KERN COUNTY ELECTRICAL WORKERS CONSTRUCTION WIREMEN AND CONSTRUCTION ELECTRICIAN HEALTH AND WELFARE TRUST

LOCAL UNION #428

SUMMARY PLAN DESCRIPTION (SPD) / PLAN RULES

Effective July 1, 2022

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INTRODUCTION

WHAT THIS DOCUMENT TELLS YOU

This Summary Plan Description (SPD)/Plan Rules describes the eligibility provisions for benefits for Active Employees and eligible Dependents along with a description of COBRA benefits, and general provisions of the group health plan ("the Plan" of the **Kern County Electrical Workers Construction Wiremen and Construction Electrician Health and Welfare Trust**. This document also highlights the insured medical/vision, dental and life and accidental death and dismemberment (AD&D) benefits of the Plan.

This document is the Summary Plan Description/Plan Rules with an Appendix that includes some benefit highlights from the separate insurance companies including the Medical Plan (which includes a vision benefit) issued by Kaiser, the Dental Plan issued by Anthem, and Life and AD&D Insurance issued by MetLife. Please contact the Trust Office if you need a copy of the medical/vision, dental, or life and AD&D Evidence of Coverage documents.

The Plan described in this document is effective **July 1, 2022**.

- To determine if you are in a class of individuals who are eligible for benefits under this Plan, refer to the Eligibility chapter in this document. Coverage for eligible dependents will be conditioned on you providing proof of dependent status, satisfactory to the Plan.
- Note that your eligibility or right to benefits under this Plan should not be interpreted as a guarantee of employment.

This document will help you understand and use the benefits provided by the Kern County Electrical Workers Health and Welfare Trust for Construction Wiremen and Construction Electricians. You should review it and share it with those members of your family who are or will be covered by the Plan. It will give all of you an understanding of the coverages provided; the procedures to follow in submitting claims; and your responsibilities to provide necessary information to the Plan.

While recognizing the many benefits associated with this Plan, it is also important to note that not every expense you incur for health care treatment and services is covered by this Plan.

All provisions of this document contain important information. If you have any questions about your coverage or your obligations under the terms of the Plan, be sure to seek help or information. A Quick Reference Chart to sources of help or information about the Plan appears in this chapter.

This Plan is established under and subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA. The medical/vision, dental, and life insurance of the Plan are insured by contracting with various insurance companies.

IMPORTANT: TRUST BENEFITS ARE SUBJECT TO CHANGE

The rules providing benefits to Active Employees and eligible Dependents of the Kern County Electrical Workers Construction Wiremen and Construction Electricians Health and Welfare Trust for are subject to change at any time by the Board of Trustees. No benefit presently provided either to Active Employees or eligible Dependents is guaranteed to remain in the plan of benefits in the future.

No Active Employee, or eligible Dependent, has a right to continue receiving the same eligibility and coverage of benefits as exist now or may have existed in the past. The benefits do not become "vested" at any length of employment or upon retirement.

The Trust attempts to maintain financial reserves which are adequate to pay claims already incurred and claims likely to be incurred under eligibility earned by Active Employees but does not maintain reserves for future eligibility of Active Employees or Retirees. The Trust pays current premiums for benefits from current contributions by employers. The Trust will pay premiums to the respective insurance carriers so

long as sufficient funds are available. However, all benefits are subject to changes in the rules governing benefits, and the Board of Trustees may make such rule changes effective on whatever date best serves the interests of the Trust and its participants.

IMPORTANT INFORMATION

Kern County Electrical Workers Construction Wiremen and Construction Electrician Health and Welfare Trust is committed to maintaining health care coverage for employees and their families at an affordable cost; however, because future conditions cannot be predicted, the Board of Trustees reserves the right to amend or terminate coverages at any time and for any reason.

As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

AUTHORIZED SOURCE OF INFORMATION

When benefits are provided by insurance contracts or health maintenance organizations (HMO's), the legal policy and terms of any group master contracts issued to the Plan will govern the interpretation of questions regarding the subject matter in this booklet.

The only source of authorized information is this booklet and riders, if any, the most recent version of the Agreement and Declaration of Trust of the Kern County Electrical Workers Construction Wiremen and Construction Electricians Health and Welfare Trust, the Rules and Regulations and the written statements of the Trust Administrator and its authorized agents located in Bakersfield, California. Statements or representations made by individuals other than those designated personnel are not authoritative sources of information. Questions as to eligibility, benefits and other matters should be submitted in writing to the Trust Office located at 3805 North Sillect Avenue, Bakersfield, California 93308.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND DESIGNEES

The Board of Trustees has full discretion and authority to interpret the rules, contracts and other documents establishing the plans benefits, including but not limited to the rules of eligibility, and to decide any factual question related to eligibility for and the type and amount of benefits.

In carrying out their respective responsibilities under the Plan, the Trust Administrator or its delegate/designee, other Plan fiduciaries, and the insurers or administrators of each Program of the Plan have been delegated and have discretionary authority to interpret the terms of the Plan including, but not limited to the discretionary authority to resolve ambiguities or inconsistencies in the Plan and to determine the extent to which a person is eligible and entitled to any Plan benefits.

Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious. Any interpretation or determination by the Plan Administrator or its delegate/designee, made in good faith which is not contrary to law, is conclusive on all persons affected.

IMPORTANT NOTICE

You or your Dependents must promptly furnish to the Trust Office information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, change in status of a Dependent Child, change in the status of a Domestic Partnership, Medicare/Medicaid enrollment or disenrollment, or the existence of other coverage.

Notify the Trust Office-preferably within 31 days, but no later than 60 days, after any of the above noted events.

Failure to give the Trust Office a timely notice (as noted above) may cause you, your Spouse and/or Dependent Child(ren):

a. to lose the right to obtain COBRA Continuation Coverage, or
b. may cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability, or
c. may cause claims to not be able to be considered for payment until eligibility issues have been resolved, or
d. may result in your liability to repay the Plan if any benefits are paid to an ineligible person.

Again, IF YOU FAIL to properly notify the Trust Office there are SIGNIFICANT CONSEQUENCES!!

SPANISH LANGUAGE ASSISTANCE

Si usted no entiende la información en este documento, por favor de ponerse en contacto con personal del departamento de Administracion en 661-325-9471.

QUESTIONS YOU MAY HAVE

If you have any questions concerning eligibility or the benefits that you or your family are eligible to receive, please contact the Trust Office at their phone number and address located on the Quick Reference Chart in this document. As a courtesy to you, the Trust Office staff may respond informally to oral questions; however, oral communications are not binding on the Plan and cannot be relied upon in any dispute concerning your benefits.

Your most reliable method is to put your questions into writing and fax or mail those questions to the Trust Office and obtain a written response from the Plan. In the event of any discrepancy between any information that you receive from the Trust Office, orally or in writing, and the terms of this document, the terms of this document will govern your entitlement to benefits, if any.

FOR HELP OR INFORMATION

When you need information, please check this document first. If you need further help, call the people listed in the following Quick Reference Chart:

<table>
<tr><th colspan="2">QUICK REFERENCE CHART</th></tr>
<tr><th>Information Needed</th><th>Whom to Contact</th></tr>
<tr><td>Trust Office/Administrative Office
• Eligibility for Coverage
• Plan Benefit Information
• Filing a Claim for Disability Benefits
• Medicare Part D Notice of Creditable Coverage
• COBRA Administration
• Assistance understanding the insured benefits of the Plan</td><td>Construction Benefits Administration, Inc.
3805 North Sillect Avenue
Bakersfield, CA 93308
Phone: (661) 325-9471
Fax: (661) 325-9498</td></tr>
<tr><td>Medical Plans for Active Employees
• Medical Plan Network Provider Directory
• Medical Claims and Appeals</td><td>Kaiser Permanente
Member Services: (800) 464-4000 (toll-free)
www.kp.org</td></tr>
<tr><td>Dental Plans
• Dental Network Provider Directory
• Dental Claims and Appeals</td><td>Anthem Blue Cross
Dental Net (DHMO) Dental Plan
21555 Oxnard Street
Woodland Hills, CA 91367
(800) 627-0004
https://www.anthem.com/ca</td></tr>
<tr><td>Vision</td><td>See Kaiser Permanente contact info above</td></tr>
<tr><td>Life Insurance</td><td>MetLife
200 Park Avenue
New York, NY 10166-0188
Phone: (800) 275-4638</td></tr>
<tr><td>COBRA Administrator
• Information About Coverage
• Adding or Dropping Dependents
• Cost of COBRA Continuation Coverage
• COBRA Premium payments
Second Qualifying Event and Disability Notification</td><td>Construction Benefits Administration, Inc.
3805 North Sillect Avenue
Bakersfield, CA 93308
Phone: (661) 325-9471
Secure Fax: (661) 325-9498</td></tr>
<tr><td>HIPAA Privacy Officer and HIPAA Security Officer
• HIPAA Notice of Privacy Practice</td><td>HIPAA Privacy Officer and HIPAA Security Officer for the Kern County Electrical Workers Health and Welfare Trust
Construction Benefits Administration, Inc.
3805 North Sillect Avenue
Bakersfield, CA 93308
Phone: (661) 325-9471
Secure Fax: (661) 325-9498</td></tr>
</table>

ELIGIBILITY RULES

HOURLY ACTIVE EMPLOYEES

Eligibility Requirements.

If you are an Active Employee under one of the following class codes:

CW1P, CW2P, CW1, CW2, CW3, CW4, CW5, CW6, CE1, CE2 AND CEF.

you earn 1 Credit Hour for each hour for each hour of Covered Employment during which you contribute toward single coverage and 2 Credit Hours for each hour of Covered Employment during which you contribute toward family coverage If you are an Active Employee, you will be eligible for benefits on the first day of the second month following the Work Month in which you have accrued 300 Credit Hours or more in Covered Employment (600 if you elect family coverage) for which contributions must be paid to the Trust. The Credit Hours must be accrued during no more than 12 consecutive work months. **Note that you accrue hours in the month that you perform the covered work even though the contributions to the fund are generally made in the month following the month in which you work.**

Example: New Employee		
	July	100 Hours
	August	75 Hours
	September	60 Hours
	October	65 Hours
	Total Hours Accrued	300 Hours

Employee has accumulated the required 300 hours through October. Therefore, the Employee is eligible for benefits on the first day of December—the second month following October. There is no coverage for November, which is often referred to as the lag month.

The term "Active Employee" used throughout this SPD is defined as a person who is employed by an employer obligated to pay hourly contributions to the Plan pursuant to a collective bargaining agreement or persons who are not currently employed by an employer obligated to pay hourly contributions pursuant to a collective bargaining agreement, but who have hours in their Hour Bank (see Reserve Hours Account section on page 6) sufficient to maintain coverage under the Plan.

Waiver of 300 Hour Requirement for Certain Active Participants Contributing to Related Plans.

Under circumstances where you would otherwise be ineligible to immediately participate in the Plan because (a) you are transferring to the Plan due to a change in job classification or (b) previously had coverage under the FMCP Plan 14 for Construction Wiremen and Construction Electricians or the Kern County Electrical Workers Jouneyman and Apprentice Health and Welfare Plan and have not accrued the necessary Credit Hours for participation, the 300 or 600 Credit Hour provision will be waived. As such, you will be eligible for benefits under this Plan on the first day of the second month following the month in which you worked 125 hours.

Continuation of Eligibility.

Eligibility for benefits is continued on a month-to-month basis and is determined by the number of hours worked (125 hours equals 1 month of coverage). See the detailed description in the Reserve Hours Account section.

Example: Previously Eligible Employee

Reserve Hours Account at the end of December*	500 hours
Deduction for January coverage	125 hours
Addition for December hours reported in January	100 hours
Reserve Hours Account at the end of January	475 hours

* This includes the November hours reported in December.

Reserve Hours Account (Hour Bank).

1. Subject to the provisions set forth below, after you have met the eligibility requirements for coverage, a Reserve Hours Account shall be established for you. Your initial Reserve Hours Account will be credited with the hours you worked for which your initial eligibility was determined. Each month thereafter, your Reserve Hours Account will be credited with hours worked in the prior month for which contributions are made, or are required to be made, on your behalf by one or more contributing employers and 125 or 250 Credit Hours will be deducted from your account for that months benefit coverage. In no event shall the number of hours in your Reserve Hours Account exceed 625 hours (1,250 if electing two party or family coverage).
2. The purpose of the Reserve Hours Account is to benefit you if you are temporarily unemployed and actively seeking covered employment with a contributing employer. The Reserve Hours Account shall not benefit you if you accept employment performing duties of the nature covered by any Collective Bargaining Agreement made by the Union, but for which no contributions are payable by the employer to the Trust.
3. No Hours Account shall be available to you if, at any time after beginning to accrue the hours accumulated in the Reserve Hours Account, you agree with or help a contributing employer to underpay contributions to the Trust in violation of the applicable Collective Bargaining Agreement. In addition, if at any time after the start of the work month you accept, or continue in, employment of the type covered by any Collective Bargaining Agreement requiring contributions to the Trust, but for which no contributions are payable by the employer to the Trust, you cannot use your Reserve Hours Account. You will only be able to use it if you work 125 Credit Hours or more (250 if electing two party or family coverage) for which contributions are made, or required to be made, to the Trust in any month within the 12 work months following the date on which this prohibited noncontributory employment begins.
4. If you engage in any of the activities prohibited by the provisions of the paragraph(s) above, you shall be treated as if you had no hours accumulated in a Reserve Hours Account. You shall notify the Trust Office promptly whenever either of the circumstances described above occurs. In the event the Trust receives information that you are not entitled to accumulate hours in a Reserve Hours Account for either reason stated above, you shall not be able to use the Reserve Hours Account immediately and you shall be given written notice of the grounds for the action taken. You shall have sixty (60) days after such notice within which to file a written request for review of the action, together with any evidence showing entitlement to a Reserve Hours Account. If you fail to make a request for review within sixty (60) days, suspension of the Reserve Hours Account shall become final. Trust Determinations regarding all review requests shall be final and binding on all persons affected by the decision, subject to the provisions for appeal of this plan.

5. If your eligibility ends because the number of hours for which contributions are made, or required to be made, on your behalf by one or more contributing employers during a month, when added to the number of hours in your Reserve Hours Account, total less than 125 Credit Hours (250 if electing two party or family coverage), any Credit Hours remaining in your Reserve Hours Account shall be canceled at the end of the twelfth (12th) consecutive month during which no contributions were made on your behalf by one or more contributing employers.

6. If you are working in covered employment but become ineligible for the benefits described in this document due to a change in job classification, but are eligible for Need a new name for the main plan Construction Electricians and Construction Wiremen Trainees Plan ("CECWT Plan") benefits and elect coverage under the CECWT Plan, the hours in your Reserve Hours Account will be maintained, so long as you continue coverage under the CECWT Plan. If your participation in the CECWT Plan ceases, and you become eligible for the benefits described in this document, your Reserve Hours Account will be reactivated and available to use for coverage in this Plan.

TERMINATION OF YOUR COVERAGE

Your coverage and that of your Dependents will end on the earliest date shown below:

- For hourly Active Employees, the first day of the second month following the Month in which the number of work hours you earn when added to the number of reserve hours in your Reserve Hours Account does not equal at least 125 Credit Hours (250 for two party or family coverage).
- The first day of the month following the date on which you entered the full-time, active uniformed service of any country, excluding service not exceeding thirty-one (31) days per year in the Reserve Armed Forces of the United States of America (but see "Self-Payment under USERRA").
- The date the Plan terminates; or
- The date the Plan is amended to eliminate the rules which permitted eligibility to be established.

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage (a rescission) except when contributions and self-payments are not timely paid, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan.

REINSTATEMENT OF ELIGIBILITY

If you are an Active Employee of an employer required to pay hourly contributions to the Trust, and you lose your eligibility for benefits, your coverage shall be started again on the first day of the second month that follows a Month in which you worked at least 125 hours in covered employment. To be eligible for this provision, you must have been covered under the Trust for at least one month out of the preceding 12 months.

Reinstatement of Reserve Hours Account After Military Service.

If you are an Active Employee whose eligibility ends because you entered full-time active military service, you shall be entitled to use your Reserve Hours Account again if the following conditions are satisfied:

- the military service was in a branch of the Armed Forces of the United States of America;
- the military service did not exceed a term of five years; and
- you apply for reinstatement of the Reserve Hours Account and are available for employment by an employer under the Trust within sixty (60) days after receiving a military discharge under a condition other than dishonorable.

Preserving Reserve Hours Account During Break In Covered Employment.

- **Election by an Active Employee:**

  If you are an Active Employee with 125 Credit Hours or more in your Reserve Hours Account, you may choose to preserve the hours, rather than to use the hours for continued eligibility, during a break in covered employment by doing the following:

  - give written notice of this choice to the Trust within thirty (30) days after leaving covered employment; and
  - within 12 months after leaving covered employment, give another written notice of your intent to reactivate the Reserve Hours Account and work 125 hours or more for which contributions are required to be paid to the Trust.

- **Effective Date of Frozen Account:**

  If the conditions of the Election by an Active Employee section above are satisfied, the Reserve Hours Account shall be frozen on the date determined as follows:

  - When the written notice required by paragraph (1) above is received by the Trustees on or before the fifteenth (15th) day of a month, the date shall be the first (1st) day of the next month; or
  - When the written notice required by the Election by an Active Employee paragraph (1) above is received by the Trustees after the fifteenth (15th) day of a month, the effective date shall be the first (1st) day of the second month after it.

- **Effective Date of Reinstatement:**

  If the conditions of the Election by an Active Employee paragraph (2) above are satisfied, the Reserve Hours Account of the Active Employee shall be reinstated on the first (1st) day of the second month thereafter.

CONTINUATION DURING LABOR DISPUTE

If your employer is required by a Collective Bargaining Agreement to pay all or part of the cost of your Trust contributions under the group policy and you stop work due to a labor dispute, you may continue your insurance during the labor dispute by the rules below:

- This continuation will be allowed if:

  a. you make a payment each month for your insurance in the ~~way an~~ amount specified below; and

  b. such payments are collected from a least 75% of the employees who stop work due to the labor dispute; and

  c. timely payment of the premiums for the insurance are made to the prepaid medical and dental plan.

- You must make your monthly payments on each premium due date to the Trust.

- The amount of your monthly payment will be equal to 120% of the amount which you and your employer would have to pay to the Trust on your behalf, if you did not stop work.

This continuation will end on the earlier of:

- the date you start active full-time work with an employer other than the employer you stop working for due to the labor dispute; and
- the last day of the sixth (6th) month that follows the date you stop working.

COVERAGE DURING FAMILY AND MEDICAL LEAVE

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks (in certain cases up to 26 weeks) of unpaid leave during any 12-month period if your employer determines that your absence is due to:

- The birth, adoption, or placement with you for adoption of a child.
- To provide care for a spouse, child or parent who is seriously ill; or
- For your own serious illness that makes you unable to perform your job.

During the leave, you can continue your medical, dental and life/AD&D coverage offered through the Plan subject to the terms of the law. (Refer to the MetLife Certificate of Insurance for details on when life/AD&D coverage can be continued under an FMLA leave of absence.) You are generally eligible for leave under the FMLA if you:

- have worked for a covered employer for at least 12 months;
- have worked at least 1250 hours over the previous 12 months; and
- work for an employer that employs at least 50 employees within a 75-mile radius.

The Plan will maintain an employee's eligibility until the end of the leave, provided the contributing employer properly grants the leave under the FMLA and makes payment of the required contributions to the Plan. Call your employer to determine whether you are eligible for FMLA leave.

FMLA Leave for Family of Military Service Members.

Pursuant to the National Defense Authorization Act for Fiscal Year 2008, two types of leave of absence are available to families of military personnel. During either of the following types of leave, you can continue your medical, dental and life coverage (but and disability benefits) offered through the Plan subject to the terms of the law. (Refer to the MetLife Certificate of Insurance for details on when life/ coverage can be continued under an FMLA leave of absence.)

- **Service Member Family Leave.** An eligible employee who is the spouse, son, daughter, parent or next of kin (i.e., nearest blood relative) of a covered service member is entitled to a total of 26 weeks of leave during a 12-month period to care for the service member. A covered service member is a member of the Armed Forces (including National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy (including on an outpatient basis) for a serious injury or illness. The injury or illness must have been incurred in the line of duty while on active duty, and it must be an injury or illness that may render the service member unfit to perform the duties of his/her office, grade, rank or rating. For an employee taking this new type of leave, along with FMLA for any other purpose (e.g., birth of a child), the combined total leave required during one 12-month period is 26 weeks.

- **Leave For Qualifying Exigency.** An eligible employee may take up to 12 weeks of leave in one 12-month period for a "qualifying exigency" (as defined in regulations issued by the Department of Labor) arising out of the fact that the employee's spouse, son, daughter or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.

CONTINUATION OF COVERAGE UNDER USERRA

If you take a military leave for 30 days or less, you will continue to receive health care coverage for up to 30 days, in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If you take a military leave for more than 30 days, USERRA permits you to continue medical and dental coverage for you and your dependents at your own expense for up to **24 months**, (Veterans Benefits Improvement Act of 2004), as long as you give your employer advance notice (with exceptions) of the leave, and provided your total leave, when added to any prior periods of military leave, does not exceed 5 years. **Except as described in this section, your rights to self-pay under USERRA are governed by the same conditions descried in the COBRA section of this SPD.** In addition, your dependent(s) may be eligible for health care coverage under TRICARE. This Plan will coordinate coverage with TRICARE.

To qualify for continuation coverage during a period of military service, you must give your employer advance notice of your military service, and elect and pay for continuation coverage. To be timely, you must apply for continuation coverage by completing an election form available from the Trust Office within 60 days of entering uniformed service. If you elect continuation coverage, you must pay premiums in the same amount (not to exceed 102 percent of the full premium under the Plan), form and manner as provided under COBRA. Instead of paying for continuation coverage, you may continue coverage during a period of military service until any reserve in your hours bank is exhausted. Coverage through the Plan will be cancelled if you depart for military service without giving advance notice to your employer, and without electing to continue coverage through this Plan in a timely manner.

Your eligibility will be reinstated on the day you return to work or register for work with your Union or your last employer, provided such former Employee notifies a Contributing Employer of the intent to return to employment within:

1. Ninety (90) days from the date of discharge if the period of service was more than one hundred eighty (180) days; or
2. Fourteen (14) days from the date of discharge if the period of service was thirty-one (31) days or more but less than one hundred eighty-one (181) days.
3. If the former Eligible Employee is hospitalized for or convalescing from any illness or injury caused by active duty, the time limits to submit the application for re-employment are extended to the end of the period necessary to recover, but in no case beyond two (2) years.

However, until you earn sufficient hours to regain eligibility as an active employee, you must pay the cost of continuation coverage upon your return to employment. Alternatively, your coverage may be reinstated immediately if you still have a reserve in your hours bank upon your return to employment.

Continuation of coverage under USERRA will terminate on the earliest of the following dates, as applicable:

1. The end of the period for which the last payment was made for coverage in a timely manner;
2. An individual returns to covered employment and becomes eligible under this Plan; or
3. The maximum continuation period has been exhausted.

During the first 18 months of coverage your eligible dependents will have all COBRA rights, such as the right to elect additional months of coverage in the event of a second Qualifying Event or a Social Security disability determination. These rights do not apply during the last 6 months of the 24-month period.

DEPENDENT'S ELIGIBILITY

For benefits offered under the Plan, the following individuals are defined as a "Dependent" under the Plan:

Spouse: means a legally married spouse of the opposite gender and a legally married spouse of the same gender. When both husband and wife are covered as Active Employees or Retired Employees, their children shall only be eligible as dependents of one person.

Domestic Partner: means a relationship between the employee/retiree and another individual of the same gender or opposite gender that meets the requirements for domestic partnership in the state in which they reside. Domestic Partners of employees or retirees that have coverage through an HMO or insurance carrier must be provided coverage that is equivalent to coverage that is available to a spouse if the domestic partnership is registered with the State of California. For further information, check with your HMO or insurance carrier.

For the purposes of Medical Plan coverage, "Dependent Child" means any of the employee's/retiree's children listed below who are **under the age of 26** (whether married or unmarried):

- **Son or daughter** (proof of relationship and age will be required).
- **Stepson or stepdaughter** (proof of relationship and age will be required).
- **Legally adopted child or child placed for adoption** with the employee/retiree (proof of adoption or placement for adoption and age will be required). Placed for adoption means the assumption and retention by the employee/retiree of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's eligibility for benefits under this provision terminates immediately if such legal obligation ends.
- A child named as an "alternate recipient" under a **Qualified Medical Child Support Order (QMCSO)**. Your dependent child(ren) will be recognized as eligible dependents in instances of divorce if the divorce decree or other order of the court stipulates that the employee is responsible for the child's medical bills or must maintain health coverage for the child. The decree or order must satisfy legal requirements. Legal requirements is a broad generic term and embraces any applicable provisions relating to Qualified Medical Child Support Orders (QMCSO) or National Medical Support Notice. The Plan has procedures to determine whether the order or other document is a QMCSO. A statement of the Plan's QMCSO procedures is available upon request at no charge. A copy of the divorce decree and/or support order must be on file in the Trust Office and the child must be enrolled in the Plan. Pursuant to federal law, a child may be enrolled by the non-employee parent or appropriate state agency.
- **Child under a legal guardianship:** An unmarried individual with respect to whom the employee/retiree has legal guardianship under a court order (proof of guardianship and age will be required). The child under a legal guardianship can continue eligibility until the earlier of the date the legal guardianship ends or the child reaches age 26, unless the child remains eligible under the disabled adult child provision of the Plan.
- **Foster child**, lawfully placed with the employee/retiree by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction (proof of relationship, age and foster child placement will be required).
- **Child of a Domestic Partner** (proof of relationship and age will be required).

In addition to the Dependent Children defined above, the following individuals are eligible for coverage under the Medical Plan:

- **Disabled Adult Child:** An **unmarried** Dependent Child (as defined above) age 26 or older who is **permanently and totally disabled** with a disability that existed prior to the attainment of the Plan's age limit and who is eligible for tax-free health coverage as a "qualifying child" or "qualifying relative" under the applicable requirements of Internal Revenue Code Section 152(c) or 152(d), respectively **OR** and who will be claimed as a dependent on the employee's/retiree's federal income tax return for each plan year for which coverage is provided.

  The Plan will require initial and periodic proof of disability. You will have 31 days from the date of the request to provide this proof before the child is determined to be ineligible. To be eligible for tax-free health coverage as a "qualifying child," an unmarried child with a permanent and total disability must have the same principal place of abode as the participant for more than half of the year and must not provide over half of his/her own support for the year. To be eligible for tax-free health coverage as a "qualifying relative," the participant must provide over half of the child's support, and the child must not be the "qualifying child" of any person.

Any spouse, domestic partner or child who is eligible under the Plan as an Active Employee or Retired Employee will not be eligible to enroll in the Plan as a Dependent.

For the Dental PPO or Dental HMO plan, your eligible dependents are your **legal Spouse** and **Domestic Partner** (as defined in the Dental plan documents) and your unmarried **Child(ren)** up to age twenty-six (26). Your unmarried children include you, your Spouse or your Domestic Partner's natural children, stepchildren, adopted children, a child for whom you, your Spouse or your Domestic Partner has been appointed legal guardian by a court of lawyer a child under a QMCSO order.

Date of Dependent's Eligibility.

Your eligible dependents will be covered under this Plan beginning:

- On the date you become eligible, if the dependent is an eligible dependent on that date; or
- On the first day of the month following the date on which the dependent becomes a dependent (see the special provision for newborns and newly adopted children, below).

Your **newborn dependent child(ren)** will be covered from the date of birth provided you enroll that newborn dependent child for coverage within 31 days of the child's date of birth and you pay any required contribution for that dependent child's coverage. Under the Medical Plan, a covered plan participant's newborn(s) are automatically covered for the first 31 days after birth. To continue coverage beyond this initial 31-day period you must enroll the child within 31 days of the date of birth.

Your **adopted dependent children** will be covered from the date that child is placed for adoption with you. A child is placed for adoption with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt. A child who is placed for adoption with you within 31 days after the child was born will be covered from birth if you comply with the Plan's requirements for obtaining coverage for a newborn dependent child. However, if the child is placed for adoption with you, and if the adoption does not become final, coverage for that child will terminate as of the date you no longer have a legal obligation to support that child.

Termination of a Dependent's Coverage.

Your dependent's coverage will end on the earliest date shown below:

- The last day of the last month in which the rules for establishing eligibility had been satisfied for at least one date in that month. (See Eligibility.)
- The date on which the person no longer qualifies as a dependent;
- The first day of the month following the date on which your dependent enters full-time, active military service of any country, except service which is no more than thirty (30) days per year in the Reserve Armed Force of the United States of America (but see "Self-Payment Under USERRA");
- The date the Plan terminates; or
- The date the Plan is amended to eliminate the rules which permitted eligibility to be established.

BENEFITS FOR SURVIVING DEPENDENTS

Death of Active Employee.

If you die while eligible for benefits under this Trust, your dependents will continue to be eligible until the end of eligibility based on your Reserve Hours Account. (See discussion of Reserve Hours Account). Your eligible dependents will be offered the opportunity to elect COBRA Continuation Coverage.

Surviving Spouse.

Eligibility for benefits for a surviving spouse is contingent on the participant being eligible for retiree benefits. There are no retiree benefits offered under the Trust, therefore please see the Kern County Electrical Workers Jouneyman and Apprentice Health and Welfare Plan SPD regarding eligibility for continued benefits for surviving dependent spouse.

When the surviving dependent spouse has eligibility for benefits according to the Surviving Spouse section, your other surviving dependent(s) shall have eligibility during the same time.

Surviving Children.

If no surviving dependent spouse qualifies for continued eligibility according to the Surviving Spouse section, any of your surviving dependent child(ren) shall be entitled to get continued eligibility for benefits by satisfying the conditions set forth in this Surviving Spouse section, except that paragraph (3) of the Surviving Spouse section need not be satisfied.

Coverage terminates for a surviving dependent child in accordance with the provisions on "Termination of a Dependent's Coverage" noted earlier in this chapter. If your surviving dependents are not eligible to continue their coverage under this section, they may be entitled to COBRA continuation coverage. (See COBRA Continuation Coverage.)

ENROLLING FOR COVERAGE

Enrollment is Required for Coverage.

You and/or your eligible Dependents may become covered under this Plan only upon completion of a written enrollment for coverage. A person who is not duly enrolled has no right to any coverage for Plan benefits or services under this Plan.

Initial Enrollment for Yourself and Your Eligible Dependents.

You must enroll within 31 days of the date on which you become eligible for coverage. If you want dependent coverage, you must enroll your eligible Dependents at the same time. Legal documentation is required for dependent enrollment (e.g. marriage certificate, birth certificate, divorce decree, etc.). (See the section entitled "Dependent's Eligibility" for more information.)

When Coverage Begins.

Your coverage will become effective on the date of eligibility. Coverage for your eligible-spouse and/or dependent child(ren) and/or Domestic Partner begins on the date your coverage begins.

Failure to Enroll During Initial Enrollment.

If you do not enroll yourself, or if you do not enroll any of your eligible dependents within 31 days of the date on which you or they first become eligible for coverage, unless you and/or eligible dependent(s) qualify for "Special Enrollment" described below, you will have to follow the "Late Enrollment" procedure described below.

Special Enrollment for Yourself and Your Eligible Dependents.

Newly Acquired Spouse and/or Dependent Child(ren)

If you are enrolled for individual coverage and if you acquire a spouse by marriage, or if you acquire any dependent children by birth, adoption or placement for adoption, you may request enrollment for your newly acquired spouse and/or dependent child(ren) within 31 days after the date of marriage, birth, adoption, or placement for adoption.

If you are not enrolled for individual coverage and if you acquire a spouse by marriage, or if you acquire any dependent children by birth, adoption or placement for adoption, you may enroll yourself and your newly acquired spouse and/or dependent child(ren) within 31 days after the date of marriage, birth, adoption or placement for adoption.

If you did not enroll your spouse for coverage within 31 days of the date on which he or she became eligible for coverage, and if you subsequently acquire a dependent child by birth, adoption or placement for adoption, you may request enrollment for your spouse together with your newly acquired dependent child(ren) within 31 days after the date of your newly acquired dependent child's birth, adoption or placement for adoption. (However, if you are entitled to enroll a newborn or newly adopted child and your spouse pursuant to this paragraph, you may not enroll any other dependent child(ren) who is not covered by the Plan and who was not enrolled for coverage on the date on which he or she became eligible for such coverage).

When you, your Spouse or Dependent Child(ren) Lose Other Coverage

You and your Dependents may also enroll in this Plan if you (or your eligible Dependents):

- Have coverage through Medicaid or a State Children's Health Insurance Program (CHIP)and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment in this Plan within 60 days (or any longer period that applies under the plan) after Medicaid or CHIP coverage ends; or
- Become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment in this Plan within 60 days (or any longer period that applies under the plan) after you (or your dependents) are determined to be eligible for such premium assistance.

If:

- You did not enroll yourself, your spouse and/or your dependent child(ren) for coverage within 31 days of the date on which you or they first become eligible for coverage because you or they had

health coverage under any other insurance policy or program or employer plan including COBRA continuation coverage, individual insurance, Medicare, Medicaid, or other public program; and

- You, your spouse and/or any dependent child(ren) cease to be covered by that other health insurance policy or plan;

you may request enrollment for yourself and/or that spouse and/or Dependent child(ren) within 31 days after the termination of their coverage under that other health insurance policy or plan, either as a result of:

- Loss of eligibility for that other coverage;
- Termination of employer contributions toward that other coverage;
- If that other coverage was COBRA continuation coverage, the coverage was exhausted;
- Moving out of an HMO service area;
- Loss of eligibility due to reaching lifetime max on ALL benefits;
- Termination of benefit package of other plan;
- Loss of dependent status under other plan; and
- Other plan ceases to offer coverage to a group of similar situated individuals.

Individuals enrolled during Special Enrollment have the same benefit options and same cost and same enrollment requirements as other similarly situated individuals. However, you may not avail yourself of this opportunity for "Special Enrollment" unless, at the time of Initial Enrollment, you indicated in writing that the reason you, your spouse and/or your dependent child(ren) were not enrolled was because they had coverage under another health insurance policy or plan.

When Coverage Begins

Except with respect to coverage of a newborn or newly adopted Dependent child, your coverage, your spouse's coverage and/or the coverage of your eligible dependent child(ren) will become effective on the first day of the month following the date of receipt by the Trust Office of the "Special Enrollment."

With respect to coverage of a newborn or newly adopted Dependent child, the child's coverage will become effective as of the date of birth, adoption or placement for adoption. Under the Kaiser Medical plans, a covered plan participant's newborn(s) are automatically covered for the first 31 days after birth. To continue coverage beyond this initial 31-day period you must enroll the child within 31 days of the date of birth.

Failure to Enroll During Special Enrollment

If you fail to request enrollment for any of your eligible dependents within 31 days from the date on which they first become eligible for "Special Enrollment," you will have to follow the "Late Enrollment" procedure described later in this section.

Open Enrollment.

Open Enrollment is the period of time during January of each year during which certain benefit changes can be made. During Open Enrollment, you will be asked to select a dental plan for yourself and your eligible Dependents. All eligible members of your family must be enrolled in the same plan. Open Enrollment procedures can differ from the process outlined in this document and if so, the procedure on

how to enroll at Open Enrollment time will be announced by the Plan at the beginning of the Open Enrollment period.

If you have been enrolled for coverage and you fail to make a new election during the Open Enrollment period, you will be considered to have made an election to retain the same dental coverage you had during the preceding plan year. However, if you are enrolled in a prepaid plan and move out of the service area before open enrollment, you may then change to the indemnity plan. If you lose eligibility before an annual open enrollment period, but re-establish at a later date, you will be able to change your plan selection at that time.

If you fail to enroll yourself and/or any of your eligible dependents within 31 days of the date on which you or they become eligible for Open Enrollment, unless your eligible dependents qualify for the "Special Enrollment" described earlier, you will have to follow the "Late Enrollment" procedure described below.

Late Enrollment.

If you and/or your eligible Dependents are not entitled to "Special Enrollment" as provided earlier in this section, you may enroll yourself and/or any of your eligible Dependents at any time. If you enroll in the Plan late, your coverage will begin on the first day of the month following enrollment. Coverage of your spouse and/or dependent child(ren) pursuant to Late Enrollment will begin on the first of the month following receipt of enrollment documents. However, your newborn dependent child(ren) will be covered from the date of birth, provided:

- You enroll that newborn dependent child for coverage within 31 days of the child's date of birth; and
- You pay any required contribution for that dependent child's coverage.
- Under the Kaiser Medical plans, a covered plan participant's newborn(s) are automatically covered for the first 31 days after birth. To continue coverage beyond this initial 31-day period you must enroll the child within 31 days of the date of birth.

Your adopted dependent child will be covered from the date that child is placed for adoption with you. A child is placed for adoption with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt. A child who is placed for adoption with you within 31 days after the child was born will be covered from birth if you comply with the Plan's requirements for obtaining coverage for a newborn dependent child. However, if a child is placed for adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child.

Qualified Medical Child Support Order (QMCSO).

The employee, non-employee parent or appropriate state agency may enroll an employee's natural or adopted child(ren) pursuant to a divorce decree or other order of the court if the order holds the employee responsible for the child(ren)'s medical bills or must maintain health coverage for the child(ren). This decree or order must satisfy legal requirements relating to a Qualified Medical Child Support Order (QMCSO). The Plan has procedures to determine whether the order or other document is a QMCSO. Contact the Trust Office for QMCSO procedures.

A statement of the Plan's QMCSO procedures is available upon request at no charge. Enrollment pursuant to a QMCSO will be effective as required by the QMCSO or as soon as administratively feasible following qualification, whichever is later.

COBRA CONTINUATION COVERAGE

A federal law known as "COBRA" requires that group health plans offer covered employees and their covered Dependents (called "Qualified Beneficiaries"), the opportunity for a temporary extension of health coverage called "COBRA continuation coverage", in certain instances called "Qualifying Events", when coverage under the Plan would end. To receive this continuation coverage, **the Qualified Beneficiaries must pay the monthly premiums** directly to the Trust. This section is intended to inform you of your rights and obligations regarding COBRA continuation coverage.

This Plan provides no greater COBRA rights than what is required by law and nothing in this chapter is intended to expand a person's COBRA rights.

COBRA Administrator: The contact information for the COBRA Administrator (the Trust Office) responsible for the administration of COBRA, and to whom you can direct questions about COBRA, is shown in the Quick Reference Chart in the front of this document.

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the **Health Insurance Marketplace**. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that plan within 31 days, even if that plan generally does not accept late enrollees.

Who Is Entitled to COBRA Continuation Coverage, When and For How Long.

Each Qualified Beneficiary **has an independent right to elect COBRA** Continuation Coverage when a Qualifying Event occurs, **and** as a result of that Qualifying Event that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. Covered employees and retirees may elect COBRA on behalf of their spouses and covered parents/legal guardians may elect COBRA for a minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals including Special Enrollment and Open Enrollment.

1. "**Qualified Beneficiary**": Under the law, a Qualified Beneficiary is any employee or retiree or the Spouse or Dependent Child of an employee or retiree who is covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.
   - A child of the covered employee or retiree who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the employee's or retiree's period of employment, is entitled to the same rights under COBRA as an eligible dependent child.
   - A person who becomes the new Spouse of an existing COBRA participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA participant but is not a "Qualified Beneficiary." This means that if the existing COBRA participant dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA for him/herself.

2. **"Qualifying Event:"** Qualifying Events are those shown in the chart on the following page. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan**. If a covered individual has a Qualifying Event but, as a result, **does not lose** their health care coverage under this Plan, (*e. g.* employee continues working even though entitled to Medicare) then COBRA is not available.

Rights of an Active Employee.

If you are an Active Employee covered by the Plan, you may have a right to choose this continuation coverage if you lose your group health coverage because of:

1. A reduction in hours resulting in loss of eligibility under the eligibility rules of the plan; (see eligibility)
2. You retire;
3. You voluntarily resign from your job; or,
4. Your employment ends (for reasons other than gross misconduct on your part).

Even if you do not elect COBRA continuation coverage, your spouse and each of your eligible dependent children have a separate right to elect it. THEREFORE, IT IS IMPORTANT THAT THE EMPLOYEE, SPOUSE AND ALL DEPENDENTS READ THIS SECTION.

Rights of a Dependent Spouse.

If you are the spouse of a covered Active or Retired Employee, you may have the right to choose continuation coverage for yourself if you lose group health coverage under the Plan for any of the following reasons:

- The voluntary resignation from or the termination of your spouse's employment (for reasons other than gross misconduct), retirement or a reduction in hours resulting in loss of eligibility in accordance with the eligibility rules of the Plan;
- Divorce or legal separation from your spouse; or
- The death of your spouse.

Note: If you satisfy certain conditions, you may be entitled to continue coverage under the special extension for surviving dependents as described in the Eligibility chapter.

Rights of Dependent Children.

A dependent child of an Active Retired Employee covered by the Plan may have the right to continuation coverage if group health coverage under the Trust is lost for any of the following reasons:

1 The voluntary resignation from or the termination of the parent's employment (for reasons other than gross misconduct), retirement or a reduction in hours resulting in loss of eligibility.
2 The parents' divorce or legal separation;
3 The dependent ceases to be a "dependent child" (See Dependent's eligibility)
4 The death of the parent who is the covered employee under this Trust.

Note: If certain conditions are satisfied, coverage for dependent children may be continued under the special extension for surviving dependents. (See the Eligibility chapter).

The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event:

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries[1]		
	Employee	**Spouse**	**Dependent Child(ren)**
Employee terminated (for other than gross misconduct).	18 months	18 months	18 months
Employee reduction in hours worked (making employee ineligible for the health care coverage).	18 months	18 months	18 months
Employee dies.	N/A	36 months	36 months
Employee becomes divorced or legally separated.	N/A	36 months	36 months
Dependent Child ceases to have Dependent status.	N/A	N/A	36 months

1:When a covered employee's Qualifying Event (e.g. termination of employment or reduction in hours) occurs within the 18-month period after the employee becomes entitled to Medicare (entitlement means the employee is eligible for and enrolled in Medicare), the employee's covered Spouse and dependent children who are Qualified Beneficiaries (but not the employee) may become entitled to COBRA coverage for a maximum period that ends 36 months after the Medicare entitlement.

Special Enrollment Rights.

You have special enrollment rights under federal law that allows you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 31 days (or as applicable 60 days) after your group health coverage ends because of the Qualifying Events listed in this chapter. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

- **Adding Dependents:** If, while you are enrolled in COBRA Continuation Coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that spouse or child for coverage for the balance of your COBRA coverage period. For example, if you have five months of COBRA left and you get married, the new spouse can be enrolled for the remaining 5 months of your COBRA coverage. You must notify the Trust Office **within 31 days** of acquiring the new dependent. There may be a change in your COBRA premium amount in order to cover the new dependent.

- **Loss of Other Group Health Plan Coverage:** If, while you are enrolled in COBRA Continuation Coverage, your spouse or dependent loses coverage under another group health plan, you may enroll the spouse or dependent for coverage for the balance of the period of COBRA Continuation Coverage. The spouse or dependent must have been eligible but not enrolled for coverage under the terms of the plan and, when enrollment was previously offered under the Plan and declined, the spouse or dependent must have been covered under another group health plan or had other health insurance coverage. You must enroll the spouse or dependent **within 31 days** after the termination of the other coverage. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

  The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause.

Procedure for Notifying the Plan of a Qualifying Event (Very Important Information).

In order to have the chance to elect COBRA Continuation Coverage after a divorce, legal separation, or a child ceasing to be a "dependent child" under the Plan, **you and/or a family member must inform the Plan in writing of that event no later than 60 days after that Qualifying Event occurs.**

That written notice should be sent to the COBRA Administrator (the Trust Office) whose address is listed on the Quick Reference Chart in the front of this document. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce documents.

> **NOTE: If such a notice is not received by the COBRA Administrator within the 60-day period, the Qualified Beneficiary will not be entitled to choose COBRA Continuation Coverage.**

Officials of the employee's own employer should notify the COBRA Administrator of an employee's death, termination of employment, reduction in hours, or entitlement to Medicare. However, **you or your family should also promptly notify the COBRA Administrator in writing** if any such event occurs in order to avoid confusion over the status of your health care in the event there is a delay or oversight in providing that notification.

Notices Related to COBRA Continuation Coverage.

When:

a. **your employer notifies the Plan** that your health care coverage has ended because your employment terminated, your hours are reduced so that you are no longer entitled to health care coverage under the Plan, you died, have become entitled to Medicare, or

b. **you notify the COBRA Administrator** that a Dependent Child lost Dependent status, you divorced or have become legally separated,

then the COBRA Administrator will give you and/or your covered Dependents notice of the date on which your coverage ends and the information and forms needed to elect COBRA Continuation Coverage. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to COBRA coverage. Under the law, you and/or your covered Dependents will then have only 60 days from the date of receipt of that notice, to elect COBRA Continuation Coverage.

> **NOTE: If you and/or any of your covered dependents do not choose COBRA coverage within 60 days after receiving notice, you and/or they will have no group health coverage from this Plan after the date coverage ends.**

The COBRA Continuation Coverage That Will Be Provided.

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the section on Paying for COBRA Continuation Coverage that appears in this chapter for information about how much COBRA Continuation Coverage will cost you and about grace periods for payment of those amounts.

If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, that same change will apply to your COBRA Continuation Coverage.

Confirmation of Coverage Before Election or Payment of the Cost of COBRA Continuation Coverage.

If a Health Care Provider requests confirmation of coverage and you, your Spouse or Dependent Child(ren) have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect **or** you, your Spouse or Dependent Child(ren) are within the COBRA election period but have not yet elected COBRA, COBRA Continuation Coverage will be confirmed, but with notice to the Health Care Provider that the cost of the COBRA Continuation Coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the COBRA Continuation Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

Notice of Unavailability of COBRA Coverage.

In the event the Plan is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent, by the COBRA Administrator an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

Period of COBRA Continuation Coverage.

If you elect COBRA continuation coverage you may continue this coverage for a maximum of three (3) years unless your coverage was lost because of a termination of employment or a reduction in hours resulting in a loss of eligibility. In these instances, the maximum continuation coverage period is eighteen (18) months unless you were totally disabled or become totally disabled at any time during the first 60 days of COBRA continuation coverage.

In addition, so long as you or your dependent receive a Social Security disability determination before the initial 18 months of continuation coverage expires, and you or your dependent report that determination to the Trust Office within sixty (60) days of the date notice was received by you or your dependent, you or your dependents' coverage may be continued for an additional eleven (11) months at increased rates up to a total of twenty-nine (29) months. In order to receive this extension, you must report the eligibility determination to the Trust Office within sixty (60) days of the date you received notice of the Social Security Disability determination. The extension applies to the disabled person or for all family members.

This extended period of COBRA continuation coverage will end on the earliest of the following:

1. The end of the 29 months from the date of the qualifying event;
2. 30 days after the last day of the month in which Social Security determines the person is no longer disabled (this must be reported to the Trust Office within 30 days after its date of issuance by Social Security);
3. the date the disabled individual becomes entitled to Medicare; or
4. pursuant to the applicable termination provisions of this section specifying when coverage ends.

When a Second Qualifying Event Occurs During an 18-Month COBRA Continuing Period.

1. If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced or legally separated, or if a covered child ceases to be a Dependent Child under the Plan, the maximum COBRA Continuation period for the affected spouse and/or child is extended to 36 months from the date of your termination of employment or reduction in hours (or the date you first became entitled to Medicare, if that is earlier, as described below).

For example, assume you lose your job (the first COBRA-qualifying event), and you enroll yourself and your covered eligible dependents for COBRA coverage. Three months after your COBRA coverage begins, your child turns 24 years old and is no longer eligible for Plan coverage. Your child can continue COBRA coverage for 33 months, for a total of 36 months of COBRA coverage.

2. This extended period of COBRA Continuation Coverage is NOT available to anyone who became your spouse after the termination of employment or reduction in hours. However, this extended period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by, or placed for adoption with you (the active employee) during the18-month period of COBRA Continuation Coverage.

3. **Medicare and Second Qualifying Events.** If:

   a. you become entitled to COBRA Continuation Coverage because of termination of employment or reduction in hours that occurred less than 18 months after the date you become entitled to Medicare, and

   b. if your spouse and/or any dependent child has a second qualifying event as described above in paragraph 1, then your spouse and/or dependent child would be entitled to a 36-month period of COBRA Continuation Coverage beginning on the date you became entitled to Medicare. For example, if your employment terminated on a date less than 18 months after you became entitled to Medicare, your spouse and/or dependent child who had a second qualifying event during the 18 months period of COBRA Continuation Coverage would be entitled to COBRA Continuation Coverage for a 36-month period beginning on the date you became entitled to Medicare. A second qualifying event for your dependents does not occur when you, the employee, become entitled to Medicare during a period of COBRA coverage. (IRS position in Revenue Ruling 2004-22).

4. In no case are you entitled to COBRA Continuation Coverage for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional COBRA Continuation Coverage period on account of disability). As a result, if you experience a reduction in hours followed by termination of employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the initial qualifying event.

5. In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months.

Duty to Notify the Plan By Contacting the Trust Office.

In order to have the chance to elect COBRA after a divorce, legal separation, or a child's loss of dependent status, the employee or family member must inform the Trust Office in writing of a divorce, legal separation or loss of dependent status by a child **within sixty (60) days** after the later of:

1. the date the event occurred; or
2. the date coverage would end as a result of the event.

<u>IF SUCH A NOTICE IS NOT RECEIVED BY THE TRUST OFFICE AT THE ADDRESS LOCATED IN THE QUICK REFERENCE CHART AT THE BEGINNING OF THIS DOCUMENT BELOW WITHIN THAT 60-DAY PERIOD, THE AFFECTED DEPENDENT WILL NOT BE ENTITLED TO CHOOSE COBRA CONTINUATION COVERAGE.</u>

When the covered employee, spouse or dependent is disabled at the time of a qualifying event involving termination, termination of Hour Bank, or reduction of hours or at any time during the first 60 days of continuation coverage, the covered employee, spouse of dependent child must notify the COBRA Administrator within 60 days of the Social Security determination of disability and before the end of the

initial 18-month period. When the Social Security Administration determines that a qualified beneficiary is no longer disabled, notice must be sent no later than 30 days after the date of the determination by the Social Security Administration.

Notice may be provided by the covered employee or qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the covered employee or qualified beneficiary. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event. Each qualified beneficiary with respect to a particular qualifying event has an independent right to elect COBRA continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. A parent or legal guardian may elect continuation coverage for a minor child.

The employee's employer will give the Trust Office information regarding other qualifying events. However, we encourage the employee or family member to inform the Trust Office promptly of **any** qualifying event to assure prompt handling of your COBRA rights, particularly in the event of an employee's death. Notice should be sent to the COBRA Administrator at their address listed on the Quick Reference Chart in the front of this document:

Deadline for Election of COBRA Continuation Coverage.

When the Trust Office is notified that a qualifying event has occurred, you will be sent an election form and other information regarding COBRA continuation coverage. You will have at least **sixty (60) days** from the date your coverage ends, or, if later, sixty (60) days from the date of the notice advising you of your election rights to make your decision. You do not have to show that you are insurable to obtain COBRA continuation coverage.

If you are an Active Employee or a dependent of an Active Employee and you elect COBRA continuation coverage, you will be entitled to the same health coverage that is provided to other active employees or family members like you in the Trust. However, life insurance, AD&D and disability benefits are not provided under COBRA continuation coverage.

If you are a dependent of a Retired Employee and you elect COBRA continuation coverage, you will be entitled to the same health coverage that is provided to retired employees or family members like you in the Plan.

Paying for COBRA Continuation Coverage (The Cost of COBRA).

Any person who elects COBRA Continuation Coverage must pay the full cost of the COBRA Continuation Coverage. The Trust is permitted to charge the full cost of coverage for similarly situated active employees and families (including both the Trust's and employee's share), plus an additional 2%. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% applicable to the COBRA family unit (but only if the disabled person is covered) during the 11-month additional COBRA period.

Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time he or she becomes entitled to it. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

NOTE: You will not receive an invoice (bill) for the initial COBRA premium payment or for the monthly COBRA premium payments. You are responsible for making timely payments for COBRA continuation coverage to the COBRA Administrator listed on the Quick Reference Chart.

IMPORTANT
There will be no invoices or payment reminders for COBRA premium payments. You are responsible for making sure that timely COBRA premium payments are made to the COBRA Administrator.

Grace Periods.

The **initial payment** for the COBRA Continuation Coverage is due to the COBRA Administrator **no later than 45 days** after COBRA Continuation Coverage is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect.

After the initial COBRA payment, **subsequent payments** are due on the first day of each month, but there will be **a 30-day grace period** to make those payments. If payments are not made within the 30-day time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

Payment Obligations.

Payment for the required premium must be made on the following basis:

1 The person eligible for continuation coverage must pay a monthly premium for such coverage. The amount of such premium shall be established by the Board of Trustees from time to time and furnished to the eligible person with the election form.

2 All payments must be made by check, cashier's check, or money order.

3 The initial COBRA continuation payment should be received by the Trust Office no later than the 20th day of the month after the month for which you desire coverage, in order to avoid possible delays in claim payments and eligibility problems. However, this initial payment will be accepted up to 45 days from the date you elect COBRA coverage. The first payment must cover the number of months from the date coverage would otherwise have ended, including the month in which the first payment is made.

4 After the first COBRA continuation payment is made, additional payments must be made every month to keep coverage. Monthly payments must be received by the 20th day of the month preceding each coverage month to avoid possible delays in claim payments and eligibility problems. For example, if you want COBRA coverage for the month of February, payment should be received by January 20th. Failure to make a monthly payment within (30) thirty days of the beginning of the payment coverage month will result in TERMINATION of coverage as of the end of the period for which payment has been made.

5 The Trust Office will NOT send monthly bills or warning notices. **It is your responsibility to submit payment when due.**

Termination of COBRA Continuation Coverage.

Continuation coverage will end when the maximum period has been reached as described previously. However, COBRA continuation coverage **will end earlier for any of the following reasons**:

1. The Trust no longer provides group health coverage;
2. Your premium for COBRA continuation coverage is not paid on tine;
3. The Lifetime benefit maximum is exhausted on all benefits.

4. You get coverage under another group health plan, as an employee, spouse or dependent of an employee unless the group health plan contains a provision that would limit or exclude coverage for a pre-existing condition. In this case COBRA continuation coverage will not end until the date the condition is covered under the new plan or the maximum time allowed under COBRA coverage is reached, whichever happens first;
5. You become entitled to Medicare other than as an ESRD beneficiary; or
6. In the case of total disability, Social Security determines that the disability no longer exists. If this happens, continuation coverage will terminate at the end of the month after the month in which the determination was made.

Notice of Early Termination of COBRA Continuation Coverage.

The Plan will notify a Qualified Beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the Qualified Beneficiary may have under the Plan to elect alternate or conversion coverage. The notice will be provided as soon as practicable after the COBRA Administrator determines that COBRA coverage will terminate early.

Entitlement to Convert to an Individual Health Plan after COBRA Ends.

At the end of the 18-month or 36-month period of COBRA Continuation Coverage, you may be allowed to enroll in an individual conversion health plan, if that right is offered by the Plan at the time your COBRA Continuation Coverage period runs out. You will be advised if conversion rights are available when your COBRA Continuation Coverage ends.

Consequences of Failing to Elect COBRA.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage may affect your future rights under federal law. You can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you to not have such a gap.

You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 31 days after your group health coverage ends because of these qualifying events (termination of employment, reduction in hours, divorce or legal separation, death of employee or ceasing to be an eligible dependent). You will also have the same special enrollment right at the end of continuation coverage if you elect continuation coverage for the maximum period of time that is available to you.

Questions About COBRA.

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Trust Office. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

Keep the Trust Informed of Any Address Changes.

In order to protect your family's rights, you should keep the Trust Office informed of any changes in the addresses of family members. You should also keep a copy of any notices you send to the Trust Office for your records.

CalCOBRA Coverage for Medical Benefits Only

In certain circumstances a COBRA Qualified Beneficiary may continue coverage under CalCOBRA after federal COBRA coverage is exhausted. Additionally, CalCOBRA may be available for Domestic Partners and Children of Domestic Partners to continue their coverage when federal COBRA does not apply. You are not eligible for CalCOBRA is you have Medicare, you have or get coverage under another group health plan, or you are eligible for or covered under federal COBRA. If you are entitled to elect CalCOBRA coverage, you will be notified by Kaiser. You can add eligible family members to your CalCOBRA. You may have to pay the whole cost of the CalCOBRA coverage you elect. For more information on CalCOBRA, contact your medical insurance company.

MEDICAL, PRESCRIPTION DRUG AND VISION BENEFITS

Eligible Active employees and non-Medicare eligible Retirees and their non-Medicare eligible Dependents are entitled to the following medical benefit plans:

- An **HMO health plan** provided through Kaiser Permanente (the "KP Traditional HMO"). You must live within the Kaiser HMO service area to be eligible to enroll. If you are enrolled in this Plan, you and your eligible Dependents are covered under the Kaiser Plan for hospital and medical services and supplies, prescription drug coverage and vision coverage.

What is Kaiser Permanente?

The Kaiser Permanente Medical Program is a direct service health care program providing healthcare and wellness benefits, prescription drug coverage and vision coverage. Eligible Active and Retired Employees and their Dependents must live in the Kaiser service area in which they enroll. It is imperative you and your eligible Dependent(s) select a primary care physician once you enroll in the Kaiser health plan. You and your Dependents are **not** however restricted to the use of solely one Kaiser Permanente physician or facility. You may receive medical care at any Kaiser Permanente facility or any hospital contracting with Kaiser Foundation Health Plan.

How does the Kaiser Permanente program work?

Employees Residing in the Kaiser HMO Zip Code Area

You cannot be covered under the HMO Plan unless you reside in one of the zip codes covered under the **Kaiser HMO Plan**. Active or retired employees and their eligible Dependents NOT eligible for Medicare who reside in one of the zip codes will be covered under the Kaiser HMO Plan. Benefits under the HMO Plan are described in Appendix A.

Employees Residing Outside the Kaiser HMO Zip Code Area

Any active employee and their eligible dependents who do not reside in the HMO zip code area will not be covered by the Plan.

Benefit Summaries.

For details on your benefit coverage, please refer to the Kaiser Foundation Health Plan, Inc. *Evidence of Coverage* for your plan. The *Evidence of Coverage* is the binding document between Kaiser and its members. For details on the benefit and claims review and adjudication procedures, please refer to Kaiser's *Evidence of Coverage* booklet.

If there are any discrepancies between the benefits addressed in this SPD and the *Evidence of Coverage, the Evidence of Coverage* will prevail.

Kaiser also provides a **Summary of Benefits and Coverage (SBC)** document for each medical plan option. Each SBC contains concise medical plan information, in plain language, about benefits and coverage, including, what is covered, what you need to pay for various benefits, what is not covered and where to go for more information or to get answers to questions. SBC documents are updated when there is a change to the benefits information displayed on an SBC. To obtain a copy of the SBCs, contact the Kaiser at 800-464-4000.

DENTAL BENEFITS

Overview.

A dental benefit plan is available to eligible Active Employees and their eligible Dependents. See the definition of Dependent child in this document in the Eligibility Rules section.

You may enroll in the following dental plan

- A **Dental HMO (DHMO)** plan provided through Anthem--the "Dental Net HMO". You must live within the DHMO designated service area to be eligible to enroll. If you are enrolled in this option, you and your eligible Dependents are covered for dental services and supplies according to the Schedule of Benefits. See Appendix B for the Anthem Dental Net HMO plan booklet.

What is the DHMO dental plan?

The Anthem Dental Net HMO offers quality dental care at an affordable cost. It is available to Active Employees and their eligible dependents living in Kern County, California. When you are enrolled in the DHMO Plan, you may select any participating dental office from a list provided by Anthem. To change dental offices contact Anthem at the contact information listed on the Quick Reference Chart in the front of this booklet.

How does the DHMO Plan work?

When you enroll in the Anthem Dental Net HMO plan there are no claim forms to fill out. Services are provided by contracted dentists at no charge to you, or at specified copayments or other cost-sharing as noted in the Schedule of Copayments. Anthem will not reimburse you for services received from non-network dentists except as described under "What happens in Emergency Cases?"

For details on the benefits provided by the Anthem Dental Net HMO, refer to the DHMO Certificate of Insurance and other documents provided by the insurance company or contact Anthem at its contact information listed on the Quick Reference Chart in the front of this booklet.

What Happens in Emergency Cases under the DHMO plan?

If you have a dental emergency and an Anthem Dental Net provider is not within 35 miles, you may seek emergency treatment at any dental office. You should contact Anthem as soon as you are able after receiving the emergency care and learn how to submit your claim. Anthem will reimburse you up to $100 toward the coast of an emergency exam, palliative care and x-rays, less any applicable *copayments*. Payments will be subject to the exclusions, limitations, and benefit maximus of your plan.

Appeal of Denied Claims.

If your claim for dental benefits is denied in whole or in part, Anthem will provide you with appeal instructions on the Explanation of Benefits document you will receive stating the reason for the denial.

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

The life insurance and accidental death and dismemberment (AD&D) insurance benefits provided to eligible participants of the Kern County Electrical Workers Construction Wiremen and Construction Electricians Health & Welfare Trust are through an insured contract with MetLife Group Insurance Policy KM05750478-G. The policy is issued by MetLife, Metropolitan Life Insurance Co, 200 Park Ave, New York, N.Y. 10166-0188. See Appendix C for more information on Life Insurance and AD&D insurance. Where the information in this chapter deviates from the policy of the insurance company and their documents, the MetLife documents will prevail.

Coverage is not certified for any individual until a certification of coverage is issued and he/she is eligible for coverage in accordance with the Trust's eligibility requirements.

This booklet is not an insurance policy. It does not become a policy when a certificate is attached. It does not amend, extend or alter the coverage afforded by the Policy listed herein. Notwithstanding any requirement, term or condition of any contract or other document with respect to which the booklet may be issued or may pertain, the insurance afforded by the Policy described herein is subject to all the terms, exclusions and conditions of such Insurance Company Policy.

Policyholder: Kern County Electrical Workers Construction Wiremen and Construction Electrician Health & Welfare Trust

Policy Number: KM05750478-G

Type of Insurance: **Group Basic Term Life Insurance & Accidental Death & Dismemberment**

Contact the Trust Office to determine if you are eligible for Life Insurance and AD&D Insurance and when this covered begins. Claims and appeals for Life Insurance and AD&D Insurance should be directed to MetLife (contact information on the Quick Reference Chart in the front of this booklet).

GENERAL PROVISIONS AND INFORMATION REQUIRED BY ERISA

COORDINATION OF BENEFITS (COB)

Many families have family members covered by more than one medical or dental plan, including having coverage under another group health plan, Medicare, Medicaid, Tricare, VA or Indian Health Services. If this is the case with your family, you must let the Insurance companies that contract with this Plan know about all your medical and dental plan coverages when you submit a claim to them for benefits.

Coordination of Benefits (or COB, as it is usually called) operates so that one of the Plans (called the primary plan) will pay its benefits first. The other plan, (called the secondary plan) may then pay additional benefits. In no event will the combined benefits of the primary and secondary plans exceed 100% of the health care expenses incurred. Sometimes, the combined benefits that are paid will be less than the total expenses.

The insurance companies that provide the health coverage in which you are enrolled are required to comply with state laws regarding coordination of benefits. Refer to the insurance company documents for information on how coordination of benefits works.

FACILITY OF PAYMENT.

If the Plan Administrator or its designee determines that you cannot submit a claim or prove that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the Health Care Provider(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Plan Administrator, claim administrator nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

SUBROGATION AND THIRD PARTY LIABILITY

A. Advance on Account of Plan Benefits

The Plan does not cover expenses for services or supplies for which a third party pays or is liable to pay due to any recovery, whether by settlement, judgment or otherwise, but it will advance payment on account of Plan benefits (hereafter called an **"Advance"**), **subject to its right to be reimbursed to the full extent of any Advance payment from the covered Employee** and/or a representative, guardian, conservator, or trustee of the Covered Individual, **and/or Dependent(s) if and when there is any recovery from any third party. The right of reimbursement will apply:**

1. even if the recovery is not characterized in a settlement or judgment as being paid on account of the medical or dental expenses for which the Advance was made; and
2. even if the recovery is not sufficient to make the ill or injured employee and/or dependent(s) whole pursuant to state law or otherwise (sometimes referred to as the "make-whole" rule); and
3. without any reduction for legal or other expenses incurred by the employee and/or dependent(s) in connection with the recovery against the third party or that third party's insurer pursuant to state law or otherwise (sometimes referred to as the "common fund" rule); and
4. regardless of the existence of any state law or common law rule that would bar recovery from a person or entity that caused the illness or injury, or from the insurer of that person or entity (sometimes referred to as the "collateral source" rule);
5. even if the recovery was reduced due to the negligence of the covered Employee or covered Dependent (sometimes referred to as "contributory negligence") or any other common law defense.

B. Reimbursement and/or Subrogation Agreement

The covered Employee **and/or** any covered Dependent(s) on whose behalf the Advance is made, must sign and deliver a reimbursement and/or subrogation agreement (hereafter called the **"Agreement"**) in a form provided by or on behalf of the Plan. If the ill or injured Dependent(s) is a minor or incompetent to execute that Agreement, that person's parent (in the case of a minor dependent child) or Spouse or legal representative (in the case of an incompetent adult) must execute that Agreement upon request by the Plan Administrator or its designee.

If the Agreement is not executed at the Plan Administrator's request, the Plan may refuse to make any Advance, but if, at its sole discretion, the Plan makes an Advance in the absence of an Agreement, **that Advance will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights**.

C. Cooperation with the Plan by All Covered Individuals

By accepting an Advance, regardless of whether or not an Agreement has been executed, the covered Employee and/or covered Dependent(s) each agree:

1. to reimburse the Plan for all amounts paid or payable to the covered Employee and/or covered Dependent(s) or that third party's insurer for the entire amount Advanced; and
2. that the Plan has the first right of reimbursement from any judgment or settlement; and
3. to do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Plan's reimbursement and/or subrogation rights; and
4. to not assign the right of recovery to any third party without the specific consent of the Plan; and
5. to notify and consult with the Plan Administrator or designee before starting any legal action or administrative proceeding against a third party alleged to be responsible for the injury or illness that resulted in the Advance, or entering into any settlement Agreement with that third party or third party's insurer based on those acts; and
6. to inform the Plan Administrator or its designee of all material developments with respect to all claims, actions, or proceedings they have against the third party.

D. Subrogation

1. By accepting an Advance, the covered Employee and/or covered Dependent(s) jointly agree that the Plan will be subrogated to the covered employee and/or covered dependent's right of recovery from a third party or that third party's insurer for the entire amount Advanced, regardless of any state or common law rule to the contrary, including without limitation, a so-called collateral source rule (that would have the effect of prohibiting the Plan from recovering any amount). This means that, in any legal action against a third party who may have been responsible for the injury or illness that resulted in the Advance, the Plan may be substituted in place of the covered Employee and/or covered Dependent(s), but only to the extent of the amount of the Advance. The Plan is subrogated in any and all actions against third parties for the portion of all recoveries that the Plan is entitled.
2. Under its subrogation rights, the Plan may, at its discretion:
    a. start any legal action or administrative proceeding it deems necessary to protect its right to recover its Advances, and try or settle that action or proceeding in the name of and with the full cooperation of the covered Employee and/or covered Dependent(s), but in doing so, the Plan will **not** represent, or provide legal representation for the covered Employee and/or covered Dependent(s) with respect to their damages that exceed any Advance; or
    b. intervene in any claim, legal action, or administrative proceeding started by the covered Employee or covered Dependent(s) against any third party or third party's insurer concerning the injury or illness that resulted in the Advance.

E. Application to Any Fund

1. The Plan's right to reimbursement and subrogation shall apply to any fund, account or other asset created:
   a. pursuant to the judgment of any court awarding damages against any third party in favor of the ill or injured Employee and/or Dependent(s) payable by any third party on account of an illness or injury alleged to have been caused by that third party; or
   b. as a result of any settlement paid by any third party on account of any claim by or on behalf of the ill or injured Employee and/or Dependent(s).

F. Lien and Segregation of Recovery

By accepting the Advance the covered Employee and/or covered Dependent agrees to the following:

1. The Plan will automatically have an equitable lien, to the extent of the Advance, upon any recovery, whether by settlement, judgment or otherwise, by the covered Employee and/or covered Dependent. The Plan's lien extends to any recovery from the third party, the third party's insurer, and the third party's guarantor and to any recovery received from the insurer under an automobile, uninsured motorist, underinsured motorist, medical or health insurance or other policy. The Plan's lien exists regardless of the extent to which the actual proceeds of the recovery are traceable to particular funds or assets.
2. The Plan holds in a constructive trust that portion of the recovery that is the extent of the Advance. The covered Employee, covered Dependent, and those acting on their behalf, shall place and maintain such portion of any recovery in a separate segregated account until the reimbursement obligation to the Plan is satisfied. The location of the account and the account number must be provided to the Plan.
3. Should the covered Employee, covered Dependent or those acting on their behalf, fail to maintain this segregated account or comply with any of the Plan's reimbursement requirements, they stipulate to the entry of a temporary or preliminary injunction requiring the placement and maintenance of any reimbursable or disputed portion of any recovery in an escrow account until any dispute concerning reimbursement is resolved and the Plan receives all amounts that must be reimbursed.

G. Remedies Available to the Plan

In addition to the remedies discussed above, if the covered Employee or covered Dependent(s) does not reimburse the Plan as required by this provision, the Plan may, at its sole discretion:

1. apply any future Plan benefits that may become payable on behalf of the covered Employee and/or covered Dependent(s) to the amount not reimbursed; or
2. obtain a judgment against the covered Employee and/or covered Dependent(s) for the amount Advanced and not reimbursed, and garnish or attach the wages or earnings of the covered Employee and/or covered Dependent(s).

HIPAA PRIVACY AND SECURITY.

Use and Disclosure of Protected Health Information (PHI). The Plan will use protected health information (PHI) to the extent of, and in accordance with the uses and disclosures permitted by the privacy regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH).

- The term **"Protected Health Information" (PHI)** includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.

- **PHI does not include** health information contained in employment records held by the Plan, or your employer in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family and Medical leave (FMLA), life insurance, disability benefits, drug testing, etc.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was previously distributed to you upon enrollment in the Plan and is also available from the Trust Office. Information about HIPAA in this SPD/Plan Rules is not intended to and cannot be construed as the Plan's Notice of Privacy Practices.

Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

1. determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for an individual's claim);
2. coordination of benefits;
3. adjudication of health benefit claims (including appeals and other payment disputes);
4. subrogation of health benefit claims;
5. establishing employee contributions;
6. risk adjusting amounts due based on enrollee health status and demographic characteristics;
7. billing, collection activities and related health care data processing;
8. claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
9. obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
10. medical necessity reviews or reviews of appropriateness of care or justification of charges;
11. utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;
12. disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI) may be disclosed for payment purposes: name and address, date of birth, social security number, payment history, account number and name and address of the provider and/or health plan); and
13. reimbursement to the Plan.

Health Care Operations include, but are not limited to, the following activities:

1. quality assessment, patient safety activities;
2. population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
3. rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
4. underwriting, (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
5. conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
6. business planning and development, such as conducting cost-management and planning related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
7. business management and general administrative activities of the Plan, including but not limited to:
   a. management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
   b. customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
8. resolution of internal grievances; and
9. due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.
10. Compliance with and preparation of documents required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, Summary Annual Reports and other documents.

The Plan will use and disclose PHI as required by law and as permitted by authorization of the Participant or beneficiary. With a written authorization, the Plan will disclose PHI to another benefit plan for purposes related to administration of that plan.

For purposes of this Section, the Board of Trustees is the Plan Sponsor. The Plan shall disclose PHI to the Plan Sponsor for the purpose of deciding health claim appeals. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to certain conditions as follows:

1. not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
2. ensure that any agents or independent contractors, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. not use or disclose PHI for employment-related actions and decisions unless authorized by the Participant or beneficiary;
4. not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized;

5. report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
6. make PHI available to an individual in accordance with HIPAA's access requirements;
7. make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
8. make available the information required to provide an accounting of disclosures; make internal practices, books and records relating to the use and disclosures of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and
9. if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI which is no longer needed for the purpose for which disclosure as made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible);
10. if a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

Adequate separation between the Plan and the Plan Sponsor must be maintained. In accordance with HIPAA, only the Board of Trustees, the Privacy and Security Officers, other Plan contracted Covered Entities and Business Associates may be given access to PHI. These individuals may only have access to and use and disclose PHI for plan administration functions that the Plan Sponsor performs for the Plan. If these individuals do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

In compliance with the HIPAA security rule compliance the Plan Sponsor will:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives maintains, or transmits on behalf of the group health plan,
2. Ensure that the adequate separation discussed above, specific to electronic PHI that it creates, receives, maintains, or transmits on behalf of the group health plan,
3. Ensure that any agent or independent contractor, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

PLAN NOTICES.

THE NEWBORN'S & MOTHERS HEALTH PROTECTION ACT OF 1996.

This Plan complies with Federal law that prohibits restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or requiring a health care practitioner to obtain authorization from the Plan (or its utilization review company) for prescribing a length of stay not in excess of those periods. The attending physician may, however, after consulting with the mother, discharge the mother and newborn earlier than 48 hours following a normal vaginal delivery, or 96 hours following a cesarean section.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998.

Under Federal Law, group health plans, insurers and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. In the case of a participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and

who elects breast reconstruction, Federal law requires coverage in a manner determined in consultation with the attending physician and the patient, for:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

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

NONDISCRIMINATION IN HEALTH CARE.

In accordance with the Affordable Care Act, to the extent an item or service is a covered benefit under the insured health plans, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. The Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

This chapter contains general provisions of the plan and also information required by the Employee Retirement Income Security Act of 1974 (ERISA).

Plan Name and Address of Plan Sponsor Maintaining the Plan.

The Plan is known as the **Kern County Electrical Workers Health and Welfare Trust**. The Plan can be contacted at:

3805 North Sillect Avenue
Bakersfield, California 93308
(661) 325-9471

Plan Sponsor and Administrator.

The Board of Trustees of the Kern County Electrical Workers Health and Welfare Trust is both the Plan Sponsor and the Plan Administrator for this employee benefits welfare plan. The routine administrative functions of the Plan are performed by an independent administrator:

Construction Benefits Administration, Inc.
3805 North Sillect Avenue
Bakersfield, California 93308
(661) 325-9471

Plan and Trust Fund Identification Number.

The number assigned to the Trust by the Internal Revenue Service is 95-6053542.

The number to the Plan is 501.

Agent For Service of Legal Process.

The name and address of the person designated as agent for the service of legal process is:

Kern County Electrical Workers Health and Welfare Trust Plan Administrator
Construction Benefits Administration, Inc.
3805 North Sillect Avenue
Bakersfield, California 93308
(661) 325-9471

Legal process may also be served on a Plan Trustee.

Trustees of the Plan.

The name and business address of the Trustees of the Plan are as follows:

Labor Trustees	Employer Trustees
Brian Holt IBEW Local #428 3921 North Sillect Avenue Bakersfield, CA 93308	Cody Brooks 4015 Coffee Rd, Suite 210 Bakersfield, CA 93308
Tony Urzanqui IBEW Local #428 3921 North Sillect Avenue Bakersfield, CA 93308	Jack Bellows VMax 7812 Fruitvale Ave Bakersfield, CA 93308
Jacob Elrod IBEW Local #428 3921 North Sillect Avenue Bakersfield, CA 93308	Paul White Contra Costa Electric 3208 Landco Drive Bakersfield, CA 93308

Collective Bargaining Agreements.

This plan is maintained pursuant to one or more Collective Bargaining Agreements. A copy of such agreement may be obtained upon written request to the Plan Administrator and is available for examination at the Plan Administrator's office.

Source of Plan Contributions.

The benefits described in this booklet are provided through employer contributions and, in some instances, participant self-pay contributions. The amount of the employer contributions is determined by the provisions of the collective bargaining agreements or participation agreements with employers or employer representatives. The amount of the self-pay contributions is determined in the sole and absolute discretion of the Board of Trustees.

Funding Medium.

Benefits are provided from the Trust's assets which are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to eligible persons and defraying reasonable administrative expenses. All self-funded benefits and fully insured premiums are paid directly by the Trust Fund.

Type of Plan.

The employee benefits welfare plan (the Plan) is maintained for the purposes of providing Life Insurance, Accidental Death & Dismemberment, Disability, Medical, Dental and vision benefits. Currently Vision benefits are provided as part of the Medical benefits.

Plan Year.

The records of the Plan are kept separately for each Plan Year. The Plan Year begins January 1 and ends, each year, on December 31.

Plan's Requirements for Eligibility and Benefits.

The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility or denial or loss of benefits are described in the Eligibility chapter in this document.

Claims Filing Procedure.

The procedure to follow in filing a claim for benefits under each of the insured health plans is described in the Evidence of Coverage booklets issued by the insurance companies. If you need an Evidence of Coverage booklet, please contact the appropriate provider listed in the Quick Reference chart on pages 4-5 of this document. The claims filing procedures related to the self-funded disability benefits and COBRA are outlined in the Disability Benefits chapter of this document and as Appendices at the end of this document.

Claims Review/Claim Appeal Procedures.

To appeal an adverse benefit determination related to services and supplies provided through the insured benefits offered by the Plan: Kaiser, MetLife (Life/AD&D Ins), Anthem DHMO and DPPO--review the appeals procedure described in the Evidence of Coverage booklets issued by the insurance companies.

Kaiser Foundation Health Plan is the named fiduciary for purposes of adjudicating claims and deciding appeals under any plan provided through Kaiser Foundation Health Plan. Anthem is the named fiduciary for purposes of adjudicating claims and deciding appeals under any plan provided for DHMO and DPPO dental benefits. MetLife (Metropolitan Life Insurance Company) is the named fiduciary for purposes of adjudicating claims and deciding appeals under any plan provided for life and accidental death and dismemberment insurance.

To appeal an adverse benefit determination related to the self-funded disability benefits of this Plan, refer to the Disability Benefits chapter in this document.

Plan Amendments or Termination of Plan.

The Board of Trustees reserves the right to amend or terminate this Plan, or any part of it, at any time without advance notice to participants. This includes the discretionary right to interpret, revise, supplement or rescind any or all portions of the Plan.

- Amendments to the Plan may be made in writing to the Board of Trustees and become effective on the written approval of the Board of Trustees), or on such other date as may be specified in the document amending the Plan.
- The Plan or any coverage under it may be terminated by the Board of Trustees, and new coverages may be added by the Board of Trustees. Upon termination, discontinuance or revocation of participation in the Plan, all elections and reductions in compensation related to the Plan will terminate.

Allocation and Disposition of Assets Upon Termination.

In order for the Trust to carry out its obligation to provide the maximum possible benefits to all Participants within the limits of its resources, the Board of Trustees has the right to take any of the following actions, even if claims that have already accrued are affected:

- To terminate any benefits provided by these Plan Rules.
- To alter or postpone the method of payment of any benefit.

- To amend or rescind any provision of these Plan Rules.

In addition, the Trust may be terminated by the Board of Trustees, provided that the termination is not effective until 60 days after the mailing of such notice. In the event the Plan terminates, the Board of Trustees, by unanimous agreement and in their full discretion, will determine the disposition of any assets remaining after all expenses of the Plan and Trust have been paid; provided that any such distribution will be made only for the benefit of former participants and for the purposes set forth in the Plan. Upon termination of the Plan, the Board of Trustees (with full power) will continue in such capacity for the purpose of dissolution of the Plan.

Statement of ERISA Rights.

As a participant in the 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 and at other locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may pay for such coverage. Review this summary plan description and documents governing the Plan or the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a 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 people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

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

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of Pension Welfare Benefits Programs, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue, N.W., Washington D. C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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TRUST OFFICE/PLAN ADMINISTRATOR
Construction Benefits Administration, Inc.
3805 North Sillect Avenue
Bakersfield, CA 93308
Phone 661-325-9471

BENEFITS CONSULTING AND ACTUARIAL SERVICES:
The Segal Company
500 North Brand Boulevard #1400
Glendale, CA 91203-2376

APPENDICES

Appendix A – Kaiser Traditional HMO Plan

Appendix B – Anthem DHMO Dental Plan

Appendix C – MetLife Life Insurance and Accidental Death and Dismemberment Insurance

<u>Appendix A – Kaiser Traditional HMO Plan</u>

Appendix B –Anthem DHMO Dental Plan

Appendix C – MetLife Life Insurance and Accidental Death and Dismemberment Insurance