



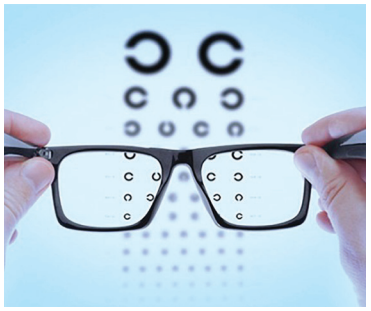

Cupertino Electric, Inc.

2019 Benefits Guide

Temporary Full-Time Employees

CUPERTINO ELECTRIC INC.

(408) 808-8000

2019 Benefits Booklet

Who we are and what we do.

At Cupertino Electric, Inc. (CEI), we deliver power and possibilities. Through our expert electrical engineering and construction services, we serve customers in a variety of industries and geographic locations. Unlike other companies that use buzzwords as substitutes for action, we focus on relationships, renowned technical expertise and delivering superior results.

What we value.

Our strong, enduring reputation is built on our core values:

Safety

We value the safety and well-being of our people, customers and communities.

Integrity

We deliver on our word. We're honest, trustworthy and operate with integrity.

Innovation

We delight in new ideas and offer innovative, flexible solutions to customers.

Excellence

We strive for excellence in the services and results we deliver.

People

We believe our people make our success possible and encourage them to bring their creativity, passion and commitment to everything they do.

Always moving forward. Always giving back.

CEI has a long-standing tradition of generosity, involvement and service to the communities where we live and work. Through our matching gift policy and inPowered volunteer efforts, the company contributes thousands of dollars annually to charitable organizations throughout the country.

We're powered by great people.

We hire the best and the brightest, and are dedicated to ensuring that our employees stay that way. Whether it is a development course, a hands-on training session or an expert lecture, we strive to create a meaningful work experience. Our employees are driven and empowered to fulfill their personal and professional goals, allowing them to grow their careers as they rise through the ranks. Our next challenge is right around the corner and we would not have it any other way.

Welcome to Your Benefits Guide

(Non-Union Temporary Full-Time Employees)

Cupertino Electric is pleased to provide you with comprehensive Medical benefits.

For information about the specific plans available to you, log on to WorkTerra at *https://www.workterra.net*, or ask your Benefits Administrator for more information.

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This guide provides an overview of the benefits program. It is not intended to be a complete description of the benefits or to be the official summary plan description for these programs. If there is a conflict between this guide and the official plan documents, the plan documents will govern. Cupertino Electric reserves the right to modify or terminate any of the described benefits at any time and for any reason. The descriptions of these benefits are not guarantees of current or future employment or benefits.

2019 Benefits and Options At-a-Glance

Medical Insurance

HMO/EPO — The ***United Healthcare EPO*** and the ***Kaiser Permanente HMO**** plans provide coverage after modest copayments, such as for physician office visits and most services authorized by a primary care physician.

** The **Kaiser** HMO plan is not available to employees residing outside of California. You can choose to enroll in the **United Healthcare EPO plan or the** High Deductible PPO Health Plan as described below.*

High Deductible PPO with Health Savings Account (HSA) — The ***United Healthcare HDHP with HSA*** plan requires you to pay a ***$1,500 Individual / $2,700 Family*** in-network deductible or a ***$3,000 Individual / $6,000 Family*** non-network deductible for services before the plan coverage begins; out-of-pocket maximums are in place to protect you from major medical expenses; includes a Health Savings Account (HSA) feature which allows you to set aside pre-tax dollars to pay for eligible health care expenses – and the HDHP plan allows for most of your medical care expenses to be paid using your Health Savings Account through ***HSA BANK***. CEI will contribute up to ***$19.23*** per week for individuals and ***$38.46*** per week for families to your HSA!

Time Off

Paid Time Off Sick Leave — You are eligible for 24 hours of paid sick leave for each year.

How to Enroll

If you are classified as a temporary full-time employee, and you work 30 or more hours per week, you can participate in medical insurance only as described in this guide.

Remember:

- You cannot change your benefits during the year unless you have a qualified family status change. (See the “qualifying events” section on page 8)
- You must enroll your dependents in the same plans in which you are enrolling for the year. Please see your Benefit Administrator for information on how to enroll.

Waiving Coverage

If you choose to waive medical, you will need to log into the WorkTerra enrollment site to decline coverage. Employees may select “waive coverage” when completing their elections. You may be subject to benefit waiting period should you become eligible to enroll in the future.

Before You Enroll

Before completing the enrollment process, you should review your personal information on file. If you see that any of your personal information is incorrect, such as your birth date or home address, contact Human Resources to submit a change of information.

Gather the following information and have it with you when you enroll:

- Your Social Security number
- The names, birth dates, and Social Security numbers of any dependents you wish to enroll, or of any beneficiaries you wish to designate

How to Enroll *(continued)*

To Enroll Online

Enrolling through the Internet is simple and secure. The website will take you through each step of the process.

1. Log on to WorkTerra — *https://www.workterra.net*

- User name will be your CEI employee ID number
- Password will be the first 4 digits of your Social Security number
- Company name is CEI (not case sensitive)
- You will be prompted to change your password upon your initial login

2. Use the tools to make smart enrollment decisions

Use the toolkit to evaluate your needs, compare options, and decide what is right for you and your family. Here's what you can do:

Compare Your Medical Plan Options – HP Assist

- Benchmark your estimated utilization against national averages
- Estimate out-of-pocket costs for better planning
- Compare plan costs by design and employee contributions
- Help determine how much to set aside in your HSA

Find a United Healthcare Medical Network Provider

- Access *www.myuhc.com*
- Select "Find a Physician, Laboratory or Facility" under the right side of the tool bar titled "Links and Tools"
- Select the option "All United Healthcare Plans"
- Click on "Select" for the EPO option or "Select Plus" for the HSA option.
- Enter your zip code and search by name or category

3. Confirm your choices

Once you have made your elections and added your dependent and beneficiary information, you will see a confirmation of your enrollment. Please verify that ALL information is updated correctly. If you want to enroll dependents, check to be sure that each dependent is listed as covered under the applicable benefit plan. If you need to make any changes, simply update your enrollment prior to finalizing your choices. Print this page and keep it for your records.

ID Cards

After you enroll, you will receive ID cards from the medical plan you select. When you receive your ID card, confirm that all information is accurate. If not, contact the plan administrator right away.

Eligibility and Changes

Eligibility

If you are classified as a temporary full-time employee, and you work 30 or more hours per week, you can participate in medical insurance only as described in this guide.

Your Dependents

Your eligible dependents include:

- Your spouse or domestic partner.
- Your same-sex or opposite-sex domestic partner who meets certain criteria (listed below).
- Dependent children who are under Age 26, regardless of student or marriage status.

Your children include:

- You or your domestic partner's natural or adopted children who can be claimed as your tax dependents.
- Your stepchildren whom you support and who live with you in a parent-child relationship.
- Children placed in your home for adoption or foster care.
- Any other children you support for whom you are the legal guardian or for whom you are required to provide coverage as the result of a qualified medical child support order.

You may be required to provide proof of dependent status. Any falsification of this information will result in disciplinary action, up to and including termination.

Domestic Partner Eligibility Criteria

Coverage is available for your Domestic Partner if you have met all eligibility requirements listed below for the previous 12 months.

- You maintain the same principal place of residence and intend to do so in the future.
- You agree to be responsible for each other's basic living expenses in the event that either of you is unable to provide such expenses for himself or herself.
- You are both 18 years of age or older.
- Neither of you is married.
- You are not related by blood to such a degree that you would be prevented from marrying in the state in which you reside (opposite sex partners only).
- Neither of you has maintained coverage for another Domestic Partner under any health plan within the last six months. (i.e.: any domestic partner that has died within the last six months.)
- You agree to notify CEI immediately upon your failure to satisfy any of the criteria of Domestic Partnership.
- You understand that it is a fraudulent act to obtain health coverage by misrepresenting any facts stated herein.

If you wish to certify your domestic partner and/or dependent(s) as your tax-qualified dependent(s) under Section 152 of the Internal Revenue Code ("Code"), contact Human Resources.

Eligibility and Changes *(continued)*

Making Changes

You can enroll in benefits as a new hire or during annual enrollment. When you elect coverage under the medical plans, coverage stays in effect for the entire plan year. You cannot change your coverage unless you have a qualified life status event.

Qualifying events include:

- Birth, adoption and marriage
- Divorce or legal separation
- A dependent child reaches age 26
- An eligible family member gains or loses coverage from another source (such as a spouse's employer plan)
- The death of a dependent, spouse or domestic partner
- Termination of employment or a reduction of hours
- Termination of employer contributions for coverage
- Exhaustion of COBRA coverage
- A change in residence that results in being outside the service area for your medical plan (only in certain circumstances)
- If the medical plan discontinues benefits for a certain group of individuals and you are part of that group

If you experience a qualified life status event, you have 31 days to report the event and request applicable benefit changes. In addition, you may need to update your address or update your tax status by completing a new W-4 form. For questions about tax forms or to update your address, contact Human Resources.

If You Leave Your Job

Your medical benefits end on the last day of the month following termination from CEI. You and your dependents that are covered under your medical coverage have the right to continue participation in group health coverage as allowed under the Consolidated Omnibus Budget Reconciliation Act (commonly referred to as "COBRA"). You have 60 days from your notification date or coverage-end date to enroll in COBRA. If you enroll in COBRA, you will pay monthly payments for the full premium plus a two (2) percent administration fee. COBRA coverage is generally available for up to 18 months, with additional extensions available under certain circumstances. For more information, contact ***IGOE Administrative Services***, CEI's COBRA Administrator, at ***(800) 633-8818, option 2*** and ask to speak to a COBRA representative.

Medical Options

Your Medical Plans

CEI offers employees a choice of medical plans through ***Kaiser Permanente*** and ***United Healthcare***. Please refer to the comparison chart below regarding your medical plan options.

For employees in states outside of California, CEI has arranged for a medical EPO Plan and a High Deductible PPO Plan option with HSA through ***United Healthcare***.

Medical HMO/EPO Plan Options

Kaiser Traditional HMO and ***United Healthcare*** Traditional EPO

HMO Options	Kaiser $30 HMO (Available in California only)	United Healthcare EPO (Available Nationwide)
Provider Network	Kaiser Providers Only	UHC Select Provider Network
Annual Deductible	$0	$0
Coinsurance	100%	100%
Office Visit Copay	$30 copay per visit (PCP & Specialist)	$20 copay per visit (PCP & Specialist)
Annual Maximum Out-of-Pocket	$1,500 (Individual) | $3,000 (Family)	$2,500 (Individual) | $5,000 (Family)
Lifetime Maximum Benefit	Unlimited	Unlimited
Outpatient & Inpatient Services: Some copays and deductibles may vary. Please see the summary of benefits for full benefit detail		
Well Child Preventive Exam	Covered 100%	Covered 100%
Well Woman Preventive Exam	Covered 100%	Covered 100%
Adult Preventive Exam	Covered 100%	Covered 100%
Diagnostic X-Ray and Lab	Covered 100%	Covered 100%
Inpatient Hospital Services	Covered 100%	$250 copay per admission
Emergency Room	$100 copay per visit; waived if admitted	$100 copay per visit; waived if admitted
Infertility Treatments	50% coinsurance per visit; may not be available at all locations	Not covered
Chiropractic	$15 copay per visit; 30 visits per year	$20 copay per visit; 20 visits per year
Prescriptions	**Kaiser Pharmacy**	**UHC Network Pharmacy**
Retail Pharmacy Copays **Tier 1 - Generic** **Tier 2 - Brand** **Tier 3 - Non-Formulary**	*Up to 30-day supply* $10 $25 N/A	*Up to 31-day supply* $15 $35 $50
Mail Order Copays **Tier 1 - Generic** **Tier 2 - Brand** **Tier 3 - Non-Formulary**	*Up to 100-day supply* $20 $50 N/A	*Up to 90-day supply* $37.50 $87.50 $125

*Please note: This chart is just a brief overview of benefits and coverage for the medical plans. You should also look at the detailed disclosure or summary documents for each plan, available from your Benefit Administrator or online at WorkTerra. For questions about a specific procedure, service or provider, please contact the medical plan directly or visit the carrier websites at www.kp.org (**Kaiser of CA**), or www.myuhc.com (**United Healthcare**). Additional carrier contact information is located on page 21 of this benefit guide.*

Medical Options *(continued)*

Medical PPO Plan Option

United Healthcare High Deductible Health Plan (HDHP)

PPO Option	United Healthcare PPO HDHP Plan with HSA (Available Nationwide)	
Provider Network	UHC Select Provider Network	
	Network	**Non-Network**
Annual Deductible	$1,500 (Individual) $2,700 (Family)	$3,000 (Individual) $6,000 (Family)
Coinsurance	90%	70%
Office Visit Copay	10% after deductible	30% after deductible
Annual Maximum Out-of-Pocket	$6,000 (Individual) $6,000 (Family)	$6,000 (Individual) $12,000 (Family)
Lifetime Maximum Benefit	Unlimited	Unlimited
Outpatient & Inpatient Services: * Some copays and deductibles may vary. Please see the summary of benefits for full benefit detail*		
Well Child Preventive Exam	Covered 100%	Not covered
Well Woman Preventive Exam	Covered 100%	Not covered
Adult Preventive Exam	Covered 100%	Not covered
Diagnostic X-Ray and Lab	10% after deductible	30% after deductible
Inpatient Hospital Services	10% after deductible	30% after deductible
Emergency Room	10% after deductible	
Infertility Treatments	Not covered	
Chiropractic	10% after deductible; 20 visits per year	30% after deductible; 20 visits per year
Prescriptions	**Network**	**Non-Network**
Retail Pharmacy Copays **Tier 1 - Generic** **Tier 2 - Brand** **Tier 3 - Non-Formulary**	*Up to 31-day supply* $10 $30 $50	*Up to 31-day supply* $10 $30 $50
Mail Order Copays **Tier 1 - Generic** **Tier 2 - Brand** **Tier 3 - Non-Formulary**	*Up to 90-day supply* $25 $75 $125	*Up to 90-day supply* Not covered Not covered Not covered

*Please note: This chart is just a brief overview of benefits and coverage for the medical plans. You should also look at the detailed disclosure/summary documents for each plan, available from your Benefit Administrator or online at WorkTerra. For questions about a specific procedure, service or provider, please contact the medical plan directly or visit the carrier website at www.myuhc.com (**United Healthcare**). Additional carrier contact information is located on page 21 of this benefit guide.*

** If you use a non-network pharmacy, you are responsible for any amount over the allowed amount*

Prescription Drugs

Your prescription drug coverage is included as part of the medical plan option you select. You should always use a participating pharmacy (one that is contracted by your medical plan) to get the best price. You can access a list of pharmacies through your plan's website or by calling member services.

The medical plans have "tiered" copayments for prescription drugs, meaning you pay a different amount for different classes or groups of drugs. Generic drugs always have the lowest copays, and non-formulary brand name drugs always have the highest copays.

Formulary Drug Lists

A formulary is a list of drugs that are preferred by the plan. Plans use formularies to make sure members are using the most cost-effective drugs. You can learn more about your plan's prescription drug coverage, including what drugs are on the formulary, by visiting your plan's website. Be aware that carriers may revise these lists often; therefore, it will be important for you to identify what prescription is covered and what your copay will be. If you request a brand-name drug when a generic is commercially available, your prescription must read "dispense as written" or "do not substitute" or you will be charged the difference in cost between the generic and brand plus the copays listed above.

Prior Authorization

Some prescription drugs require prior approval before they can be dispensed. In the event your doctor has not done so, the pharmacist will inform you when you go to have the prescription filled. If this occurs, let your physician know immediately.

Specialty Drugs

Specialty Drugs require coordination of care and close monitoring. Some Specialty drugs may require extensive patient training that generally cannot be met by a retail pharmacy, so ***United Healthcare*** offers these drugs at a Network Specialty Pharmacy. Specialty Drugs may also require special handling or manufacturing processes, restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty Drugs are generally high cost.

Preventive Care

Preventive care benefits are available so that you can make the most of your life. They are designed to help detect potential health concerns early, which can ward off more serious health issues. If you have a known diagnosis that you are checking or monitoring this would not be covered as preventive. Talk to your doctor about what types of preventive care are appropriate for you.

Examples of Preventive Care Services:

- Well Baby and Well Woman Exams
- Routine Physicals
- Colorectal and Prostate Cancer Screening
- Flu Shots and Immunizations
- Mammograms

Note:
Routine In-Network Preventive Services are covered at 100%!

United Healthcare Value Adds

www.myuhc.com

Look up a claim, check status on deductible, manage pharmacy or look for a network doctor or facility 24/7/365.

Virtual Appointments with your Doctor

When you have a minor issue like a sore throat, you could save time with a virtual visit. A doctor can speak to you about minor medical concerns, provide a diagnosis and if necessary, can send a prescription to your local pharmacy. Log into *myuhc.com*, select "Virtual Visit" and choose a provider.

Health4Me Smart Phone App

Available for iPhone and Android

- Look up benefits
- Map nearest network facility
- View ID Cards

myClaims Manager on myuhc.com

- Manage your claims on *myuhc.com*
- View your benefits
- View your claims summary

Health & Wellness

Visit *www.uhc.com/health-and-wellness* to access ***United Healthcare's*** online tool to help you with Fitness, Nutrition and Heart Health. Find recipes, online seminars, and strategies to simplify your life.

24-Hour Nurse

Members can talk to a nurse 24 hours a day, seven days a week. Depending on your issues, a UHC nurse may provide information on symptoms or medication, self-care, and care management programs. Call the phone number on your ID card or connect through *myuhc.com*.

Kaiser Permanente Value Adds

www.kp.org

You have access all of your medical information online at *kp.org*. You can schedule appointments, find a doctor or facility, view your benefits, and order prescriptions.

Smartphone App

The ***Kaiser*** smartphone app is available for iPhones and Androids, giving you access to the same features as *kp.org* on your mobile device.

Virtual Appointments with your Doctor

You can schedule a private and secure video visit for yourself or with your doctor wherever you are located. When scheduling an appointment through the Advice line, ask if a video visit is right for your symptoms. You may be offered a video visit if it is available when you schedule an appointment online at *kp.org*.

Wellness

Visit the Health and Wellness tab at *kp.org* to find information on various topics:

- Living Health: physician reviewed health information
- Conditions and Diseases: health guides and symptom checker
- Drugs and Natural Medicines: resource for medicines
- Programs and Classes: online programs, special rates and coaching

Classes and Education

As a ***Kaiser*** member, you can sign up for a variety of health classes held at ***Kaiser*** Facilities, or online at *kp.org*. Most classes are free to members but some may require a fee to attend. Classes include eating healthy, managing pain, reducing stress and much more. You can also find special rates for members on fitness club discounts and acupuncture, chiropractic and other complementary or alternative care.

How to Choose the Best Medical Plan for You and Your Family

When choosing a medical plan, it is important to look at your budget, your preferences and the age and health of you and your covered dependents. You should consider the key differences between plan types and choose one that best suits you and your family. The plans differ in the following areas:

- Cost of coverage, including payroll contributions, and how you and the plan pay for services throughout the year.
- Convenience, covered services, access to providers and ease of use.

Cost of Coverage: How You Pay for Health Care Costs

You share the costs of health care services with the medical plan and your company. As you choose your medical plan, consider the following types of costs:

- **Premium:** A premium is the total cost of your medical insurance. You and your company share this cost. You pay your portion through payroll deductions.
- **Deductible:** A deductible is the amount you must pay before the plan begins sharing the cost of services. You pay this full amount, if required by your plan. The PPO HDHP plan has this feature.
- **Shared Expenses:** After you pay the deductible (if required), you and the plan share the cost of health care services. You may pay a copayment (set price for a specific service) or coinsurance (a percentage of the cost of services). Your portion of these expenses is called your "out-of-pocket" costs.
- **Out-of-Pocket Maximum:** The annual out-of-pocket maximum is in place to protect you from major medical expenses. This is the most you would pay for eligible expenses during a plan year. Once you reach the out-of-pocket maximum, the plan pays 100 percent of allowed charges.

Medical Plan Costs – Who Pays?

Type of Cost	Premium	Deductible	Shared Expenses	Out-of-Pocket Maximum
Who pays?	You and your company	You	You and the plan; You pay through copays and coinsurance	The plan pays for all eligible expenses if you meet the out-of-pocket maximum

Your Personal Needs

As you think about your personal needs, consider these questions:

- What kind of health care needs do you and your dependents have?
- How much do you spend each year on out-of-pocket medical expenses?
- Do you anticipate a hospital stay or any major health issues in the coming year?
- Do you want to be able to see any doctor?
- Do you see a specialist regularly?

How to Choose the Best Medical Plan for You and Your Family *(continued)*

Convenience, Covered Services, Access to Providers and Ease of Use

The HMO plan strictly limits your coverage to network providers (except in the case of certain emergencies). The PPO High-Deductible Health Plan provides coverage for both in-network and out-of-network services (but you pay less when you use in-network providers). Generally, your premium and ongoing costs will be lower with a more restrictive plan and higher with a plan that has broader coverage and more flexibility. When trying to decide which plan to choose, consider these questions:

- Will network providers meet your needs?
- How convenient are the providers in the plan's network?
- How easy is the plan to understand and use?
- Which services are covered under the plan?
- How much does the plan pay?

Health Plan Assist

Health Plan Assist is an innovative software product that can help you estimate your annual out-of-pocket costs and premium responsibility for the medical plans offered by CEI. The available plans are pre-loaded into the site, making it easy for you to enter your information.

What You Need To Do: Go to *www.healthplanassist.com*, and enter your registered email address and company access code (***cuper14***) to gain entry into the model. Once you are in the program, you can complete the following information:

- **Demographics:** Information about you and your family members such as age, gender and zip code
- **Benefit Plans:** Choose the medical plan that will cover you and your family members
- **Known Expenses:** Incorporate any known medical expenses or estimates
- **Utilization (Medical and Rx):** Enter whether you consider yourself a high medium or low user of healthcare services

After you enter your information, ***Health Plan Assist*** will provide you with credible answers in an educational format that is quick to use and easy to understand.

Health Plan Assist allows you to:

- Compare your estimated utilization of services against national averages
- Estimate your out-of-pocket costs and premium responsibility for better financial planning
- Help you determine how much to set aside in your HSA or personal savings account

Health Advocate

Health Advocate

If you have questions or unresolved issues after contacting Member Services for one of our insurance providers, you are welcome to contact ***Health Advocate***. One of their professionals will answer any questions and assist you with any unresolved issues that you may have concerning your employee benefits or claims.

With ***Health Advocate***, you can get help with finding a provider, untangling your medical bills, securing a second opinion and navigating your insurance plan. When you call Health Advocate you speak with a Personal Health Advocate (PHA) who them becomes *your* Personal ***Health Advocate*** who will be "by your side" helping you throughout the process. You can reach Health Advocate 24-hours a day toll-free at ***(866) 695-8622***, or online at *www.HealthAdvocate.com/members*.

High-Deductible Health Plans (HDHP) & Health Savings Account (HSA)

If you enroll in the High-Deductible Health Plan (HDHP), you are eligible to open your own Health Savings Account (HSA). Health Savings Accounts were created by the federal government to give people a new way to pay for their medical expenses and save for future needs. An HSA is considered "tax-advantaged" because you are not taxed at the federal level on contributions, earnings or withdrawals – and your balance rolls over year to year. You own and manage the account.

You can use your HSA to:

- Pay for expenses, such as deductibles, prescriptions, coinsurance or other health care expenses
- Pay for future health care expenses, even if you are no longer enrolled in a HDHP
- Pay for things other than health care (*but you will be taxed on those payments and subject to penalties*)

Funding your HSA account

For Temporary Full-Time employees enrolled in the HDHP, CEI will contribute up to **$19.23** per week for individuals and **$38.46** per week for families!

You can also choose to contribute additional funds to your HSA account through convenient payroll deductions. In 2019 the annual contribution limit is **$3,500** for individuals and **$7,000** for families. If you are age 55 and older you are eligible to make a catch-up contribution of up to $1,000.

The High-Deductible Health Plan and your HSA work together

High-Deductible Health Plan (HDHP)	Health Savings Account (HSA)
• Comprehensive medical coverage (after you pay the deductible) • Preventive care (before you meet the deductible) • Out-of-network benefits so you can see any doctor • Plan pays a percentage of covered services • Out-of-pocket maximum protects you from high costs	• You can contribute up to the annual limit each year; your employer may contribute as well • Helps pay your deductible and other expenses • Tax-free contributions, earnings and payments (for qualified expenses)* ** This is federal tax information. State taxes may apply. Tax information is for general purposes only. For more detailed information about the tax implications of an HSA, please contact a professional tax advisor*

High-Deductible Health Plans (HDHP) & Health Savings Account (HSA) *(continued)*

Important Notes Regarding High-Deductible Health Plans and Health Savings Account (HSA)

- **The High-Deductible Health Plans have what is called an "aggregate" family deductible and family out-of-pocket maximum.** This means that if you cover any dependents, your family must pay the total family deductible (not just the individual deductible) before the plan begins to share costs with you. You must also meet the total family out-of-pocket maximum before the plan pays a percent of the allowed charges.
- **You can contribute to a health savings account only if you are enrolled in a qualified High-Deductible Health Plan.** You cannot be covered under any other traditional "non HSA qualified" medical plan, including your spouse's plan.
- **If you have an HSA, you cannot be enrolled in a general-purpose Health Care Flexible Spending Account. (Including coverage under your spouse's flexible spending account).** You can only have a "limited use" spending account, which only allows for dental and vision reimbursement.
- **If your employer contributes to the HSA account, they will do so weekly.** This means that you will not have access to the full annual contribution at the beginning of the year – it will accrue over the course of the year.

Important Notes Regarding Health Savings Account (HSA) and Medicare

- **You cannot contribute to an HSA in any month that you are enrolled in Medicare.** However, you should know that when you finally sign up for Social Security retirement benefits and if you are already at least six months beyond your full retirement age, Social Security will backdate your retirement benefits including Medicare by six months. This means your enrollment in Part A will also be backdated by six months.
- **Under IRS rules, you are ineligible to participate in the HSA when receiving any Medicare benefit;** therefore; both you and your employer may not contribute to the HSA for the period of time Medicare backdates your eligibility into Medicare Part A.
- **To avoid any penalties and or tax consequences, you and/or your employer will need to stop contributing to your account six months before you apply for Social Security retirement benefits.** Because everyone's individual situation is different, we recommend you contact your Tax and/or Legal Advisor.

Facts Regarding Your Medical Plans

Cupertino Electric, Inc. is required to make annual notification to employees/spouse/families regarding a number of topics regarding your Health and Welfare benefit plans. The following information summarizes the Annual Notices. These complete notices are included in this guide starting on page 22, or they are available through your benefit administrator.

Medicare Part D

Group health plans providing prescription drug coverage must provide a notice to any individual covered by or eligible for the group health plan who is eligible for Medicare (an "eligible individual"). The notice must explain whether the plan's prescription drug coverage is creditable. Coverage is creditable if it is actuarially equivalent to coverage available under the standard Medicare Part D program. In order to satisfy the distribution timing requirements, the notice is generally distributed upon an individual's enrollment in the plan, each year during open enrollment and during the plan year if the status of the coverage changes (either for the plan as a whole or for the individual).

Women's Health & Cancer Rights Act (WHCRA)

Notification that your health plan offers coverage for mastectomies and provides certain additional mastectomy-related benefits.

Health Insurance Marketplace Coverage Notice

Notice providing some basic information about the new marketplace to assist you as you evaluate options for you and your family.

HIPAA Notice of Special Enrollment

Outlines the circumstances under which you and your dependents may make changes to your health plan elections.

HIPAA Notice of Privacy Practices

If the group health plan is required to maintain a notice of HIPAA privacy practices, the notice must be distributed upon an individual's enrollment in the plan. Notice of availability to receive another copy must be given every three (3) years. In the event this is in your yearly open enrollment materials, this tri-annual requirement is satisfied.

Patient Protection Notice

Required for plans that permit or require a designation of a primary care physician if the information is not included in the medical carrier(s)' SPD/EOC.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

The Employer Notice requirements include the following:

- The Notice must be provided annually;
- The Notice must be provided on an automatic basis and free of charge; and
- The Notice must inform each employee (regardless of enrollment status) of potential opportunities for premium assistance in the state in which the employee resides.

Summary of Tax Treatment of Payments for Domestic Partners and Children of Domestic Partners'

If employer offers health coverage to eligible domestic partners and their dependents, there may be tax implications. Different tax rules apply towards the payment of premiums for domestic partner coverage than the tax rules that apply to a spouse

- **Certification of Federal Tax Dependent Status Form** (Return signed notice if your dependent child(ren) are over the age of 27 and/or do not meet the IRS definition of a Qualifying Child or Qualifying Relative). Contact Human Resources for more information.

2019 Employee Costs Per Week

2019 Employee Cost Per Week for Medical Coverages [1]

Coverage Rate Tier	United Healthcare		Kaiser
	EPO	HDHP/HSA	HMO*
EE	$23.98	$23.98	$23.98
EE + Spouse/DP	$209.42	$190.51	$178.63
EE + Children	$147.61	$135.00	$152.86
EE + Family	$348.52	$315.43	$281.73

**HMO plan is available in California only.*

[1] All Premium contributions are deducted from your paycheck on a pre-tax basis, unless otherwise requested by you in writing. Insurance premiums are withheld on a weekly basis, except when there are five paychecks in a month. The fifth check is a "no deduction" check and insurance premiums are not deducted from that check. Premiums are subject to change.

If You Have Questions

If you have questions, you can contact your Benefit Administrator or the plan carriers. Use this chart to help guide you to the right resource on the first try.

Cupertino Electric Contact Information

	Cupertino Electric	Plan Carriers
What	• Questions about benefit issues • To update personal information, such as your name or address • Eligibility questions	• Questions about claims, precertification or what is covered • Questions about what doctors or hospitals are in the network
How	• Wendy Solomon, Benefits Coordinator (408) 808-8069, Wendy_Solomon@cei.com • Talin Andonians, Chief People Officer (408) 808-8024, Talin_Andonians@cei.com	• Carrier Contact information is listed below
When	• During normal business hours	• Varies by plan

Carrier Contact Information

Carrier and Plans	Contact info
United Healthcare (909417) High Deductible PPO Plan with HSA EPO Plan Pharmacy (OptumRx)	***www.myuhc.com*** (866) 314-0335 (866) 633-2446 (888) 290-5416 | ***www.optumrx.com***
Kaiser - California Employees Only (009680) Medical North ASH (Chiropractic Care)	***www.kp.org*** (800) 464-4000 (800) 678-9133 | ***ashlink.com/ash/kp***
HSA Bank HSA Customer Service	(800) 357-6246 | ***www.hsabank.com***
Health Advocate Customer Service	(866) 695-8622 | ***www.HealthAdvocate.com/members***
Health Plan Assist Estimate your cost tool	***www.healthplanassist.com*** | Access Code: **cuper14**
WorkTerra	***https://www.workterra.net***

Legal Notices

Cupertino Electric Inc. 2019 Annual Notices

We recommend that you review the attached notices to determine if any of them apply to you. In some cases, you might need to return a signed form to HR.

Medicare Part D – Creditable Coverage

Important Notice from Cupertino Electric Inc. about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Cupertino Electric Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Cupertino Electric Inc. has determined that the prescription drug coverage offered by the ***United Healthcare*** and ***Kaiser Permanente*** plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 - December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will not be affected. If you are enrolled in both Medicare Part D and the ***United Healthcare*** and ***Kaiser Permanente***, this health plan will coordinate with Part D coverage to determine payment of benefits (e.g., whether Medicare will pay benefits on a primary or secondary basis). If you do decide to join a Medicare drug plan and drop your current Cupertino Electric Inc. coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Cupertino Electric Inc. and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Coverage

For further information, call ***United Healthcare*** at 866-633-2446 and ***Kaiser Permanente*** at 800-464-4000. ***NOTE:*** You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Cupertino Electric Inc. changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage: Visit ***www.medicare.gov***, Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help, Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	1/1/2019
Name of Entity/Sender:	Cupertino Electric Inc.
Contact—Position/Office:	Wendy Solomon, Benefits Coordinator
Address:	1132 North Seventh Street, San Jose, CA 95112
Phone Number:	(408) 808-8069

Women's Health & Cancer Rights Act (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA).

For individuals receiving mastectomy related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the breast to produce a symmetrical appearance:
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the medical plan.

Contact your Human Resources Department for more information.

Health Insurance Marketplace Coverage

PART A: General Information

Effective January 1, 2014, the Health Insurance Marketplace was introduced as a new way for you to buy health insurance. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins on November 1, 2018 for coverage starting as early as January 1, 2019.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that does not meet certain standards. The savings on your premium that you are eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.66% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources Department.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information about Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name: Cupertino Electric Inc.	4. Employer Identification Number (EIN): 94-1340523
5. Employer Address: 1132 North Seventh Street	6. Employer phone number: (408) 808-8069
7. City: San Jose	8. State: CA ZIP: 95112
10. Who can we contact about employee health coverage at this job? Wendy Solomon	
11. Phone number (if different from above): (408) 808-8069	12. Email address: wendy_solomon@cei.com

Here is some basic information about health coverage offered by this employer:

As your employer, we offer a health plan to some employees. Eligible employees are all full time employees working 30+ hours per week (excluding union employees).

With respect to dependents, we do offer coverage. Eligible dependents are your spouse, domestic partners, and children.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

HIPAA Notice of Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse or domestic partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Also, you may be entitled to special enrollment rights pursuant to the Children's Health Insurance Program Reauthorization Act of 2009 (the Act) if you or your dependents:

1. Lose coverage under a Medicaid or State Plan; or
2. Become eligible for group health premium assistance under a Medicaid plan or State Plan.

If a special enrollment right is provided pursuant to the Act, you may change your election consistent with such special enrollment right within 60 days as long as the election is made consistent with the special enrollment.

Waiver of Coverage

If you elect to waive coverage for yourself or your dependents (including your spouse), you acknowledge that you and your spouse and/or dependent child(ren) can only enroll later during an annual open enrollment period. An exception to this is if you and your spouse and/or dependent child(ren) are entitled to enroll in accordance with the "Special Enrollment Rights" described above. To request special enrollment or obtain more information, contact your Human Resources Department.

Memo Regarding HIPAA Privacy Notices

Cupertino Electric Inc. Employee Benefit Plan- Notice of Privacy Practices- For the Use and Disclosure of Protected Health Information (PHI)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The ***Cupertino Electric Inc. Employee Benefit Plan (Plan)*** is required by law to maintain the privacy of Protected Health Information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. PHI is information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. This Notice of Privacy Practices (Notice) describes how we may use and disclose PHI to carry out treatment, payment or health care operations and for other specified purposes that are permitted or required by law. This Notice also describes your rights with respect to PHI about you.

The Plan is required to follow the terms of this Notice. We will not use or disclose PHI about you without your written authorization, except as described in this Notice. We reserve the right to change our practices and this Notice, and to make the new Notice effective for all PHI we maintain. Upon request, we will provide any revised Notice to you.

Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it. Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and Disclosures to Carry Out Treatment, Payment, and Health Care Operations

The Plan and its business associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations. The Plan also will disclose PHI to ***Cupertino Electric Inc.*** for purposes related to treatment, payment and health care operations. The Plan Sponsor has amended its plan documents to protect your PHI as required by federal law.

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 providers.

For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorization).

For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

If PHI is used or disclosed for underwriting purposes, the Plan is prohibited from using or disclosing any of your PHI that is genetic information for such purposes.

Uses and Disclosures That Require Your Written Authorization

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you. In addition, your written authorization will be obtained for uses and disclosures of PHI for marketing purposes and disclosures that constitute a sale of PHI.

Uses and Disclosures That Require That You Be Given an Opportunity to Agree or Disagree Prior to the Use or Release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care; and,
- you either have agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and Disclosures for Which Consent, Authorization or Opportunity to Object is not Required

Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

1. When required by law.
2. When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

3. When authorized by law to report information about abuse, neglect, or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose or reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
4. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
5. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.
6. When required for law enforcement purposes (for example, to report certain types of wounds).
7. For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Covered Entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.
8. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
9. The Plan may use or disclose PHI for research, subject to conditions.
10. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
11. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
12. Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Rights of Individuals

Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operation, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative

means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the following officer: ***Talin Andonians, Phone: 408-808-8024, Address: 1132 North Seventh Street, San Jose, CA 95112***.

Note, however, that a covered entity (generally, a health care provider) must agree to your request to restrict the disclosure of your PHI to a health plan for any health care or operations purpose that relates to a health care item or service that you have paid in full out-of-pocket, or paid in full by a third party (other than a health plan) on your behalf.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set", for as long as the plan maintains the PHI.

- ***Protected Health Information (PHI)*** includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.
- ***Designated Records Set*** includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the Covered Entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the following officer: ***Talin Andonians, Phone: 408-808-8024, Address: 1132 North Seventh Street, San Jose, CA 95112***.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of U.S. Department of Health and Human Services.

Right to Amend PHI

You have the right to request the plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a designated record set should be made to the following officer: ***Talin Andonians***.

You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set.

The Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made:

1. to carry out treatment, payment or health care operations;
2. to individuals about their own PHI;
3. prior to the compliance date; or,
4. based on your written authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

The Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice contact the following officer: ***Talin Andonians***.

The Right to Be Notified of a Breach of Unsecured PHI

The Plan is required by law to notify you following a breach of any Unsecured PHI.

The Right to Opt-Out of Fundraising Communications

If we conduct fundraising and we use communications like the U.S. Postal Service or electronic email for fundraising, you have the right to opt-out of receiving such communications from us. Please contact ***Talin Andonians*** to opt-out of fundraising communications if you chose to do so.

A Note about Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or,
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices.

This notice is effective beginning January 1, 2019 and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided (to all past and present participants and beneficiaries) for whom the Plan still maintains PHI.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another Covered Entity, the plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law; and,
- uses or disclosures that are required for the Plan's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the Group Health Plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a Group Health Plan; and from which identifying information has been deleted in accordance with HIPAA.

Your Right to File a Complaint with the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the following officer: ***Talin Andonians, Phone: 408-808-8024, Address: 1132 North Seventh Street, San Jose, CA 95112, Email: talin_andonians@cei.com***.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following officer: ***Talin Andonians, Phone: 408-808-8024, Address: 1132 North Seventh Street, San Jose, CA 95112, Email: talin_andonians@cei.com***.

Patient Protection Notice

HMO plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, the HMO may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the carrier.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the carrier.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial ***1-877-KIDS NOW*** or ***www.insurekidsnow.gov*** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and ***you must request coverage within 60 days of being determined eligible for premium assistance.*** If you have questions about enrolling in your employer plan, contact the Department of Labor at ***www.askebsa.dol.gov*** or call ***1-866-444-EBSA (3272)***.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
http://myalhipp.com 1-855-692-5447	The AK Health Insurance Premium Payment Program ***http://myakhipp.com*** Phone: 1-866-251-4861, Email: CustomerService@MyAKHIPP.com Medicaid: ***http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx***
ARKANSAS – Medicaid	COLORADO – Medicaid
http://myarhipp.com 1-855-MyARHIPP (855-692-7447)	Medicaid Website: ***http://www.colorado.gov/hcpf*** Medicaid Customer Contact Center: 1-800-221-3943
FLORIDA – Medicaid	GEORGIA – Medicaid
http://flmedicaidtplrecovery.com/hipp 1-877-357-3268	***http://dch.georgia.gov/medicaid*** - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
INDIANA – Medicaid	IOWA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 ***http://www.hip.in.gov*** / Phone: 1-877-438-4479 All other Medicaid: ***http://www.indianamedicaid.com*** Phone 1-800-403-0864	***http://www.dhs.state.ia.us/hipp*** Phone: 1-888-346-9562
KANSAS – Medicaid	KENTUCKY – Medicaid
http://www.kdheks.gov/hcf / Phone: 1-785-296-3512	***http://chfs.ky.gov/dms/default.htm*** / Phone: 1-800-635-2570
LOUISIANA – Medicaid	MAINE – Medicaid
http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	***http://www.maine.gov/dhhs/ofi/public-assistance/index.html*** Phone: 1-800-442-6003, TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP	MINNESOTA – Medicaid
http://www.mass.gov/MassHealth Phone: 1-800-462-1120	***http://mn.gov/dhs/ma*** Phone: 1-800-657-3739

MISSOURI – Medicaid	MONTANA – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	***http://dphhs.mt.gov/MontanaHealthcarePrograms/HIP***P Phone: 1-800-694-3084
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: ***http://dwss.nv.gov*** Phone: 1-800-992-0900	***http://www.dhhs.nh.gov/oii/documents/hippapp.pdf*** Phone: 603-271-5218
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
http://www.state.nj.us/humanservices/dmahs/clients/medicaid Medicaid Phone: 609-631-2392 CHIP Website: ***http://www.njfamilycare.org/index.html*** CHIP Phone: 1-800-701-0710	***http://www.nyhealth.gov/health_care/medicaid*** Phone: 1-800-541-2831
NEBRASKA – Medicaid	NORTH CAROLINA – Medicaid
http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx / Phone: 1-855-632-7633	***http://www.ncdhhs.gov/dma*** Phone: 919-855-4100
NORTH DAKOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
http://www.nd.gov/dhs/services/medicalserv/medicaid Phone: 1-844-854-4825	***http://www.insureoklahoma.org*** Phone: 1-888-365-3742
OREGON – Medicaid	PENNSYLVANIA – Medicaid
http://www.oregonhealthykids.gov or ***http://www.hijossaludablesoregon.gov*** / Phone: 1-800-699-9075	***http://www.dhs.pa.gov/hipp*** Phone: 1-800-692-7462
RHODE ISLAND – Medicaid	SOUTH CAROLINA – Medicaid
http://www.eohhs.ri.gov / Phone: 401-462-5300	***http://www.scdhhs.gov*** / Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	TEXAS – Medicaid
http://dss.sd.gov / Phone: 1-888-828-0059	***http://gethipptexas.com*** / Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	VERMONT– Medicaid
Medicaid: ***http://health.utah.gov/medicaid*** CHIP: ***http://health.utah.gov/chip*** / Phone: 1-877-543-7669	***http://www.greenmountaincare.org*** Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	WEST VIRGINIA – Medicaid
Medicaid ***http://www.coverva.org/programs_premium_assistance.cfm*** Medicaid Phone: 1-800-432-5924 CHIP: ***http://www.coverva.org/programs_premium_assistance.cfm*** CHIP Phone: 1-855-242-8282	***http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx*** Phone: 1-877-598-5820, HMS Third Party Liability
WASHINGTON – Medicaid	WISCONSIN – Medicaid and CHIP
http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473	***https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf*** Phone: 1-800-362-3002
WYOMING – Medicaid	
https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531	

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Summary of Tax Treatment of Payments for Domestic Partners and Children of Domestic Partners' Coverage

Plan Participation

The Cupertino Electric (Plan) extends medical health coverage to an eligible employee's domestic partner and the domestic partner's eligible children. Please review the applicable Summary Plan Description (SPD) and enrollment materials for the Plan's eligibility provisions and for the procedures you must follow to enroll these individuals for coverage. It is important to understand that different tax rules apply towards the payment of premiums for domestic partner coverage than the tax rules that apply to a spouse.

Tax Treatment of Payments for Domestic Partner Coverage (including Children of DPs)

The Internal Revenue Code (Code) allows employees to pay for health coverage for employees and their spouses (and children) on a pre-tax basis under a cafeteria plan. In addition, the employee does not have to pay any taxes for any employer contributions that are paid towards their health coverage.

Unfortunately, this tax-free treatment is not applicable to the health coverage premiums for a domestic partner or his/her children. This means two special rules apply:

1. Employee contributions: any amounts that you pay towards their premiums must be done on a post-tax basis (i.e., your contributions are deducted from payroll with after tax dollars).
2. Employer contributions: any amounts that Cupertino Electric Inc. ("Company") pays towards domestic partner coverage premiums must be treated as taxable income to you. This is commonly referred to as "imputed income" which is the term the IRS uses when they consider/deem something you receive as if it was income.

Calculating Imputed Income

In accordance with the IRS rules, the fair market value (FMV) of the coverage paid by the Company towards the premiums for domestic partner will be included in your gross income. The amount is subject to federal income tax withholding plus employment taxes, and will be reported on your Form W-2. Generally, the FMV is calculated as the difference between the amount the Company would pay for the employee alone and the amount the Company would pay for a couple or family.

Example: Assuming that the Company pays $100 for Employee Only coverage and $500 for Employee + DP coverage, then the imputed income amount is:

$500 Employee + DP payment

– $100 Employee Only payment

= $400 is the fair market value for the DP portion of the coverage → $400 is imputed income

Tax-Free Treatment for Code Section 152 Tax Dependents

If your domestic partner qualifies as your tax dependent for health coverage purposes under Section 152 of the Code (as defined below), then the same favorable tax treatment will apply to him/her as it would for a spouse. This means that you can pay for his/her coverage on a pre-tax basis under the cafeteria plan and any Company paid premium is tax-free to you. The same is true for the children of your domestic partner if they qualify as your tax dependent under Section 152 of the Code.

It is generally difficult for your domestic partner to qualify as your tax dependent if he/she earns compensation similar to (or roughly in the same ballpark as) yours. Employees with registered domestic partners in a community property state should consider those laws when calculating the support test under Section 152. You should consult with a tax professional about whether your domestic partner and/or his or her children might qualify as your Section 152 dependents.

Section 152—When Is a Domestic Partner a Qualified Tax Dependent for Health Coverage Purposes?

In order for your domestic partner (and/or his or her children) to be covered under the Plan, you and your partner must simply satisfy the requirements in the Domestic Partner Affidavit. However, in order for them to qualify as your tax dependent for health coverage purposes, your partner must meet the "qualifying relative" test (except the exemption amount) under Section 152 of the Internal Revenue Code. All of the following conditions must be met:

1. you and your domestic partner have the same principal place of abode for the entire calendar year;
2. your domestic partner is a member of your household for the entire calendar year (the relationship must not violate local law);
3. during the calendar year you provide more than half of the total support* for your domestic partner;
4. your domestic partner is not your (or anyone else's) "qualifying child" under Code §152(c) and
5. your domestic partner is a U.S. citizen, a U.S. national, or a resident of the U.S., Canada, or Mexico.

For requirement #3 above, you must compare the amount of support you provide versus the amount of support your partner receives from all sources. (Support includes food, shelter, clothing, medical care, education, etc.) You should review and use the support worksheet in IRS Publication 501 (Exemptions, Standard Deduction, and Filing Information).

*Important Note: Employees with registered domestic partners in a community property state should consider those laws when calculating the support test under Code §152.

A child of your domestic partner may also qualify as your tax dependent for health coverage purposes under federal tax law by satisfying either the "qualifying relative" or "qualifying child" test under Code Section 152. Unless your domestic partnership is registered under the state law where you reside (e.g., California, Nevada, Oregon, Washington, etc.), it can be more difficult for the child of your domestic partner (who is not also your child) to satisfy these tests and qualify as your tax dependent for health coverage purposes. Consult with your professional tax advisor for the information needed to make these tax determinations.

Stepchildren Rule under State Law for Children of Registered Domestic Partners

For employees who registered their domestic partnership in a state that has domestic partnership laws and a state registry, e.g. in California, Oregon, etc., the IRS has stated that if children of a registered domestic partner are considered stepchildren under the laws of the state where they reside, the IRS will also consider them as stepchildren for federal tax purposes. This means that the premiums to cover the children of registered domestic partners' children are subject to favorable tax treatment (i.e., paid on pre-tax basis and no imputed income).

Note that at the state level, tax treatment of health coverage for domestic partners or their children may differ from the federal level. For example, a state that has domestic partnership laws may exclude registered domestic partner coverage from gross income for state income tax purposes, even if the domestic partner is not a tax dependent for health coverage purposes under federal law.

Next Steps

Review the relevant IRS publications (e.g. Pub. 501) and the local state laws with your tax professional. If you wish to enroll your domestic partner and/or his or her children for coverage under the Plan, you will need to complete and submit the Affidavit of Domestic Partner Eligibility [or replace with the actual name the Company wishes to use for the affidavit] along with the other normal enrollment materials. If you wish to declare your dependents as your Section 152 qualified tax dependents, you will need to complete and submit the Certification of Code Section 152 Federal Tax Dependent Status Form.

This summary was provided for educational and informational purposes only and is not intended as and shall not be construed as legal, financial or tax advice. The applicable state and federal laws are subject to constant and rapid changes; therefore, you should consult with a professional tax advisor if you have questions about the information contained herein.

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