or loss) on those Accounts for the Plan Year, at the discretion of the Board of Trustees. Regardless of whether income or losses are allocated to HRA Accounts, the Board of Trustees reserves the right to assess an administrative charge against HRA Accounts. The Plan will provide Participants with a statement annually on the amount in their HRA as of December 31 of each year. Such statements will be provided within a reasonable period after the end of the year. The Board of Trustees has the discretion to provide statements more often.

3. Retiree Benefits

HRA Accounts are intended primarily to be used to assist retirees in having access to medical benefits during retirement. Once a Participant is enrolled in retiree welfare coverage under this Plan, the amounts accrued in his or her HRA Account may be used to pay a portion or all of the monthly charge for retiree coverage set by the Board of Trustees.

4. Other Plan Premiums

Any Participant may use his or her HRA Account to make Self-Payments for his or her coverage, when otherwise eligible to make Self-Payments and/or COBRA payments.

A surviving spouse or surviving eligible dependent (as permitted by the Internal Revenue Code) of a Participant may use the Participant's HRA Account to make monthly required payments for Plan survivor benefits, or to pay premiums for COBRA coverage based on the death of the Participant. If the eligible dependent(s)' Plan survivor coverage or COBRA continuation coverage period ends before the Participant's HRA Account is exhausted, that Account may be used to pay for the extended coverage for the Participant's dependent(s), at the COBRA continuation coverage rate, until the earlier of the following time (i) the HRA Account is exhausted; (ii) other coverage becomes available (including, but not limited to, coverage through Medicare or through another group health plan); or (iii) for a surviving child, the child attains the applicable limiting age under the plan.

5. Qualified Expenses/Minimum Amount

Any active or retired Participant who is eligible for benefits under this Plan may be reimbursed from his or her HRA account for any qualified expenses that are not otherwise covered under the Plan. \$100 is the minimum amount that can be left in the Account. A Participant can withdraw less than \$100 but not draw to a balance of under \$100. (Administration fees and other expenses may, however, reduce an HRA balance to less than \$100.) To qualify for payment through a Participant's HRA Account, an expense must satisfy all of the following requirements:

The expense must have been for medical care as defined in Internal Revenue Code Section 213(d), except as follows: An expense for premiums for medical coverage shall be reimbursable only if (i) the expense is authorized pursuant to the Plan or (ii) the Participant is on Self-Pay or COBRA or covered as a retiree, and the premium is for coverage of a dependent under insurance or a group health Plan other than this Plan.

The expense must have been incurred while the Participant was covered by the Plan, or while retired, regardless of when the claim is made.

The expense must have been incurred by the Participant or by a person who was then either a covered eligible dependent of the Participant or by a person who was a dependent within the meaning of the Internal Revenue Code Section 152.

The claim for HRA Account benefits must be made within one year of the time the expense was actually incurred. Extensions of this time limit will be granted only for good cause shown, at the sole discretion of the Board of Trustees.

The expense must have been incurred on or after January 1, 2010.

The Participant or dependent must provide proof, satisfactory to the Board of Trustees that the claim satisfies the requirement of this Section.

6. Procedures for Payment of Benefits

Benefits will be paid only to a Participant or surviving eligible dependent. Benefits will be paid only after an eligible person has incurred a Qualified Expense, and timely submitted a claim with supporting documents. Assignment of HRA Account benefits is not allowed.

Benefits will be paid in the manner and time established by the Board of Trustees. If a Participant, retiree, or dependent is aggrieved by the action on a claim he or she may appeal that action to the Board of Trustees, under the Plan's general appeal procedure.

7. Forfeiture

An HRA Account shall be immediately and permanently forfeited if either of the following applies to the Participant:

- The Participant accepts employment in any capacity and of any duration from a contractor in the Electrical Industry who is not signatory to the collective bargaining agreement with IBEW Local 413 or any other IBEW Local Union, except for Salting employment approved by IBEW Local 413; or
- The Participant is an owner of a company/business/entity in the Electrical Industry, which is not signatory to a collective bargaining agreement of an IBEW Local Union having jurisdiction of the work.

8. No Cash Death Benefits Paid from HRA/Compliance with Internal Revenue Code and Lawful Regulations

To the extent required by the Internal Revenue Code and/or lawful regulations cash death benefits from an HRA Account Participant's Account are not permitted. Any pertinent rule of the Internal Revenue Code and/or the IRS Regulations as applied to an HRA shall apply to this Plan.

9. Effect of Forfeiture

Any Participant who regains eligibility for coverage under the Plan after forfeiture of his or her HRA Account shall be allowed to accrue new credit, but will not regain the credits that were forfeited. Forfeitures shall be credited to the HRA Accounts of other Participants, in the same manner as earnings.

IX. COBRA

IF YOUR COVERAGE ENDS BECAUSE OF:	COVERAGE MAY CONTINUE FOR UP TO:
<p>Termination of employment (for any reason other than gross misconduct) or reduction in work hours</p>	<p>18 Calendar Months*</p> <p>(*29 Calendar Months (18 Calendar Months plus an additional 11 Calendar Months), if employment ends due to termination of employment or reduction in hours, and at any time during the first 60 days of continuation coverage, the Member or his or her Dependent is totally disabled (as determined by Social Security).</p> <p>Under CAL-COBRA, participants receive an additional 18 calendar months of coverage.</p>
<p>Death of Member</p> <p>Member's entitlement to health care coverage under Medicare</p> <p>Legal separation, divorce, cessation of domestic partnership</p> <p>Dependent Child no longer qualifies for Dependent coverage under the Plan</p>	<p>36 Calendar Months for Dependent</p>

The Consolidated Omnibus Budget Reconciliation Act of 1985 (a federal law known as COBRA) requires that 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 or your hours are reduced so that you become ineligible for coverage, you and your eligible dependents may elect COBRA continuation coverage for up to 18 months from the date your coverage would otherwise have ended. Under CAL-COBRA, Participants receive additional 18 months coverage.

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 up 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. The disability extension ends immediately if the disabled individual recovers.

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 Trust 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 or a reduction in hours, 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.

To be eligible for COBRA coverage on any grounds other than termination of employment or due to a reduction in hours, you or your dependents must provide notice of the qualifying event within 60 days of the qualifying event. This means that you or your dependents are

responsible for notifying the Trust Office if you or any of your dependents will be losing coverage because of any of the following qualifying events:

- (a) your death;
- (b) divorce or legal separation;
- (c) a child ceasing to qualify as an eligible dependent for any reason, including age, termination of enrollment in a qualifying educational program, or ceasing to be disabled; or
- (d) your loss of COBRA coverage on the grounds of becoming eligible for Medicare.

Once you receive a COBRA notice, you will have 60 days to respond if you wish to elect COBRA coverage. You or your dependents must also pay your COBRA premiums within 45 days after you or your dependents signed the election form and returned it to the Trust Office. You must pay the premium retroactively to your qualifying event.

4. Employer Decertification

If an employer decertifies and goes non-union and as a result does not contribute to this Plan causing a loss of coverage, you do not have a right to COBRA as there is no qualifying event; thus, your coverage will cease.

Please note: It is the Participant's responsibility to meet the deadlines of COBRA coverage. You and/or your dependents will lose your right to COBRA coverage if you or they fail to give a required notice of a qualifying event, or fail to make a COBRA election in the time allowed, or fail to make a payment on time.

5. Cost of COBRA

If you elect COBRA continuation coverage, you must pay the cost of such coverage plus 2%. 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.

6. 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 Trust 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; and
- f) The expiration of the applicable 18-month, 29-month, or 36-month COBRA continuation period.
- g) The date the Plan is terminated;

If your coverage ends because of the termination of employment or reduction of hours or because of your death, you or your dependents will receive information from the Trust 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 coverage's elected.

7. Election of COBRA Coverage

You will have 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, your 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. Information related to individual conversion health Plans may be obtained from the insurance company or HMO.

If you or your spouse or dependent have COBRA continuation coverage through the Anthem Blue Cross HMO and you are terminated from the program because you move out of the HMO's service area before the applicable COBRA period expires you or your spouse or dependent will lose coverage. Under no circumstances would such a transfer prolong the period of your COBRA continuation coverage. Please contact the Trust Office for additional details.

In order to assure receipt of COBRA materials and other announcements describing changes in the Plan, you and your dependents should advise the Trust 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 Trust Office in a timely fashion. You must make your first payment within 45 days after the date that COBRA continuation coverage is elected. After this first premium, COBRA payments must be paid monthly in advance for the continued coverage. 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 larger 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. Certification of Creditable Coverage Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this Fund 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:

Santa Barbara County Electrical Workers Health Trust
c/o United Administrative Services
1120 S. Bascom Avenue
San Jose, California 95128
(408) 288-4400

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 Employees 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.

D. HIPAA Special Enrollment Rights under SCHIP

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

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

E. 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 claims (including appeals), determinations of cost-sharing amounts, utilization reviews, medical necessity reviews, preauthorization reviews, and billing and collection activities. Health care operations include but are not limited to performing quality assessment reviews, implementing disease management programs, reviewing the competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes legal services and auditing functions for the purpose of creating and maintaining fraud and abuse programs, compliance programs, business Planning programs, and other related administrative activities.

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 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 Trust 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 by Personal Representatives to PHI

This Plan will treat your personal representative as you with respect to uses and disclosures of PHI, and all the rights afforded you by the Privacy Rule, under certain circumstances, but only to the extent such PHI is relevant to their representation. For example, a personal representative with 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 Trust 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 its use or purchase. However, this Plan may use PHI without authorization in certain situations, including but not limited to sending information describing the participating providers in its provider network(s), and the benefits provided under the Plan, providing information for the management of treatment, or recommending alternative treatment, providers, or health coverage.

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 Trust 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:

Santa Barbara County Electrical Workers Health Trust
c/o United Administrative Services
1120 S. Bascom Avenue
San Jose, California 95128
(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 agent, 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

1. 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:

- a. 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;

- b. Any Participant or dependent that 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
- c. 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 employee 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.

2. Coordination of Benefits

General Coordination of Benefits Rule: If a covered participant or dependent is entitled to benefits from another Plan, the HMOs, 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).

3. 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 the entire required premium.

4. Exclusion for Fraud

No benefits are paid for fraudulent claims or services or supplies by a covered 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 an HMO, PPO, insurance company or any other entity. This does not preclude the Plan, HMO, 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.

5. Source of Financing of the Plan

The Plan is funded by payments made to the Trust by employers who are signatory to a Collective Bargaining Agreement in accordance with the provisions of any of the Collective Bargaining Agreements and, in the case of certain non-bargaining unit employees, in accordance with the terms of the appropriate Employer Participation Agreements.

6. Disclaimer

The Trust Fund has established the current Plan for the exclusive benefit of eligible participants and their dependents. The Plan is intended to be maintained for an indefinite period of time. The Plan, however, may be amended by the Board of Trustees from time to time as to both eligibility requirements, benefit structures and selection of service providers as may be deemed necessary. The Board further reserves the right to terminate the Plan should contributions from contributing employers become insufficient to provide benefits.

7. Not in Lieu of Workers' Compensation

The Plan is not in lieu of and does not affect any requirements for coverage by Workers' Compensation insurance.

8. Claims and Appeal Procedures

General

The Board of Trustees has established the claims and appeal procedures, which comply with the regulations, issued by the Department of Labor (“DOL”).

Limited Applicability – Insurance Company and HMO Rules Apply.

The claims and appeal procedures set forth below apply only for non-insured, non-HMO (health maintenance organization) benefits. Claims and appeals for insured and HMO benefits are governed by the rules of the specific insurance companies and HMOs, which are available upon written request from the applicable insurance company, HMO or other provider or entity.

Discretionary Authority of the Board of Trustees.

The Board of Trustees has the discretionary authority to determine eligibility for and the amount of benefits and to construe the terms of any Plan, the Trust Agreement, other documents, and any rules and regulations issued hereunder. The Board of Trustees has the discretionary authority to make all factual determinations concerning any claim or right asserted under or against the Plan.

1. Initial Denial of Claim/Adverse Benefit Determinations

Different Types of Claims/Applicable Time Periods

a. Pre-Service Claims – Advance Approval of Claims

A “Pre-Service Claim” is a claim for a benefit, in whole or in part, on approval of the benefit in advance of obtaining the medical care.

The Plan must decide and communicate a pre-service claims within 15 days of the Plan’s receipt of such request. The Plan may extend this period for up to 15 days for reasons beyond the Plan’s control but the Plan must notify you in writing of why there is a delay and the date that a determination is expected.

If additional time is needed due to your failure to submit the information necessary to decide the claim, the Plan’s extension notice will describe the specific information needed by the Plan. The Plan will permit you 45 days from receipt of the notice to provide the specified information. If the information is not provided within that time, your claim will be denied.

b. Post-Service Claims

The Plan must decide and communicate its decision on a “Post-Service Claim”, which include claims for payment or reimbursement for medical care that you have already received (such as a bill for a doctor’s office visit), within 30 days after the Plan’s receipt of the claim. This

period may be extended for an additional 15 days. You may have an additional 45 days to provide necessary information in the same manner as is summarized in “section a” above.

c. Urgent Care Claims

An “Urgent Care Claim” is a claim for medical care or treatment in which delays in a decision could seriously jeopardize your life or health or your ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The Plan will decide Urgent Care Claims (adverse or not) within 72 hours of receipt taking into account the medical emergencies of the situation. The Plan may communicate its decision to you orally (and follow-up with a written determination within three days).

If an Urgent Care claim is incomplete, so that the Plan cannot make a determination on whether benefits are covered or payable under the Plan, the Plan will notify you within 24 hours of the Plan’s receipt of the claim, specifying what information is needed to complete the claim. The Plan will then provide you with at least 48 hours to provide the information. Once the Plan receives the additional information, the Plan will decide the claim within 48 hours of the earlier of the Plan’s receipt of the specified information or the end of the period given to you to provide the specified additional information.

d. Concurrent Care Decisions

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, the Plan’s reduction or termination of such previously approved treatment before the end of such period is considered an adverse benefit determination and notice will be provided in accordance with these procedures. A request to extend treatment beyond the time or number of treatments will be decided within 24 hours of the Plan receiving the request.

2. Content of Notice of Denial

If your claim is denied, the Plan’s notice of denial or other adverse benefit determination will provide:

- The specific reason or reasons for the denial;
- References to the specific Plan provisions on which the denial or adverse determination is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
- Appropriate information as to the steps to be taken if you wish to appeal the denial or adverse benefit determination; and

- A statement to your right to bring civil lawsuit under ERISA Section 502(a) following the Plan's decision on the appeal of an adverse benefit determination. If the Plan relied upon an internal rule or guideline in rejecting your claim, the Plan will provide such rule or guideline without charge upon a written request.

In addition, if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion, an explanation of the scientific or clinical judgment for the determination will be provided upon your written request.

3. Appeal or Claim Denial or Adverse Benefit Determination Right to Appeal Adverse

If your claim or request for benefits is denied or otherwise results in an adverse determination, you may request that the Board of Trustees review the decision. This process is also known as an appeal. Your written appeal should state the reason(s) for your disagreement with the denial and include any relevant documents or information relation to the claim not already furnished to the Plan.

You have 180 days following your receipt of a notification of an adverse benefit determination within which to appeal the determination, with certain exceptions noted below.

4. No Deference to Initial Decision

In determining your appeal, the Board of Trustees will not defer to the initial adverse benefit determination.

5. Decisions Based on Medical Judgment/Health Care Professional

Prior to deciding an appeal of a denial that is based in whole or in part on a medical judgment, the Board of Trustees will consult or contract with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment in the manner consistent with the DOL regulations.

6. Documents Available Upon Written Request

As part of the appeal process you or your authorized representative will be provided, upon request and free of charge, reasonable access to, and copies of, the documents, records, and other information relevant to your claim. Relevant information includes the identity of a medical or vocational expert whose advice was obtained in connection with the Plan's adverse benefit determination. You also have the right to review your claim file and to obtain pertinent information relevant to the denial upon written request.

7. Decision on Appeal/Timing of Decision

The Board of Trustees or a committee appointed by the Trustees and authorized to act on appeals will review the appeal. Your comments, documents, records and other information submitted to the Plan relating to the claim will be considered. The applicable appeal time periods include:

a. Urgent Care Claim Appeals – 72 Hours

The Plan will decide and communicate its decision on an urgent care appeal within 72 hours of the Plan's receipt of the appeal.

b. Pre-Service Claim Appeals – 30 Days

The Plan will decide and communicate its decision on a pre-service claim appeal within 30 days of the Plan's receipt of the appeal. Any extensions are permitted consistent with the DOL regulations.

c. Post-Service or Disability Claims

The Board of Trustees will make its decision on a post-service or disability claim at the next succeeding regular Board of Trustees meeting following its receipt of the appeal request, except for an appeal received within 30 days preceding the date of such meeting. If that occurs, the Plan's decision will be made no later than the second meeting following the Plan's receipt of the appeal. If special circumstances require a further extension of time for processing, the Plan's decision on the benefit appeal will be made no later than the third meeting following receipt of the appeal.

The Board of Trustees, or its delegate, will notify you in writing of the Trustees' decision on an appeal within five days after the appeal decision is made. The Plan's notice of denial of your appeal will include:

The reasons(s) for the determination;

- Reference to the specific Plan provision(s) on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of, documents, records and other information relevant to your claim; and
- A statement of your right to bring a legal action under ERISA Section 502(a).

If you desire additional time to present evidence for your appeal, you may submit to the Plan a written request for additional time, which must be received before the appeal decision is made.

The failure to file an appeal within the above time periods constitutes a waiver of your right to review. Consequently, the initial decision would be final and binding.

8. Disability Claims and Appeals – Special Rules

Time Periods for Disability Claim Determination

Decisions on disability claims and appeals have different time periods. If the Plan denies your application for disability benefits, the Plan will notify you of the denial within 45 days after the Plan's receipt of your application or claim.

An extension of item exceeding 30 days may be necessary due to matters beyond the Plan's control. If a decision cannot be rendered due to matters beyond the control of the Plan prior to the expiration of the 30 day extension, the period for making a determination may be extended for up to an additional 30 days, in which event notice will be sent to you prior to the expiration of the first 30 day extension.

The notice of extension will include in addition to the information set forth above, the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. You will be afforded at least 45 days to provide the specified information, if any. The deadline for the Board of Trustees to render its decision is tolled from the date on which the notification of the extension is sent to you until the date a response from you is received.

The denial notice of a disability claim should include the same information as that set forth above pertaining to non-disabled claims.

9. Right to 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 of 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 Board meeting.

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 than one year after services were provided or benefits partially or totally denied or an otherwise adverse determination was made against you or, if the Claim is for short-term disability benefits, more than one year 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.

10. Decision by Trustees

Under the Plan of Benefits and the Trust Agreement creating the Fund, the Trustees or persons acting for them, such as a claims appeal committee, have sole authority to make final determinations regarding any application for benefits and the interpretation of the Plan of Benefits, the Trust Agreement and any other regulations, procedures or administrative rules adopted by the Trustees. Decision of the Trustees (or, where appropriate, decision of those acting for the Trustees) in such matters are final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees or those acting for the Trustees is challenged in court, it is intention of the parties to the Trust that such decision is to be upheld unless it is determined to be arbitrary or capricious.

11. Relations Between Plan & Health Care Providers

No health care provider is an agent or representative of the Plan or the Board of Trustees. The Plan does not control or direct the provision of health care services and/or supplies to Plan participants and beneficiaries by anyone. The Plan makes no representation or guarantee of any kind that any provider will furnish health care service or supplies that are malpractice-free. This statement also applies to all entities (and their agents, employees, and representatives), which contract with the Plan to offer health-related services or supplies to participants and beneficiaries. Nothing in this Plan affects the ability of any provider to disclose alternative treatment options to a participant or beneficiary.

12. Construction

The validity of the Plan or any of its provisions will be determined under and will be construed according to ERISA and other federal law and, to the extent permissible, according to the laws of the State of California. This Plan is intended to be construed as a whole, but in the event any provision of this Plan is held illegal or invalid for any reason, such determination will not affect the remaining provisions of this Plan and the Plan will be construed and enforced as if said illegal or invalid provision had never been included.

13. Incorporation of HMO Contracts As Part of Plan

At any time that the Board of Trustees enters into a new or different contract and/or renewal contract with an HMO, such contract(s) shall be incorporated in this Plan by reference as if fully set forth herein, effective as of the effective date of such contract, provided same has been executed by the Board of Trustees or a duly authorized representative of the Board of Trustees.

14. Consequence of Election of HMO Plan by Participant

Benefits Not Part of HMO

Benefits payable to an Employee, Participant and/or eligible dependent(s) who has elected enrollment in an HMO shall be determined solely in accordance with the contract between the Trustees and the HMO.

HMO Rules Apply

In addition, any rules or regulations set forth herein regarding, but not limited to, eligibility for dependent coverage, claims review and/or appeals shall be governed by the rules and regulations of the HMO without regard to similar rules and regulations that may be otherwise set forth in this Plan.

15. Administration and Operation

Administration Responsibilities

The Board of Trustees of the Plan is the named fiduciary with authority to control and manage the operation and administration of the Plan. The Board shall make rules, interpretations and computations and take such other actions to administer the Plan, as the Board, in its sole discretion, may deem appropriate. The rules, interpretation, computations and actions of the Board shall be binding and conclusive on all persons.

Standards of Interpretation

The Board of Trustees, and/or persons appointed by Board, shall have the full discretionary authority to determine eligibility for benefits and to construe the terms of this Plan and any regulations and rules adopted by the Board. Only the Fund Manager and/or the Board of Trustees acting upon appeals properly before the Trustees shall have the authority to bind

the Trustees to an interpretation of the provisions of this Plan. Nonetheless, claims and appeals for matter relating to an HMO are subject to that HMO's rules and procedures.

Delegation of Duties and Responsibilities

The Board of Trustees may engage such Employees, accountants, actuaries, consultants, investment manager, attorneys and other professionals or other persons to render advice and/or to perform services with regard to any of the its responsibilities under the Plan, as it shall determine to be necessary or appropriate.

All of the benefits provided by the Fund are subject to the following general provisions:

Availability of Fund Resources

It is recognized that the benefits provided through this Plan can be paid only to the extent that the Plan has available adequate resources for such payments. No Contributing Employer has any liability, directly or indirectly, to provide the benefits established hereunder, beyond the obligation of a Contributing Employer to make contributions as provided in the Collective Bargaining Agreement. In the event that at any time the Fund does not have sufficient assets to permit continued payments hereunder, nothing contained in this Plan shall be construed as obligating any Contributing Employer to make benefits payments or Contribution (other than the contributions for which the Contributing Employer may be obligated by the Collective Bargaining Agreement) in order to provide for the benefits established hereunder.

There shall be no liability upon the Board of Trustees, individually or collectively, or upon any Employer, the Union, Signatory Associations or other person or entity to provide benefits established hereunder if the Plan does not have sufficient assets to make such benefit payments.

Funding Methods and Benefits

The Trustees may provide benefits either by insurance or HMO or by any other lawful means or methods upon which they may determine. The coverage to be provided shall be determined in the sole discretion of the Board of Trustees and limited to such benefits as can be purchased with the funds available, together with any available reserves of the Trust.

Any Participant may direct that benefit due him or her be paid to a provider of drug, dental or other covered health services or supplies in consideration for services rendered or supplies furnished, or to any other agency that may have provided or paid for any benefits provided hereunder.

16. No Vested Right

Nothing in this Plan shall be construed as giving Employees retired or terminated, dependents or any other person a vested right to continued coverage under this Plan. The Trustees retain full authority to amend or terminate coverage at any time.

17. Assignment

Benefits under the Plan are not assignable and shall not be subject to any manner of anticipation, alienation, sale or transfer, unless approved by the Board of Trustees or its delegate.

18. Facility of Payment

Any death benefit payable to a minor may be paid to the legally appointed guardian of the minor, or if there is no such guardian, to such adult or adults as have complied with the Requirements of California or other applicable law for receipt of such benefit on behalf of the minor, after which the Plan shall have no further obligations with respect to such minor. The Plan may require that a guardianship or other court order be obtained prior to issuing payments to a minor or incompetent person.

19. Available Assets for Benefits

Benefits provided by this Plan can be paid only to the extent that the Fund has available adequate resources for such payments. No contributing Employer has any liability, directly or indirectly, to such payments. No contributing Employer has any liability, directly or indirectly to provide the benefits established hereunder beyond the obligation of the contributing Employer to make contributions as required in the Collective Bargaining Agreement.

In the event that any time the Fund does not have sufficient assets to permit continued payments hereunder, nothing contained in this Plan shall be construed as obligating any contributing Employer of electrical Workers Health and Welfare Trust Fund of Santa Barbara County to make benefit payments or contributions in order to provide for the benefits established hereunder. Likewise, there shall be no liability upon the Board of Trustees, individually or collectively, or upon any contributing Employer, the Union, signatory association or any other person or entity of any kind to provide the benefits established hereunder if the Fund does not have sufficient assets to make such benefit payments.

20. Miscellaneous Provisions

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 from 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 is stipulated in the collective bargaining unit agreements.

WARNING: BENEFITS CAN BE REDUCED OR ELIMINATED

The Board of Trustees reserve 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. AMENDMENT/TERMINATION/MERGER OF PLAN

1. Amendment of Plan

The Board of Trustees has the discretion to amend the Plan at any time.

Any amendment may apply to all groups and/or Participants covered by the Plan or only to certain groups of Participants. Retroactive amendments may be made to the extent permissible under ERISA.

2. Termination of Plan

It is anticipated that the Plan is permanent and will continually be in operation. It is, however, legally necessary to consider the possibility of termination of the Plan. The parties to the Collective Bargaining Agreements between IBEW Local 413, NECA, Central Coast California Chapter, may terminate the Plan in whole or in part. Although there is no intent to terminate the Plan, there is no guarantee that the Plan will last forever.

3. Merger or Consolidation

In the event of a merger or consolidation of the Plan with, or transfer in whole or in part, of the assets or liabilities of the Plan to any other Pension Plan, each Participant is entitled to a benefit immediately after the merger, consolidation or transfer which is at least equal to the benefit such Participant would be entitled to receive before such merger, consolidation or transfer.

XV. 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:

1. 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.

2. 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 Health and Welfare benefits.

3. 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 section on Third Party Liability.

4. Coordination of Benefits

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

5. 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.

6. 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.

7. 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.

8. Failure to Enroll in Medicare Parts A and B

If you are eligible for and fail to timely enroll in Medicare Parts A and B, (and timely pay the required Part B premiums), the plan will not pay any of your claims.

9. Failure to Complete Application

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.

10. 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.

11. Plan Termination

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

XVI. GENERAL INFORMATION

(As Required by ERISA)

1. Name and Address of the Plan: Santa Barbara County Electrical Workers Health Trust, 1120 Bascom Avenue, San Jose, California 95128.

2. Type of Plan: This is a Health Care Plan, providing the following Health Care Benefits Plan –Hospital, Surgical, Medical, Disability, Dental, Life, and AD&D coverage's.

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 various employers and Santa Barbara Electrical Workers Health and Welfare Trust Fund. Upon written request to the Plan Administrator, participants and beneficiaries may determine whether a particular employer is a sponsor of the Plan, and, if so, this 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 in the Claims and Appeals section 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 December 31st, and the Trust’s records are maintained on that basis.

8. Employer Identification Number: 95-6121015

9. Plan Number: 501

10. 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, Internal Revenue Service and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The 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 a certificate of creditable coverage before losing coverage; or
- if you request a certificate of creditable coverage 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 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 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 a copy of Plan documents or the latest summary 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 \$110.00 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

No lawsuit may be filed (started) more than one year after services were provided or benefits partially or totally denied or an otherwise adverse determination was made against you or, if the claim is for short-term disability benefits, more than one year after the onset of the disability.

If you have a claim for benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available 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 or domestic relations 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.

11. Names and Addresses of the Board of Trustees:

Mr. Charles Huddleston
IBEW Local 413
100 Thomas
Buellton, CA 93427

Ms. Shari Brunner
NECA
530 E. Main Street
Santa Maria, CA 93455

Mr. Joe Furino
IBEW Local 413
100 Thomas
Buellton, CA 93427

Mr. Steve Mussel
Santa Maria Electrical
408 N. Broadway
Santa Maria, CA 93454

Mr. LeRoy Villa
IBEW Local 413
333 Apple Grove Lane
Santa Barbara, CA 93105

Mr. Robert Spitzer
1170 N. Refugio
Santa Ynez, CA 93460

12. Name and Address of Contract Administrator:

Santa Barbara County Electrical Workers Health Trust
c/o United Administrative Services
1120 S. Bascom Avenue
San Jose, California 95128
(408) 288-4400

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

Mr. Richard Grosboll
Neyhart, Anderson, Freitas, Flynn and Grosboll
369 Pine Street, Suite 800
San Francisco, CA 94104-3323

XVII. 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 Health 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 HealthCare

5995 Plaza Drive M/S CY20-220
Cypress, CA 90630
Provides medical benefits.

Anthem Blue Cross

6701 Center Drive West
Los Angeles, CA 90045
Provides medical benefits.

Delta Dental

Delta Tower
100 First Street
San Francisco, CA 94105
Provides dental benefits.

Prudential

1990 Westwood Blvd.
Los Angeles, CA 90025

ERISA 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".