NORTHERN CALIFORNIA PIPE TRADES TRUST FUNDS FOR UA LOCAL 342

935 Detroit Avenue, Suite 242A, Concord, CA 94518-2501 • Phone 925/356-8921 • Fax 925/356-8938
tfo@ncpttf.com • www.ncpttf.com

APRIL 2025

TO: ACTIVE AND RETIRED PARTICIPANTS

RE: ANNUAL NOTICES AND IMPORTANT INFORMATION

This Notice includes Annual Notices that the Northern California Pipe Trades Health and Welfare Plan **(**"Plan") is required to provide you with under the Affordable Care Act ("ACA") and other Federal Laws. This Notice is intended for informational purposes only and to remind you of certain Plan rules. **No action is necessary on your part for certain items.**

YOU SHOULD RETAIN THIS DOCUMENT WITH YOUR COPY OF THE PLAN'S SUMMARY PLAN DESCRIPTION ("SPD")/PLAN DOCUMENT (also known as the "Plan rules").

A. AFFORDABLE CARE ACT

GRANDFATHERED HEALTH PLAN (FOR ALL RETIREE MEDICAL PLAN OPTIONS)

As a reminder, the Board of Trustees believes the Northern California Pipe Trades Health and Welfare Plan (hereafter "Plan") for its Retiree Medical Plan Options (through Kaiser Permanente and Blue Shield of California, hereafter known as "Kaiser" and "Blue Shield") is a "Grandfathered Health Plan" under the ACA. As permitted by the ACA, a Grandfathered Health Plan can preserve certain basic health coverage that was already in effect when that ACA was enacted. Being a Grandfathered Health Plan means that your Plan is not required to include certain consumer protections of the ACA that apply to other plans (known as Non-Grandfathered Plans); for example, requiring the provision of preventive health services without any cost sharing. However, Grandfathered Health Plans must comply with certain other consumer protections in the ACA, such as the elimination of annual and lifetime limits on the Plan's Essential Health Benefits. (For a definition of what constitutes as Essential Health Benefits, visit ***www.healthcare.gov/glossary/essential-health-benefits***.)

Questions regarding which protections apply and which protections do not apply to a Grandfathered Health Plan and what might cause a Plan to change from Grandfathered Health Plan status can be directed to the Employee Benefits Security Administration, U.S. Department of Labor ("DOL") at 866/444–3272 or ***www.dol.gov/ebsa/healthreform***. This website has a table summarizing which protections do and do not apply to Grandfathered Health Plans.

AVAILABILITY OF SUMMARY OF BENEFITS AND COVERAGE ("SBC")

Group Health Plans, Insurers, and Health Maintenance Organizations ("HMOs") are responsible for providing an SBC annually to all eligible Participants as well as to all future eligible new Participants and their Dependents upon initial and special enrollment, as well as 60 days prior to a mid-year material modification of the SBC. The SBC provides a summary of what the Plan covers and what it costs and allows you to compare the Plan's benefit options (currently Kaiser Permanente HMO, Blue Shield of California HMO, or Blue Shield of California PPO) offered to you and/or your eligible Dependents. You have the right to request and receive within seven (7) business days an SBC for the Plan's benefits offered through Kaiser and Blue Shield. If you would like to receive a copy of the SBC, contact the TFO and if you would like more details about your coverage, contact Kaiser or Blue Shield directly.

MINIMUM ESSENTIAL COVERAGE

The ACA establishes a minimum value standard of benefits for health plans. The minimum value standard is 60% (actuarial value) and Grandfathered Health Plans (such as the Retiree Medical Plan Options) are considered minimum essential coverage. **This Plan provides minimum essential coverage and meets the minimum value standard for the benefits it provides (exceeds 60%).**

Depending on which Plan option you are enrolled in, Kaiser or Blue Shield should have already sent you a statement (known as Form 1095-B) about the 2024 coverage you and/or your Dependents were enrolled in. Kaiser and Blue Shield are required to file these Forms with the IRS. If you have not received such a statement yet, contact your selected Health Plan.

PATIENT DESIGNATION OF PROVIDERS PROTECTION REMINDER

As a reminder, the Plan's Kaiser or Blue Shield HMO benefits, and the Blue Shield PPO benefits generally require or allow the designation of a Primary Care Provider ("PCP") and Pediatrician. You have the right to designate any PCP and Pediatrician for your child who participates in the network and is available to accept you and your family members. If the Plan or Health Insurance Coverage designates a PCP for you, then until you make this decision, the Insurer will designate one on your behalf. For more information on how to select a PCP or Pediatrician, and for a list of participating providers, contact Kaiser or Blue Shield directly.

You do not need prior authorization from this Plan or any other person (including a PCP) in order to obtain Obstetrical or Gynecological care from a Health Care Professional who specializes in those areas in the Plan's HMO or PPO Network. 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 and Gynecology in the Kaiser Permanente HMO or Blue Shield HMO or PPO, contact the appropriate Carrier directly.

B. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA") AVAILABILITY OF THE NOTICE OF PRIVACY PRACTICES

The Board of Trustees of the Plan have adopted a Notice of Privacy Practices. The Notice of Privacy Practices describes the permitted ways that the Plan uses and discloses your Protected Health Information ("PHI"), your HIPAA privacy rights, and the Plan's legal responsibility regarding your PHI. A copy is available on the Plan's website at ***www.ncpttf.com*** or by contacting the Trust Fund Office ("TFO") to request a copy of the Notice at any time. The Notice is also automatically provided to you at least once every three years or when there is a material change to the Notice. Depending on the insured coverage you are enrolled in, Kaiser or Blue Shield have their own HIPAA Notice of Privacy Practices and may also send you a copy of their own rules.

C. WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Under Federal Law, Group Health Plans, Insurers, and HMOs (such as Kaiser and the Blue Shield HMO option) that provide medical and surgical benefits in connection with a mastectomy must provide benefits for reconstructive surgery, in consultation with the attending physician and patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed; and
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient.

Coverage is subject to the Plan's annual deductibles, coinsurance, and copayment provisions (consistent with those established with other benefits under your Plan). This Plan complies with these requirements. If you have any questions about whether your Plan covers mastectomies or reconstructive surgery, contact your selected Health Plan (Kaiser or Blue Shield) directly.

D. NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Under Federal Law, Group Health Plans, Health Insurance Issuers, and Health Maintenance Organizations (such as Kaiser and the Blue Shield HMO option) may not generally, restrict benefits for any hospital length of stay in connection with childbirth for the Mother or Newborn child less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or Issuer (Kaiser or Blue Shield) may pay

for a shorter stay if the attending provider (e.g., your Physician, Nurse, Midwife, or Physician Assistant), after consultation with the Mother, discharges the Mother or Newborn earlier.

In addition, under Federal Law, Plans and Issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the Mother or Newborn than any earlier portion of the stay. A Plan or Issuer may not, under Federal Law, require that a physician or other Health Care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification.

For information on precertification or if you have any questions about your Plan's coverage as it relates to childbirth or a newborn child, you may contact your selected Health Plan (Kaiser or Blue Shield) directly.

E. 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, the State you reside in may have a Premium Assistance Program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these Premium Assistance Programs. **Note: If you live in California, you can contact the California Department of Health Care Services for further information on eligibility and premium assistance under the Health Insurance Premium Payment (HIPP) Program at: *www.dhcs.ca.gov/hipp* and by email at HIPP@dhcs.ca.gov, or by phone at 916/445-8322.**

If you or your Dependents are already enrolled in Medicaid or CHIP and you live in a State (outside California) that provides Premium Assistance, you can 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 think you or any of your Dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office at **877/KIDS NOW** or ***www.insurekidsnow.gov*** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored Plan.

If it is determined that you or your Dependents are eligible for Premium Assistance under Medicaid or CHIP, as well as eligible under the Plan rules, you may enroll in your employer Plan if you are not already enrolled. The employer cannot stop you from enrolling. 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, you can contact the Department of Labor electronically at *www.askebsa.dol.gov* or by calling 866/444-EBSA (3272).

To find out if the State you reside in provides assistance in paying your employer health Plan premiums or for more information on eligibility, visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra for a list of participating States.

To see if any more States have added a Premium Assistance Program since January 31, 2025, or for more information on special enrollment rights, you can also contact either:

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

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

F. NO SURPRISES ACT – YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

Pursuant to Federal Law under the No Surprises Act, when you get emergency care or are treated by an Out-Of-Network provider at an In-Network hospital or ambulatory surgical center (such as Emergency Medicine, Anesthesia, Pathology, Radiology, Lab Work, Neonatology, Assistant Surgeon, Hospitalist, or Intensivist Services), you are protected from balance billing. As a reminder, this Plan is fully insured with Kaiser and Blue Shield. As such, the responsibility to comply with the No Surprises Act is with the Carriers. Furthermore, the most you can be billed is the Insured Plan's In-Network cost-sharing amount. In these cases, you should not be charged more than your insured Plan's applicable copayment, coinsurance, and/or deductible. You are never required to give up your protection from balance billing. You are also not required to get Out-Of-Network care.

For more information about your rights and protections and the required notice that the Insured Carriers needs to post on their websites, visit either Blue Shield or Kaiser's websites, depending on the medical option you are enrolled in.

If you think you have been wrongly billed, contact the number on the back of your Blue Shield or Kaiser member card. You can also contact the California Department of Managed Health Care ("DMHC") online at **https://www.dm.hc.ca.gov** or by calling toll-free at 888/466-2219 for assistance or more information about your rights and protections against surprise medical bills.

G. PLAN REMINDERS

ONE (1) YEAR LIMITATION PERIOD FOR FILING A LAWSUIT

Under the Plan's Claims and Appeals rules, no lawsuit may be brought against the Plan and/or the Board of Trustees and/or any Individual Trustee and/or any other person or entity involved or associated with the denial decision more than one (1) year after services were provided, or benefits were partially or totally denied, or an adverse benefit determination was issued. This would be one year from the date on the appeal determination letter you receive. In addition, you must first utilize the Plan's Appeal Procedures before commencing a lawsuit, if any, against the Plan and/or the Board of Trustees and/or any Individual Trustee and/or any other person or entity involved or associated with the denial decision. Any outside entity providing services for the Plan (e.g., Kaiser, Blue Shield, Delta Dental of California, Vision Service Plan ("VSP"), Principal Life Insurance Company) has their own Claims and Appeals procedures, and you would need to contact them for more information.

If you are enrolled in Kaiser, Blue Shield, Delta Dental of California and/or VSP, refer to the applicable Evidence of Coverage Documents for its Appeal and Grievance procedures.

RETIREE RETURNING TO COVERED EMPLOYMENT

If you are Retired and considering returning to work, prior to commencing any Work After Retirement, you **must** submit a written request to the Board of Trustees for a determination on whether your contemplated Work After Retirement would be considered "Prohibited Employment" under Plan rules.

Returning to any type of "Prohibited Employment" will suspend your monthly Retirement Benefit. In addition, if you retired under an Early Retirement and return to any type of "Prohibited Employment," your Retirement Benefit will be suspended until you attain Normal Retirement Age (Age 65).

If you are eligible for Retiree Health and Welfare Benefits, and your Retirement Benefit is suspended more than once due to returning to Prohibited Employment, you will permanently lose your rights to Retiree Health and Welfare Benefits. Refer to Article XIII, Section A.10 of the SPD for more details.

When there is Full Employment, or Full Employment in certain designated positions, and the Board of Trustees establishes a Temporary Retiree Return to Work Program, special rules will apply.

Refer to the Northern California Pipe Trades Pension Plan, Suspension of Retirement Benefits Notice for additional information. This information is available at *www.ncpttf.com*.

RECIPROCITY – LOCAL 342 WORKING IN ANOTHER LOCAL'S JURISDICTION

When you are working on a Travel Card (working reciprocity) outside of the jurisdiction of UA Local 342, your Health and Welfare benefits and eligibility remain under the Northern California Pipe Trades Health and Welfare Plan. However, all incoming reciprocal Health and Welfare contributions are applied to ACTIVE Eligibility **ONLY** and **DO NOT** apply toward any Retiree Health and Welfare Benefits, Eligibility for Retiree Health and Welfare Benefits, or the Health Reimbursement Account. If you have any questions, contact the TFO.

MEDICARE COORDINATION – YOU ARE REQUIRED TO ENROLL

Medicare is our country's Federal Health Insurance Program for people who worked at least ten (10) years in Medicare-covered employment who are age 65 or older, for people under age 65 with certain disabilities, and for people of any age who have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). If you are receiving Social Security Disability Income ("SSDI") benefits, you generally become eligible for Medicare coverage 24 months after your SSDI benefits begin.

Under the Medicare program, the hospital insurance portion is called **Medicare Part A** (premium free), and the medical insurance portion, such as for the cost of physicians, is called **Medicare Part B**. Medicare Part A is financed by payroll taxes, and if you are eligible to receive, it is based on your own or your Spouse's employment. You do not pay a premium. Medicare Part B is partly financed by monthly premiums paid by individuals enrolled for Medicare Part B coverage. Most working people are entitled to Medicare Part A and Part B when they reach age 65 because either they or their Spouse paid Medicare taxes while working. Failure to timely notify the TFO of your Medicare entitlement may result in penalties.

The Plan coordinates benefits with Medicare as if you are covered under both Medicare Part A (hospital benefits) and Part B (medical benefits). This means you and/or your Spouse must enroll in both Medicare Part A and Part B as soon as you and/or your Spouse are eligible for Medicare. If you and/or your Spouse do not enroll in Medicare (Part A and Part B), the Plan will not make up for the portion of expenses that Medicare would have paid, and you will be required to pay an additional Retiree Health and Welfare Premium, currently $275 per month.

However, if you or your Spouse are still working (after reaching Age 65), Medicare works a little differently. Generally, if you have job-based health insurance through your (or your Spouse's) current job, you don't have to sign up for Medicare while you (or your spouse) are still working. You can wait to sign up until you (or your Spouse) stop working or you lose your health insurance (whichever comes first).

Medicare's prescription drug Plan (Medicare Part D) is available to Medicare beneficiaries and is part of your coverage if you are enrolled in the Retiree Health and Welfare Plan. If you earn a higher income (above $106,000 annually for individuals or above $212,000 annually for married couples), Federal Law requires that you pay an additional premium for your Medicare Part D coverage to the Social Security Administration. NOTE: If your income is $106,000 or less (single) or $212,000 or less (married) you will not be assessed for the Medicare Part D additional premium.

This additional premium is called the Income-Related Monthly Adjustment Amount (also known as "IRMAA"). The premium is based on your modified adjusted gross income as reported on your IRS tax return from two years prior (thus, the fee in 2025 will be based on your adjusted gross income on your 2023 tax return). If you must pay a higher premium, Medicare will send you a letter with your premium amounts and the reason for their determination.

For more information on Medicare Part D or IRMAA, call Medicare at 800/MEDICARE (800/633-4227) or visit *www.medicare.gov*. TTY users should call 877/486-2048. If you have any questions on the requirements to enroll in Medicare Parts A and B, contact the TFO.

HIPAA GROUP SPECIAL ENROLLMENT RIGHTS

Under Federal Law, if you declined enrollment for yourself and/or your Dependents (including your Spouse) because of having other sufficient group health coverage, you may be able to enroll yourself and/or your Dependents in this Plan, if you or your Dependents lose eligibility for that other coverage. You must request enrollment within 30 days after you or your Dependents' other coverage ends.

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement of adoption, you may be able to enroll yourself and your Dependents within 30 days of marriage, birth, adoption, or placement for adoption, provided you complete and submit an Enrollment/Change Form along with any other Plan required documentation (e.g. Certified Marriage Certificate, Certified Birth Certificate, Court Adoption Order) to the TFO within 30 days after the marriage, birth, adoption or placement for adoption.

The Plan will also allow a Special Enrollment opportunity if you and/or your eligible Dependents either: (1) lose Medicaid or CHIP coverage because you are no longer eligible; or (2) become eligible for a State's Premium Assistance Program under Medicaid or CHIP. For these enrollment opportunities you will have 60 days from the date of the Medicaid/CHIP eligibility change to request enrollment in the Plan.

Although there is a Special Enrollment period required by Federal Law, this Plan also allows Participants to make changes throughout the year. For more information, contact the TFO.

DELTA DENTAL FEDERAL AND STATE PRIVACY OBLIGATIONS

Federal and State laws require Delta Dental of California to notify enrollees on a periodic basis about enrollee rights and privacy practices. Delta Dental of California has a website that lists notices for enrollees such as Delta's HIPPA Notice of Privacy Practice, Gramm-Leach-Bliley (GLB), Notice of Non-Discrimination, Language Assistance Notice and Summary, CA Financial Privacy Notice, CA Grievance Process, and Ca Timely Access to Care. All these Notices and more can be found at *www.deltadentalins.com*.

DOMESTIC PARTNERSHIP PREMIUM PAYMENTS

Pursuant to the Plan rules, a Participant is responsible for the timely monthly payment in full of imputed income taxes for coverage of an eligible Domestic Partner and the Domestic Partner's Natural Child(ren). This payment is due one month in advance of the month the eligibility is provided. Failure to remit the required payment in full by the due date may result in immediate termination of your Domestic Partner's coverage on the last day of the month in which the payment is not received. Contact the TFO for more information and refer to pages 19 to 22 of the SPD for details on the Plan's Domestic Partnership rules. The Plan allows enrollment for registered Domestic Partnerships and Non-Registered Domestic Partnerships that complete and return the required documentation to the TFO.

LOSS OF COVERAGE FOR A FORMER SPOUSE

Pursuant to the Plan rules, notification is required within 60 (sixty) days of the Final Date of Divorce or Legal Separation. A former Spouse is not eligible for coverage as a Dependent under the Plan rules. However, a former Spouse may be eligible to continue medical, prescription drug, dental, and vision coverage under COBRA Continuation of Coverage if timely notice of Divorce has been provided to the TFO. If the Participant and/or former Spouse do not notify the TFO timely, the overpayment period will be calculated beginning 60 days after the Date of Divorce/Legal Separation and continue until the TFO is notified. The Ex-Spouse will be terminated at the end of the month in which the notification is received. **NOTE**: **IT IS YOUR RESPONSIBILITY TO TIMELY NOTIFY THE TFO SO YOU DO NOT INCUR OVERPAYMENT CHARGES.** Contact the TFO for more information.

ENROLLMENT PROVISIONS REMINDERS AND YOUR OBLIGATIONS

It is your responsibility to notify the TFO of changes to your address and/or changes in your life circumstances (e.g., divorce, legal separation, Dependent Child ceases to be an eligible Dependent). You will be required to complete the appropriate Enrollment/Change Form or Change Request Form, both of which are available at *www.ncpttf.com*.

You should update your Beneficiary Designation Form when you have a change in your life circumstances. The Beneficiary Designation Form is available at *www.ncpttf.com* or you may contact the TFO.

No benefits will be paid by the Plan for fraudulent premiums, fraudulent Beneficiary Designation Forms, claims or services made by a Participant, Dependent, or any other person, for any other reasons (including, but not limited to enrolling ineligible Dependents, failing to notify the Plan that a previously eligible Dependent no longer qualifies as a Dependent, failure to timely enroll in Medicare, or failure to notify the TFO of you or your Dependent's eligibility to enroll in Medicare). **If payment is made on behalf of any person for fraudulent claims, the Participant, and any person on whose behalf a fraudulent claim was submitted will be responsible for repaying the Plan**.

The following classifications are only permitted to enroll in the Plan's Kaiser HMO option (except under limited special circumstances):

- Residential and Residential Light Commercial Employees and their eligible Dependents;
- Tradesmen and Servicemen Employees and their eligible Dependents;
- Shortline Helper and MLA Helper Employees and their eligible Dependents;
- U.A. National Distribution Agreement Employees and their eligible Dependents;
- Safety Attendants Levels 2-4, Foreman, General Foreman, and Senior General and their eligible Dependents.

Below is a list of Contacts for your convenience:

Provider/Contact	Type of Benefit	Website	Phone Number
Kaiser Permanente	Medical & Rx	*www.kaiserpermanente.org*	800/464-4000
Blue Shield of California	Medical & Rx	*www.blueshieldca.com*	855/256-9404
Delta Dental of California	Dental	*www.deltadentalins.com*	800/765-6003
Vision Service Plan	Vision	*www.vsp.com*	800/877-7195
NWPS	Health Reimbursement Account	*htpps://nwps.lh1ondemand.com*	855/512-1170

If you or your Dependents have any questions, contact the TFO at 925/356-8921 ext. 246.

Respectfully submitted,

Fund Manager
On Behalf of the Board of Trustees