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# BOARD OF TRUSTEES

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- **Scott Strawbridge, Chair**  
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  Northern Cal. MCA  
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  NCPT Trust Fund Office  
  1855 Gateway Blvd., Suite 350  
  Concord, CA 94520-8445

### LEGAL COUNSEL

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  San Francisco, CA

### AUDITOR

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  Lindquist, LLP  
  San Ramon, CA

### BENEFIT CONSULTANT

- **Sidney Kaufmann**  
  Kaufmann & Goble  
  San Jose, CA
# HELPFUL CONTACTS

## NORTHERN CALIFORNIA PIPE TRADES HEALTH & WELFARE TRUST FUND

| Trust Fund Office: | (925) 356-8921 or (800) 780-8984  
|                   | (Listen to voice message for guidance through menu)  
|                   | Fax (925) 356-8938  
| E-mail:          | tfo@ncpttf.com  
| Access by Web:   | www.ncpttf.com  
| Street/Physical Address: | 1855 Gateway Blvd., Suite #350, Concord, CA 94520-8445 |

## KAISER PERMANENTE (Group No. 31342)

| Kaiser Member Access Services: | Provides prepaid medical benefits with payment of these benefits. | (800) 464-4000  
|                               |                                                             | (800) 777-1370 (toll-free TTY for hearing/speech impaired)  
|                               |                                                             | (800) 788-0616 (Spanish)  
|                               |                                                             | (800) 757-7585 (Chinese)  
| Claim Inquiry:                |                                                             | (800) 390-3510  
| Access by Web:                |                                                             | http://www.kaiserpermanente.org  
| Medicare members:             |                                                             | (800) 443-0815 (toll-free) or  
|                               |                                                             | (800) 777-1370 (toll-free TTY for hearing/speech impaired) |

## BLUE SHIELD OF CALIFORNIA

| Blue Shield Member Services: | Provides prepaid medical benefits with payment of these benefits. | (855) 256-9404  
| Mail Order Prescription Drug Program: |                                                             | (866) 346-7200  
| Access by Web:                |                                                             | http://www.blueshieldca.com |

## VISION SERVICE PLAN (VSP) (Group No. 12005611)

| VSP: | Provides prepaid vision benefits with payment of these benefits. | (800) 877-7195  
| Access by Web: |                                                             | (800) 428-4833 (toll-free TTY for hearing/speech impaired) |

## DELTA DENTAL OF CALIFORNIA (Group No. 17422)

| DELTA DENTAL Member Services: | Provides prepaid dental & orthodontia benefits with payment of these benefits. | (800) 765-6003  
| Access by Web: |                                                             | http://www.deltadentalins.com |

## HEALTH REIMBURSEMENT ACCOUNT

| Kaufmann & Goble (HRA Administrator) | T: (800) 767-1170  
|                                       | F: (408) 298-1180 |

*These providers process/pay claims and handle claims appeals related to their programs and benefits.*
Dear Plan Participant:

This booklet is both the actual Plan document and Summary Plan Description for the Northern California Pipe Trades Health and Welfare Plan (“Plan”). The Plan’s purpose is to provide medical and related benefits for members of the United Association or Journeyman and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada (“UA Local 342”) and their Dependents (as defined by the Plan). This booklet contains an explanation of the eligibility provisions for both active and retired Participants. Additional information on the Plan, including a variety of forms, can be obtained from the Trust Fund’s website, which is www.ncpttf.com.

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

The Trust Fund Office may respond in writing to your written questions. If you have an important question about your benefits, you should write to the Trust Fund Office at the above address. As a courtesy to you, the Trust Fund Office may respond informally to oral questions; however, oral information and answers are not binding upon the Board of Trustees or the Plan and cannot be relied on in any dispute concerning your benefits.

You must notify the Trust Fund Office immediately upon becoming eligible for Medicare. If you are about to retire and/or you and/or any eligible Dependents are eligible for Medicare coverage, you must ensure that you and/or your eligible Dependents are enrolled in Medicare. If you elect not to enroll in Medicare (Part A and/or Part B), the Plan may charge you a monthly penalty premium in addition to the rate currently paid, until the Medicare coverage goes into effect. Please refer to Article XIII which covers all aspects of your Retiree Health and Welfare coverage.

Plan rules and benefits may change from time to time. Your benefits under the Plan are NOT vested. The Board of Trustees may reduce, eliminate or change any benefit provided under the Plan (or any insurance policy, HMO or other entity) at any time. Participants may also be required to make new or additional contributions for benefits provided by the Plan.

Please direct any questions you have concerning your benefits to the Trust Fund Office at the above address or at (925) 356-8921 or toll free (800) 780-8984.

Fraternally,

Board of Trustees
IMPORTANT NOTICES:

FUTURE PLAN AMENDMENTS

Future amendments to the Plan may be made from time to time to comply with new laws passed by Congress, rulings by federal agencies or courts, and other changes deemed necessary or prudent by the Trustees. You will be notified if there are important amendments to the Plan through written notification. Before you decide to retire, you may want to contact the Trust Fund Office to determine if there have been Plan amendments or other developments that may affect your retirement plan options.

LIMITATION UPON RELIANCE ON BOOKLET AND STATEMENTS

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

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

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

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

NO VESTED RIGHTS

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

NO GUARANTEE OF PROVIDER

The continued participation of any one physician, hospital, or other provider cannot be guaranteed. The fact that a physician or provider may perform, prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it medically necessary or guarantee that it is a covered service.

ALERT: No lawsuit may be filed or started more than (1) one year after services were provided or benefits were denied, or an otherwise adverse determination was made against you.
I. GENERAL

A. ESTABLISHMENT OF PLAN

1. Restatement of Plan: The Board of Trustees of the Northern California Pipe Trades Health and Welfare Trust restates the Northern California Pipe Trades Health and Welfare Plan by this Plan Document as of January 1, 2015. The Plan's medical benefits are offered through Blue Shield of California (hereafter “Blue Shield”) or Kaiser Permanente (HMO) (hereafter "Kaiser"). You should refer to the Evidence of Coverage booklets for each Plan for information on coverage and benefits. The Plan offers certain other benefits as listed below in subsection 5 of this section.

The Plan is intended to be maintained for the exclusive benefit of Participants and their eligible Dependents. It is also intended that this Plan Document shall conform to the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA), as that Act applies to multiemployer health and welfare employee benefit plans such as this Plan.

2. Health Maintenance Organization (HMO) Benefit Option: The Board of Trustees offers Participants the option to elect enrollment by the eligible Participant and his or her eligible Dependents in one or more Health Maintenance Organizations (HMO). Currently, the Plan offers HMO benefits through Blue Shield and Kaiser. An HMO uses a group of doctors and other health care professionals who emphasize preventive care and early intervention. HMO services are prepaid and a designated premium covers services. You share costs, however, by paying a fee called a co-payment (e.g., $20) for some services and products.

To be eligible to enroll in an HMO, you must live within the HMO's service area. Moreover, in most situations services may not be covered unless preauthorized by your Primary Care Physician (PCP). For medical services to be covered you must follow the HMO procedures and you must use an HMO network provider. You are required to include a residence address when you complete your Enrollment Form. If you move out of the geographic area of the HMO, you may be required to change your coverage under the Plan. You and your family members are required to have the same coverage selection (for example, one family member cannot select Kaiser and the other Blue Shield).

The times and the geographic areas in which such enrollment is open to Plan Participants will be determined by mutual agreement between the Board of Trustees and the HMO.

3. Preferred Provider Organization (PPO) Benefit Option: Currently, the Plan also offers PPO benefits through the Blue Shield Spectrum PPO plan. The PPO option allows you to receive care from any of the doctors, other health care professionals, and hospitals within the Plan’s network, as well as outside of the network for covered services. Unlike the HMO option, the advantage of choosing the PPO option includes the flexibility of seeking care with an out-of-network provider (subject to higher deductible and/or coinsurance) and the ability to visit any specialist without obtaining a referral from your primary physician.

To illustrate how the PPO option works, you pay a co-payment (e.g., $20) at the time of your office visit. You may also have a yearly deductible (e.g., $100 individual) to meet before Blue Shield starts paying your medical costs. After that, some services you receive may be 100% covered or you may have to pay a coinsurance (e.g., 10%) which is your share of costs calculated as a percentage of the allowed amount for your covered service.

4. Incorporation of HMO and Insured Contracts as Part of the Plan: At any time or times that the Board of Trustees enter into a new or different contract and/or renewal contract with an HMO or Carrier, such contract(s) shall be incorporated in this Plan effective as of the date of such contract, provided the same has been executed by the Board of Trustees or a duly authorized representative of the Board of Trustees.
5. **Additional Benefits:** The Northern California Pipe Trades Health and Welfare Plan provides the following types of additional benefits subject to certain eligibility provisions and exclusions to eligible Participants and their Dependent(s):

(1) **Life Insurance and Death Benefit** (through Principal Life Insurance Company) (Actives only);
(2) **Dental Care** (through Delta Dental);
(3) **Orthodontic** (through Delta Dental, Actives only);
(4) **Vision Care** (through VSP);
(5) **Hearing Aid Benefits** (self-funded);
(6) **Residential Treatment Benefit for Chemical Dependency** (through HMO or Carrier).

**HMO and Carrier Rules Apply.** All rules and/or regulations set forth herein regarding claims review and/or appeals, shall be governed by the rules and regulations of the HMO and Carrier without regard to similar rules and regulations that may be otherwise set forth in this Plan.

B. **PLAN MAY BE CHANGED**

The Board of Trustees of the Plan expressly reserves the right to amend, modify, revoke or terminate the Plan, in whole or in part, at any time. Benefits provided under this Plan are **NOT** vested. The Board of Trustees expressly reserve the right, in its sole discretion, to:

(1) Terminate or amend either the amount or condition with respect to any benefit, even though such termination or amendment affects claims which have already accrued; and
(2) Alter or postpone the method of payment of any benefit; and
(3) Amend, terminate or rescind any provision of the Plan; and
(4) Merge the Plan with other plans, including the transfer of assets; and
(5) Terminate any HMO or insurance company; and
(6) Restrict coverage to those living only in certain geographic areas.

The authority to make any changes to the Plan rests solely with the Board of Trustees.

C. **ADMINISTRATION AND OPERATION**

1. **Board of Trustees Responsibilities:** The Plan is administered by a Board of Trustees comprised of up to ten Trustees. One-half of the Trustees, called "Employer Trustees," are selected by the Employer Associations signatory to Collective Bargaining Agreements with UA Local 342 and one-half of the Trustees, called "Union Trustees," are selected by UA Local 342. The current Trustees are listed on Page v of this booklet. The Trust Agreement permits an Alternate Trustee to attend meetings and take action when a regular Trustee is not available. The Trustees have many powers and functions including investing the Plan's assets, interpreting Plan provisions, amending the Plan, answering policy questions, and contracting with Advisors and Consultants, such as an Auditor, Legal Counsel, and Investment Manager. The Plan is self-administered by the Plan’s Trust Fund Office located at:

   **1855 Gateway Blvd., Suite 350**  
   Concord, California 94520-8445

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

2. **Standards of Interpretation:** The Board of Trustees, and/or persons appointed by the Board, shall have the full discretionary authority to determine eligibility for benefits and to construe the terms of this Plan and any regulations and rules adopted by the Board. Only the Fund Manager (the designated representative of
the Board of Trustees) and/or the Board of Trustees acting upon appeals properly before the Trustees shall have the authority to bind the Trustees to an interpretation of the provisions of this Plan. Nonetheless, claims and appeals for matters relating to an Insured benefit are subject to that Insured benefit's rules and procedures.

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

4. **Employer Contributions:** Employer contributions are made to the Plan pursuant to the terms of Collective Bargaining Agreements with UA Local 342. Contribution rates for each hour of your Covered Employment are set, from time to time, by the parties to the Collective Bargaining Agreements. Your Employer is required to contribute only for such hours of work that are required by the Collective Bargaining Agreement. Such amounts may change at any time if agreed to by the bargaining parties.

Your Employer is required to make monthly contributions for your Covered Employment and mail such payments to the Bank so that it is received by the 22nd day of the month following the month in which your work was performed. For example: January hours generate Employer Contributions paid in February which are posted on the Plan's books when received but are not credited to Participants until on or about March 1st. For Servicemen in the refrigeration service and supermarket construction industry, your monthly Health and Welfare hours are capped at 155 hours. Each monthly payment made by your Employer is accompanied by an Employer Report of Contributions (ERC) that contains the names, Social Security numbers, and hours of work performed by each Covered Employee as defined in the Collective Bargaining Agreement between your Employer and UA Local 342, together with a payment to the Plan. The Employer Contributions to the Plan are not subject to withholding for FICA, FUTA, or state or federal taxes.

The Trust Fund Office reviews the ERC’s for mathematical accuracy and notifies the Employer if there is any error in the Employer's computations which requires correction.

**IMPORTANT NOTICE:**

**Notify the Union and the Trust Fund Office immediately** if you believe that your Employer has not contributed and/or is not contributing the full amount on your behalf as required under your Collective Bargaining Agreement. Please refer to your dispatch as a reference.

The amount of Employer Contributions made to the Plan for non-bargaining unit employees (such as applicable employees of the Union, the JATC, the Trust Fund Office and others not working under a Collective Bargaining Agreement) are governed by individual Subscription Agreements entered into with the Plan and any rules adopted by the Board of Trustees.

5. **Loss of Eligibility if no Contributions:** You may lose eligibility with the Plan if Employer Contributions are not timely received by the due date for Employer contributions at the Bank. However, the Board of Trustees has discretion to extend your coverage for additional months.

6. **Availability of Fund Resources:** Benefits provided through the Plan are paid only to the extent that the Plan has adequate resources for such payments. No Contributing Employer has any liability, directly or indirectly, to provide the benefits established hereunder, beyond the obligation to make contributions as provided in the Collective Bargaining Agreement. If at any time the Plan does not have sufficient assets to permit continued payments hereunder, nothing contained in this Plan shall be construed as obligating any Contributing Employer to make benefit payments or contributions (other than the contributions for which the Contributing Employer may be obligated by the Collective Bargaining Agreement) in order to provide for the benefits established hereunder.
7. **Funding Methods and Benefits:** The Board of Trustees may provide benefits either by insurance or HMO or by any other lawful means or methods upon which they may determine. The coverage to be provided shall be determined at the sole discretion of the Board of Trustees and limited to such benefits as can be purchased with the funds available.

8. **Special Exclusion for Fraud/Reimbursement Obligation for Overpayments:** No benefits will be paid for fraudulent premiums, claims of services or supplies made by a Participant, eligible Dependent, or any other person or for any other reasons (including, but not limited to enrolling an ineligible Dependent under the Plan, failing to notify the Plan that a previously eligible Dependent no longer qualifies as a Dependent, or failure to timely enroll in Medicare). If payment on behalf of any person, both the Participant and any person on whose behalf a fraudulent claim was submitted will be liable to the Plan for repayment. The Participant or Dependent will not be eligible for coverage until he/she has signed a written repayment agreement with the Plan providing for payments of at least $250 a month until the overpayment is fully paid, including reasonable interest. However, for situations in which significant amounts are owed to the Plan, the Plan may require a greater monthly repayment amount. The Participant and person on whose behalf a fraudulent claim was submitted will also be responsible for any attorney’s fees and costs incurred by the Plan as a result of the fraudulent acts.

If a Participant or any eligible Dependents of the Participant has any outstanding liability due to fraudulently paid claims, neither the Participant nor any eligible Dependents may assign any rights to benefits to a provider of service until all fraudulently paid benefits have been repaid in full. If fraudulently paid benefits are not repaid in full, any purported assignment of benefits by a Participant or eligible Dependent may be disregarded by the Plan. However, if any payment of benefits is made by the Plan under a purported assignment, this would not be a waiver of the right of the Plan to refuse to acknowledge other purported assignments.

If any fraudulent claims have not been repaid when a Participant or eligible Dependent incurs covered charges, the Participant or eligible Dependent shall pay all charges directly and file a claim for credit in lieu of benefits, until the entire amount of the fraudulent claims have been credited. The Plan may offset any amounts owed against any benefits that may be payable under the Plan for a Participant and/or his Dependents.

In addition, any Participant or eligible Dependent who owes money to the Plan may be required to sign a written agreement before a notary agreeing to have any owed amounts deducted, offset, or paid from any Jury Duty benefit, Hearing Aid benefit, Death benefit, benefits payable from a life insurance company with which the Plan has a contract, or payment from any distribution from the NCPT Pension Plan and/or the NCPT Supplemental 401(k) Retirement Plan.

9. **Plan Year:** The Plan Year commences July 1st of each year and ends on June 30th of the following year.

D. **YOUR RESPONSIBILITIES**

1. **Your Mailing Address:** It is your responsibility to notify the Trust Fund Office of changes to your address so that you continue to receive notices of important Plan changes that may affect your coverage. You should complete the appropriate Enrollment Form or Change Request Form, both of which are available on the Trust Fund’s web page for the Plan at www.ncpttf.com.

2. **Enrollment/Change Form:** Full completion and return of the Enrollment/Change Form is mandatory for all Plan Participants for enrollment, changes and upon request by the Trust Fund Office. Please remember to sign and date your Enrollment Form before submitting it to the Trust Fund Office. You are required to complete a new Enrollment Form and submit to the Plan required proof when you have a change in life circumstances (e.g., marriage, separation, divorce, birth of child, spouse or child no longer residing with you, Dependent status changes, Medicare eligibility, QMCSO, address etc.). Generally, any changes will be effective the first day of the following month after your updated Enrollment Form is received on or by no later than the 20th of the month. **After submitting your Form, you will have online access to view your**
eligibility, work history, contributions, and other important information using the NCPTTF ISSI System (ISITE) link at www.ncpttf.com. The Trust Fund Office will send you a letter with your user ID and password to access ISITE once you have established eligibility and have enrolled in the Plan. For additional clarification, please refer to Article VI.

3. **Beneficiary Form:** You should complete a Beneficiary Form at the time of Initial Enrollment. If you decide to change your Beneficiary, you must complete a new Beneficiary Form. Also, please periodically update your Beneficiary Form when you have a change in your life circumstances. For additional information, please refer to Article VI, Section D. The Beneficiary Form is available at www.ncpttf.com.

4. **Protected Health Information (PHI):** There are Privacy Rules to protect you based on the federal legislation known as the Health Insurance Portability Accountability Act of 1996 ("HIPAA"). If you wish to authorize someone other than yourself to access information from the Trust Fund Office on your behalf, you must complete the Protected Health Information Authorization Form (available at the Trust Fund Office) and return it to the Trust Fund Office. The Plan's Notice of Privacy Practices is available at www.ncpttf.com.

5. **Identification (ID) Cards:** ID cards provide information but are not a guarantee of eligibility or benefits. Eligibility and benefits are verified on a month to month basis. Depending on the Health Plan selection elected on your Enrollment Form, you will be sent either a Kaiser ID card or Blue Shield ID card to access your Medical and Prescription Drug benefits (including Delta Dental ID card to access your dental benefits). When you submit correspondence to the Trust Fund Office, you should include the last four digits of the Plan Participant’s Social Security number.

6. **Payment Obligations:** As a courtesy, the Trust Fund Office may send monthly billing statements and/or correspondence. It is the responsibility of the Plan Participant and/or Dependent to submit payments when due. Once coverage has been terminated due to non-payment, the Plan Participant and/or Dependent may not be allowed to restate coverage (e.g., COBRA coverage, Domestic Partnership). Payment for the required premium and/or imputed tax must be made accordingly:
   a. All payments must be made by check, cashier’s check, or money order. **Cash and/or credit cards cannot be accepted as a method of payment.** Checks, cashier’s checks and/or money orders should be made payable to: NCPTTF
   b. Payments must be submitted by the due date requested, which is generally received by the 20th day of the coverage month or, the 20th day prior to the coverage month. **Refer to your billing statement for your due date for your payment.** Failure to submit the required payment(s) timely may cause a delay and/or termination of coverage. Furthermore, those required to submit payment by the 20th day of the coverage month (e.g., Active Self-Pay, COBRA Self-Pay) will NOT have eligibility and/or benefits verified until the payment has been received and processed by the bank. Eligibility may be posted retroactively.
   c. You must submit both your payment and the top portion of your billing statement directly to the bank as follows:
      
      NCPTTF
      PO Box 55606
      Hayward, CA 94545-0606
      
      Processing of payments received at the Trust Fund office will be delayed.
   d. The Trust Fund Office can accept three (3) months of pre-paid self-payments for all types of payments, with the exception of Domestic Partner tax payments. Payments received for more than three (3) months, or any Domestic Partner payments in excess of one (1) month will be refunded to the payee. (Please note payments for Domestic Partner Dependents can only be made based on the appropriate billing statement).
   e. **If at any time you and/or any Dependent(s) become Medicare eligible, you must immediately contact the Trust Fund Office.**
   f. Payments must be made timely and consecutively (when applicable).
II. SUMMARY OF AGREEMENTS AND BENEFITS

Please review the table below according to your classification. If a “YES” appears in the Benefit column, you may be eligible to receive this benefit should you meet the Plan requirements as defined in this Summary Plan Description (SPD) booklet. If a “NO” appears in the Benefit column, you are not eligible for this benefit. Please refer to this SPD booklet for additional details and eligibility requirements.

* All incoming reciprocity hours are prorated at the standard Master Labor Agreement Contribution rate for Active coverage. Please refer to Article IV for additional information.

<table>
<thead>
<tr>
<th>Classification</th>
<th>Initial Eligibility Requirement</th>
<th>Hours Required for Monthly Eligibility</th>
<th>Reserve Hour Bank</th>
<th>Jury Duty</th>
<th>Disability Extension</th>
<th>Active Subsidized Self-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTIVE (MLA + Others)</td>
<td>300 hours in consecutive 6-mos.</td>
<td>125</td>
<td>6-mos. Max (750 hours)</td>
<td>YES</td>
<td>YES</td>
<td>12-mos. Max &amp; overall 18-mos. Max in rolling 36 month period</td>
</tr>
<tr>
<td>HELPER (MLA)</td>
<td>125 hours in consecutive 6-mos.</td>
<td>125</td>
<td>2-mos. Max (250 hours)</td>
<td>NO</td>
<td>NO</td>
<td>12-mos. Max &amp; overall 18-mos. Max in rolling 36 month period</td>
</tr>
<tr>
<td>SHORTLINE (including Shortline Helper)</td>
<td>300 hours in consecutive 6-mos.</td>
<td>125</td>
<td>6-mos. Max (750 hours)</td>
<td>YES</td>
<td>YES</td>
<td>12-mos. Max &amp; overall 18-mos. Max in rolling 36 month period</td>
</tr>
<tr>
<td>PG&amp;E (including PG&amp;E Helper)</td>
<td>300 hours in consecutive 6-mos.</td>
<td>125</td>
<td>6-mos. Max (750 hours)</td>
<td>NO</td>
<td>NO</td>
<td>12-mos. Max &amp; overall 18-mos. Max in rolling 36 month period</td>
</tr>
<tr>
<td>RESIDENTIAL (KAISER ONLY)</td>
<td>120 hours in consecutive 6-mos.</td>
<td>120</td>
<td>3-mos. Max (360 hours) if worked 1200 hours in each of preceding 2 calendar years</td>
<td>NO</td>
<td>NO</td>
<td>4-mos. Max &amp; overall 6-mos. Max in rolling 36 month period</td>
</tr>
<tr>
<td>TRADESMAN (KAISER ONLY)</td>
<td>300 hours in consecutive 6-mos.</td>
<td>125</td>
<td>2-mos. Max (if worked 800 hours granted 1 mo.; plus 1 additional mo. after working 1600 hours)</td>
<td>NO</td>
<td>NO</td>
<td>4-mos. Max &amp; overall 6-mos. Max in rolling 36 month period</td>
</tr>
<tr>
<td>SERVICEMAN (Other Applicable Agreements) (KAISER ONLY)</td>
<td>300 hours in consecutive 6-mos.</td>
<td>125</td>
<td>6-mos. Max (750 hours)</td>
<td>NO</td>
<td>NO</td>
<td>4-mos. Max &amp; overall 6-mos. Max in rolling 36 month period</td>
</tr>
<tr>
<td>NON-BARGAINING</td>
<td>1 HW Flat Rate Contribution</td>
<td>1 HW Flat Rate</td>
<td>NONE</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
</tbody>
</table>
A. EMPLOYEES/ACTIVE PARTICIPANTS

Your eligibility for benefits depends on the continued and timely reporting and payment of Employer Contributions on your behalf. In accordance with Plan rules, if your Employer fails to make a contribution when it is due, your eligibility may terminate (depending on the available hours in your Reserve Hour Bank). The number of hours required to maintain eligibility each month could increase in the future, at the discretion of the Board of Trustees.

Please remember that the hours you work in any given month determine your eligibility in the second calendar month following your hours worked (known as “lag month”). In addition, employers may not always report on a full calendar month due to their specific payroll cut offs and therefore hours reported are based on ONLY those hours reported by your Employer and not necessarily all hours worked in a given calendar month.

<table>
<thead>
<tr>
<th>Example:</th>
<th>Hours Worked</th>
<th>Reported by Employer to Trust Fund by February 22nd</th>
<th>Determine Eligibility / Coverage in:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>January</td>
<td></td>
<td>March</td>
</tr>
</tbody>
</table>

Once you enroll in the Plan, the Trust Fund Office will send you your user ID and password to access your eligibility and contribution history on ISITE at www.ncpittf.com. Below is an example, of a Participant Eligibility Status on ISITE.

View Eligibility
This information is based on data as of the previous business day and is subject to change. Documentation may be received at the Trust Fund Office that is currently in process. All information is subject to Plan rules and may be amended by the Board of Trustees from time to time.

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>Month</th>
<th>Status</th>
<th>Plan</th>
<th>Standard Hour Bank</th>
<th>Residential Hour Bank</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/01/2014</td>
<td>10/31/2014</td>
<td>ELIGIBLE</td>
<td>KAISER</td>
<td>263.50</td>
<td>0.00</td>
</tr>
<tr>
<td>09/01/2014</td>
<td>09/30/2014</td>
<td>ELIGIBLE</td>
<td>KAISER</td>
<td>388.50</td>
<td>0.00</td>
</tr>
<tr>
<td>08/01/2014</td>
<td>08/31/2014</td>
<td>ELIGIBLE</td>
<td>KAISER</td>
<td>513.50</td>
<td>0.00</td>
</tr>
<tr>
<td>07/01/2014</td>
<td>07/31/2014</td>
<td>ELIGIBLE</td>
<td>KAISER</td>
<td>488.50</td>
<td>0.00</td>
</tr>
<tr>
<td>06/01/2014</td>
<td>06/30/2014</td>
<td>ELIGIBLE</td>
<td>KAISER</td>
<td>419.50</td>
<td>0.00</td>
</tr>
<tr>
<td>05/01/2014</td>
<td>05/31/2014</td>
<td>ELIGIBLE</td>
<td>KAISER</td>
<td>387.00</td>
<td>0.00</td>
</tr>
<tr>
<td>04/01/2014</td>
<td>04/30/2014</td>
<td>ELIGIBLE</td>
<td>KAISER</td>
<td>412.00</td>
<td>0.00</td>
</tr>
<tr>
<td>03/01/2014</td>
<td>03/31/2014</td>
<td>ELIGIBLE</td>
<td>KAISER</td>
<td>424.00</td>
<td>0.00</td>
</tr>
<tr>
<td>02/01/2014</td>
<td>02/28/2014</td>
<td>ELIGIBLE</td>
<td>KAISER</td>
<td>387.00</td>
<td>0.00</td>
</tr>
<tr>
<td>01/01/2014</td>
<td>01/31/2014</td>
<td>ELIGIBLE</td>
<td>KAISER</td>
<td>309.00</td>
<td>0.00</td>
</tr>
<tr>
<td>12/01/2013</td>
<td>12/31/2013</td>
<td>ELIGIBLE</td>
<td>KAISER</td>
<td>245.00</td>
<td>0.00</td>
</tr>
<tr>
<td>11/01/2013</td>
<td>12/31/2013</td>
<td>ELIGIBLE</td>
<td>KAISER</td>
<td>250.00</td>
<td>0.00</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>10/31/2013</td>
<td>ELIGIBLE</td>
<td>KAISER</td>
<td>375.00</td>
<td>0.00</td>
</tr>
<tr>
<td>09/01/2013</td>
<td>09/30/2013</td>
<td>ELIGIBLE</td>
<td>KAISER</td>
<td>500.00</td>
<td>0.00</td>
</tr>
<tr>
<td>08/01/2013</td>
<td>08/31/2013</td>
<td>ELIGIBLE</td>
<td>KAISER</td>
<td>625.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>
1. **Bargaining Unit Employees Eligibility to Participate:** Active Employees who are members of UA Local 342 covered by Collective Bargaining Agreements negotiated by UA Local 342, requiring contributions by Contributing Employers into this Health and Welfare Plan, are eligible for benefits under the conditions authorized by the Board of Trustees as set forth in this Plan. If you work under multiple contracts during the same month, you are encouraged to verify your benefits with the Trust Fund Office. In addition, there may be other contracts not covered under the Master Labor Agreement which may have special provisions and you would need to check with the Trust Fund Office to verify your benefits.

2. **Initial Eligibility requirements for Bargaining Unit Employees** (300 Hours in Six Consecutive Months)

   a. **Employees Working Under Master Labor Agreement, Shortline Agreement, and Other Applicable Agreements.** A new Employee who is a member in good standing of UA Local 342 working in Covered Employment under the Master Labor Agreement, Shortline Agreement, and Other Applicable Agreements becomes covered under the Plan on the **first day of the second calendar month** following the month in which the Employee accumulates 300 hours of Covered Employment within a period of six consecutive months.

   b. **Employees Working Under Residential Agreement.** A new Employee who is a member in good standing of UA Local 342 and working in Covered Employment under the Residential Agreement will become covered under the Plan on the **first day of the second calendar month** following the month in which the Employee accumulates 120 hours of Covered Employment in a period of six (6) consecutive months.

   **EXAMPLE 1:** You work 120 hours in January. February is a lag month. Your coverage would begin March 1st.

   **EXAMPLE 2:** You work 60 hours in January and 60 hours in February. March is a lag month. Your coverage would begin April 1st.

If a new Employee fails to accrue the required 300 hours by the **end of a six consecutive month period**, starting with the first month in which the Employee first performs Covered Employment, the Employee loses the hours earned in the first month and the succeeding month shall be treated as the first month in which the Employee performed Covered Employment, for the purpose of qualifying for initial eligibility.

Employees working under the Master Labor Agreement, Shortline Agreement, and Other Applicable Agreements are entitled to Disability Extension, Jury Duty and Retiree Health and Welfare Benefits. Employees under the Master Labor Agreement may be entitled to **Active Subsidized Self-Pay** for up to 12 consecutive months with an overall maximum of 18 months in a consecutive 36 month period.

ELIGIBILITY EXAMPLES

**EXAMPLE 1:** You work in January, February and March (100 hours in each month for a total of 300 hours). April is the lag month. Your coverage would begin May 1st and you would also have coverage for June based on the remaining hours in your Reserve Hour Bank.

**EXAMPLE 2:** You work in January and February (100 hours in each month), but you do not work in March or April. You then work in May and June (50 hours in each month for a grand total of 300 hours). July is the lag month. Your coverage would begin August 1st and you would also have coverage for September based on the remaining hours in your Reserve Hour Bank.

If a new Employee fails to accrue the required 120 hours by the **end of a six consecutive month period**, starting with the first month in which the Employee first performs Covered Employment, the Employee shall lose the hours earned in the first month and the succeeding month shall be treated as the first month in which the Employee performed Covered Employment, for the purpose of qualifying for initial eligibility.
Effective January 1, 2015, the following provisions apply to Existing and New Employees working under the Residential Plumbing Agreement:

1. Existing and New Employees (including their eligible Dependents) may only enroll in the Kaiser HMO Program (which includes Medical, Prescription, and Residential Treatment Benefits), if not already enrolled in the Kaiser HMO Program and **are entitled** to Hearing Aid, Life Insurance, Dental, Orthodontic, and Vision benefits (through VSP). **However, the bargaining parties have discretion to waive the Kaiser enrollment requirement for existing Employees under limited special circumstances.**

2. Existing and New Employees are **NOT** entitled to Disability Extension, Jury Duty, or Retiree Health and Welfare Benefits because of their lower contribution rate.

The eligibility requirements and other rules in this section are subject to change by agreement of the bargaining parties and/or the Board of Trustees at any time.

Employees under the Residential Agreement may be entitled to **Active Subsidized Self-Pay** for up to 4 consecutive months with an overall maximum of six (6) months in a consecutive 36 month period.

Employees working under the Residential Agreement are **NOT** entitled to Disability Extension, Jury Duty or Retiree Health and Welfare Benefits because of their lower contribution rate.

c. **Employees working under the Helper (MLA) Classification.** A new Employee who is a member in good standing of UA Local 342 and working in Covered Employment under the Helper (MLA) Classification will become covered under the Plan on the **first day of the second calendar month** following the month in which the Employee works 125 hours.

**EXAMPLE 1:** You work 125 hours in January. February is a lag month. Your coverage would begin March 1st.

**EXAMPLE 2:** You work 65 hours in January and 60 hours in February. March is a lag month. Your coverage would begin April 1st.

There is a maximum 2 months Reserve Hour Bank for Employees working under the Helper classification. Employees working under the Helper Classification may be entitled to **Active Subsidized Self-Pay** for up to 12 consecutive months with an overall maximum of eighteen (18) months in a consecutive thirty-six (36) month period.

Employees working under the Helper Classification are **NOT** entitled to Disability Extension, Jury Duty or Retiree Health and Welfare Benefits because of their lower contribution rate.

d. **Tradesmen & Servicemen Working Under the Refrigeration and Air Conditioning Agreement and Food Store Addendum and Other Applicable Heating & Air Conditioning Agreements.** An employee who is a member in good standing of UA Local 342 working in Covered Employment under the Northern California and Northern Nevada Refrigeration and Air Conditioning Agreement will become covered under the Plan on the **first day of the second calendar month** following the month in which the Employee accumulates 300 hours of Covered Employment within a period of six consecutive months.

**EXAMPLE 1:** You work January, February, and March (100 hours in each month for a total of 300 hours). April is a lag month. Your coverage would begin May 1st.

**EXAMPLE 2:** You work January and February (100 hours in each month for a total of 200 hours), but do not work March and April. You then work May and June (50 hours in each month for grand total of 300 hours). July is a lag month. Your coverage would begin August 1st.
The following provision(s) apply to Existing Tradesmen and/or Servicemen working under the Refrigeration and Air Conditioning Agreement and Food Store Addendum, effective July 1, 2014 and also apply to Employees working under Other Applicable Agreements, effective January 1, 2015:

1. Existing Tradesmen and Servicemen (including their eligible dependents) must enroll in the Kaiser HMO program (which includes Medical, Prescription, and Residential Treatment benefits), if not already enrolled and are entitled to Life Insurance, Dental, Orthodontic, and Vision benefits (through VSP) until they incur a gap in coverage. However, the bargaining parties have discretion to waive the Kaiser enrollment requirement for existing Tradesmen and/or Servicemen under special circumstances.

2. Existing Tradesmen and Servicemen are not entitled to Disability Extension, Hearing Aid, Jury Duty, and Retiree Health and Welfare Benefits because of their lower contribution rate.

3. Existing Tradesmen are entitled to keep their existing hour banks. However, once they have used and reduced their hour bank to two (2) months remaining or have had a gap in coverage, the new two (2) month maximum will apply.

4. Existing Tradesmen and Servicemen are entitled to Active Subsidized Self-Pay for up to four consecutive months with an overall maximum of six (6) months in a consecutive thirty-six (36) month period.

Please contact the Trust Fund Office to verify whether you fall under this category and whether the Applicable Agreement you are working under covers certain benefits. The eligibility requirements and other rules in this section are subject to change by agreement of the bargaining parties and/or the Board of Trustees at any time.

The following provision(s) apply to New Tradesmen and/or Servicemen hired on or after January 1, 2014 working under the Refrigeration and Air Conditioning Agreement and Food Store Addendum:

1. Effective July 1, 2014, New Tradesmen and Servicemen (including their eligible dependents) must enroll in the Kaiser HMO program (which includes Medical, Prescription, and Residential Treatment benefits) and are entitled to Life Insurance, Dental, Orthodontic, and Vision benefits (through VSP).

2. New Tradesmen and Servicemen are not entitled to Disability Extension, Hearing Aid, Jury Duty, and Retiree Health and Welfare Benefits because of their lower contribution rate.

3. New Tradesmen shall be granted one month in their hour bank after initially working 800 hours and an additional one month shall be granted into their hour bank after working 1600 hours. There is a maximum two (2) month Reserve Hour Bank.

4. New Tradesmen and Servicemen are entitled to Active Subsidized Self-Pay for up to four consecutive months with an overall maximum of six (6) months in a consecutive thirty-six (36) month period.

Effective July 1, 2014, the following provision(s) apply only to Refrigeration Service and Supermarket Servicemen:

1. The Health and Welfare Contribution shall be capped at 155 hours per calendar month for all existing and newly hired Servicemen (including Journeyman and Apprentices) in the Refrigeration Service and Refrigeration Supermarket Construction Industry Only.

Multiple Contracts: If you work under multiple contracts during the same month, you are encouraged to verify your benefits with the Trust Fund Office. In addition, there may be other contracts not covered under the Refrigeration and Air Conditioning Agreement and Food Store Addendum which may have special provisions and you would need to check with the Trust Fund Office to verify your benefits.
The eligibility requirements and other rules in this section are subject to change by agreement of the bargaining parties and/or the Board of Trustees at any time.

3. **Bargaining Unit Employees – Monthly Hours Required for Continuation of Coverage:** Once an Employee is eligible to participate, the Participant must maintain 125 hours per month to continue his or her eligibility under the Master Labor Agreement (including the Refrigeration and Air Conditioning Agreement) or 120 hours per month under the Residential Agreement. The number of hours required to maintain eligibility each month could increase in the future, at the discretion of the Board of Trustees. In addition, Employers may not always report on a full calendar month due to their specific payroll cut offs and therefore hours reported are based on ONLY those hours reported by your Employer and not necessarily all hours worked in a given calendar month.

4. **Reserve Hour Bank Rules:** Coverage for Employees is based on the accrual of hours at the current contribution rate, determined by the Board of Trustees, for the accumulation of hours in a Participant’s Reserve Hour Bank. Hours are credited for actual work hours in a particular month subject to any cap in hours. Thus, hours reported late because of late contributions, reciprocity or because of insufficient payments discovered through a payroll audit may not increase your Reserve Hour Bank. Any hours remaining in your Reserve Hour Bank are cancelled after twelve (12) consecutive months of failing to maintain eligibility. **You do not have a vested right to your Reserve Hour Bank. The Board could reduce and/or cancel these hours at any time.**

   a. **Master Labor Agreement-6 Month Reserve Hour Bank.** When a Covered Employee working under the Master Labor Agreement accumulates at least 125 hours during a month, any hours in excess of 125 are banked in his or her Reserve Hour Bank to provide coverage for a later month when the employee is not working sufficient hours. Up to 125 hours will be deducted from the Reserve Hour Bank to provide each month's coverage. **A Participant may accumulate excess hours to a maximum of 750 hours or six (6) months.**

   b. **Residential Agreement-3 Month Reserve Hour Bank.** When a Covered Employee working under the Residential Agreement accumulates at least 120 hours during a month, any hours in excess of 120 are banked in his or her Reserve Hour Bank to provide coverage for a later month when the employee is not working sufficient hours. Up to 120 hours will be deducted from the Reserve Hour Bank to provide each month's coverage. **A Participant may accumulate excess hours to a maximum of 360 hours or three (3) months.**

      A Residential Employee who has worked at least 1200 hours in each of the preceding two calendar years, and who has March eligibility through hours worked or his or her Reserve Hour Bank, will receive up to 360 hours (3 months) in his or her Reserve Hour Bank. This benefit is reviewed annually every March. Once you qualify for this benefit you can continue to accumulate up to the 360 hours (3 months) maximum.

      **EXAMPLE:** *In March 2015, if you worked at least 1200 hours in each of the preceding two calendar years (2013 and 2014), you will automatically be granted up to 360 hours (3 months) in your Reserve Hour Bank.*

   c. **Shortline and PG&E Agreement-6 Month Reserve Hour Bank.** When a Covered Employee working under the Shortline Agreement accumulates at least 125 hours during a month, any hours in excess of 125 are banked in his or her Reserve Hour Bank to provide coverage for a later month when the employee is not working sufficient hours. Up to 125 hours will be deducted from the Reserve Hour Bank to provide each month's coverage. **A Participant may accumulate excess hours to a maximum of 750 hours (6 months).**

   d. **Helper (MLA) Classification-2 Month Reserve Hour Bank.** When a Covered Employee working under the Helper classification accumulates at least 125 hours during a month, any hours in excess of 125 are banked in his or her Reserve Hour Bank to provide coverage for a later month when the employee is not working sufficient hours. Up to 125 hours will be deducted from the Reserve Hour
Bank to provide each month's coverage. **A Participant may accumulate excess hours to a maximum of 250 hours (2 months).**

e. **Tradesmen Under Refrigeration and Air Conditioning Agreement – 2 Month Reserve Hour Bank.** When a Covered Employee working under the Refrigeration and Air Conditioning Agreement accumulates at least 125 hours during a month, any hours in excess of 125 are banked in his or her Reserve Hour Bank to provide coverage for a later month when the employee is not working sufficient hours. Up to 125 hours will be deducted from the Reserve Hour Bank to provide each month's coverage. **A Participant may accumulate excess hours to a maximum of 250 hours or two (2) months.**

f. **Servicemen Classification – 6 Month Reserve Hour Bank.** When a Covered Employee working under the Servicemen classification accumulates at least 125 hours during a month, any hours in excess of 125 are banked in his or her Reserve Hour Bank to provide coverage for a later month when the employee is not working sufficient hours. **A Participant may accumulate excess hours to a maximum of 750 hours or six (6) months.**

g. **Reserve Hour Bank – May Be Cancelled.** The Board of Trustees reserves the right to reduce and/or terminate your Reserve Hour Bank at any time, including hours previously earned but not used. **There is no vested right to such benefits.**

h. **Reserve Hour Bank – May be Exhausted due to Retirement and Death (of Active Plan Participant).** You and/or your eligible Dependents will be able to exhaust your Reserve Hour Bank at no additional cost if due to:

   (1) **Retirement:** When you Retire, Active coverage may continue until you have exhausted the hours in your Reserve Hour Bank.

   **EXAMPLE:** If you have 250 hours in your Reserve Hour Bank upon retirement, you will receive 2 additional months of Active Eligibility.

   (2) **Death:** Upon death (Active Plan Participant), Active coverage for your Eligible Dependent(s) may continue as long as you have sufficient hours in your Reserve Hour Bank. After your Reserve Hour Bank exhausts, your Surviving Spouse and/or Dependent(s) may qualify for COBRA Continuation Coverage or Plan Continuation Coverage under the Retiree Health and Welfare Plan (if you qualify). Please refer to Article XI and Article XIII to see if you qualify.

   **EXAMPLE:** If the Plan Participant has 250 hours in his or her Reserve Hour Bank on June 1st based on April hours and the Plan Participant passes away in June, his or her eligible Dependents would receive 2 additional months of Active Eligibility.

   Please refer to Article XIII for additional information regarding the Retiree Health & Welfare Plan.

5. **Cancellation of Reserve Hour Bank:** If you lose your UA Local 342 “Union” Membership and/or are no longer considered a member in good standing, you will lose your Reserve Hour Bank.

   a. **Expelled** from the Union means a member goes more than six (6) months without paying his or her Union dues. The first day of the 7th month is when the person is expelled. At that point, the person is no longer a member.

   b. **Honorable Withdrawal** is when a member does not want to pay Union dues but wants the chance to guarantee a way back into the Local Union. He or she is no longer a Union member on the date the withdrawal is entered in the Union's records.
c. **Dropped** members are those who have been dropped from the UA Local 342 Joint Apprenticeship and Training Committee (JATC Apprenticeship School) for not keeping up with their obligations to the school. When a member is dropped from the program, and with verification from the school, the person is dropped from membership of the Union.

d. **Resignation** is when a member does not want to be a member of the Union, for any reason. The person writes a letter to the UA. Upon receipt of the letter by UA Local 342 or notice of such from the UA, whichever is earlier, the person is no longer a member.

e. **Non-Covered Employment** is when an Employee performs employment (including self-employment and/or owning a business) of the type performed by Employees of Employers who contribute to the Plan pursuant to a Collective Bargaining Agreement for an Employer who does not contribute to a Health and Welfare Plan maintained pursuant to a Collective Bargaining Agreement of a Local Union of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada, AFL-CIO.

**EXAMPLE:** If the Trust Fund Office receives notification from UA Local 342 stating that you have been expelled, taken an Honorable Withdrawal, been dropped, resigned and/or are working Non-Covered Employment in March 15th, your Reserve Hour Bank will be cancelled effective May eligibility.

Loss of Union membership and/or if no longer considered a member in good standing resulting in the cancellation of your Reserve Hour Bank is NOT considered a COBRA qualifying event. Therefore, you will not be eligible for COBRA Continuation of Coverage. Furthermore, you will not be eligible to make Active Subsidized Self-Payments. (Please refer to Article X, Section A).

Once a person loses his or her Reserve Hour Bank, he or she will have to reestablish his or her eligibility for coverage as described under the Initial Eligibility requirements. **Reinstatement requirements vary depending on your classification.**

Please refer to Article III for information concerning obtaining Initial Eligibility.

6. **Loss of Eligibility - Depletion of Reserve Hour Bank:** This applies to all Active Participants with a Reserve Hour Bank. A Participant’s eligibility shall terminate at the end of any month in which the Participant’s Reserve Hour Bank falls below the minimum monthly hour requirement (amount of hours vary depending on your Agreement/Classification). If a Participant’s eligibility terminates, the Participant may qualify for Continuation of Coverage through COBRA Continuation of Coverage and/or Active Subsidized Self-Payment, or may re-qualify for coverage under the Plan’s Reinstatement of Eligibility rules described directly below in subsection 7. (If disabled please refer to the Disability Section at Article X, Section B).

7. **Reinstatement of Eligibility:** This applies to all Active Participants. A Participant who has lost eligibility will regain eligibility the first day of the month following the month in which the Participant has at least the minimum hours in his or her Reserve Hour Bank (amount of hours vary depending on your Agreement/Classification) as long as it occurs within the 12 consecutive months immediately following the loss of eligibility. If the Participant is unable to reinstate eligibility within the 12 consecutive month period, any hours in his or her Reserve Hour Bank will be cancelled and he or she must regain eligibility as described under the Initial Eligibility requirements described in Article III. Log onto your ISITE account to view your reinstatement information.

B. **EMPLOYERS AND NON-BARGAINING UNIT EMPLOYEES**

1. **Non-Bargaining Unit Employees.** Non-Bargaining Unit Employees of Contributing Employers, pursuant to eligibility rules and Subscription Agreements approved by the Board, are eligible to participate in the Health and Welfare Plan, pursuant to the conditions set forth herein and by the Board of Trustees. This
includes, without limitation, employees of UA Local 342, the UA Local 342 Joint Apprenticeship Trust, the Trust Fund Office or any other related entity approved by the Board of Trustees.

**IV. RECIPROCITY – AGREEMENTS AND AUTHORIZATIONS**

The Board of Trustees of this Plan realizes that you may work in several locations and in the jurisdiction of other UA Local Union’s during your career. This Plan participates in the National Reciprocity Agreement with certain other UA Health and Welfare Plans, which provides for “Money Follows the Person” reciprocity.

1. **Reciprocal Authorizations and Agreements (Active Participants only):**
   A Reciprocal Authorization Form requesting to transfer Employer Contributions to another UA Local Union’s Trust Fund may act as a release and waiver of any and/all claims against this Plan. If you are working within UA Local 342's jurisdiction and you are not a member of UA Local 342 (Outgoing Reciprocity), per the Money Follows the Person rule, once the Trust Fund Office for UA Local 342 receives and processes the Employer Contributions, they will be reciprocated to your Home Trust Fund within a reasonable period. **Employer Contributions cannot be reciprocated retroactively due to benefits already being granted and premiums paid.**

2. **UA Local 342 Member working under another UA Local’s Jurisdiction:** If you are working under another UA Local Union’s jurisdiction (Incoming Reciprocity) and wish to have Employer Contributions reciprocated to the Trust Fund Office for UA local 342, the Trust Fund of the UA Local Union that your are working under the jurisdiction of may require you to sign a Reciprocal Authorization Form before beginning work on that job. A delay in signing the Form will delay and/or prohibit the transfer of Employer Contributions. (If you transfer to another UA Local Union, please review Article V). If you have signed a Reciprocal Authorization Form, you should monitor your Health and Welfare eligibility. You can access information on your eligibility, work history, and contributions by logging into your ISITE account at www.ncptf.com (See Article VI, Section A for information on obtaining your ISITE username and password). Due to the delay in receiving Reciprocal Employer Contributions, your Health and Welfare Coverage may terminate if you do not have sufficient hours in your Reserve Hour Bank.

**Please note:** Incoming Reciprocal contributions for UA Local’s 159, 343, 355, 393, 447, 467 and DC 36 will be credited based on actual hours worked. For all other UA Locals, if you are working at a non-standard Employer Contribution rate, during periods of incoming reciprocal hours, all hours and your Reserve Hour Bank are pro-rated at the standard rate ($16.05 effective February 2015 hours).

**EXAMPLE** - You are a member of UA Local 342 and worked 125 hours in February 2015 (April 2015 eligibility) for XYZ Plumbing in UA Local 111’s jurisdiction. UA Local 111’s Health and Welfare contribution rate is $8.00 per hour and UA Local 342’s is $16.05 per hour. As a result, the following would apply:

- **XYZ Plumbing contributes $1,000.00 (125 hours x $8.00 per hour) to UA Local 111.**
- These contributions are due at UA Local 111’s Trust Fund by approximately March 20th.
- **The UA Local 111 Trust Fund closes the month and prepares reports of those Participants who are not UA Local 111 Participants.**
- **UA Local 111’s Trust Fund sends $1,000.00 to the Northern California Pipe Trades ("NCPT") Health & Welfare Plan as outgoing reciprocity during April.**
- **Upon receipt, approximately late April, the NCPT Health & Welfare Fund receives the $1,000.00 and divides it by the current standard hourly rate, $16.05 per hour, which equals 62.31 hours.**
- **62.31 hours would be applied towards your Health and Welfare as hours worked in February which provides eligibility for April (please note that this is just one example and**
you can see that most of April has passed by the time this information is available to the Trust Fund Office).

- **Hours are always applied to the month in which they were worked and cannot be posted based on the time the hours are reported and received at the Trust Fund Office. This often creates eligibility posted several months after the month has passed and there are retroactive limitations that cannot be overruled by the Plan.**

As a reminder, you must have at least 125 hours in your Reserve Hour Bank in order to maintain eligibility each month. Although a Participant has worked 125 hours out of UA Local 111, he or she is only credited with 62.31 towards NCPT Health and Welfare eligibility at UA Local 342 because of UA Local 111’s lower Employer Contribution rate. You may wish to have a Subsidized Self-Payment on file to avoid a lapse in Health and Welfare Coverage. Contact the Trust Fund Office for UA Local 342 for assistance.

V. TRANSFERS (From UA Local 342 to another UA Local Union)

A member who transfers from UA Local 342 to another UA Local Union will not have his or her Reserve Hour Bank cancelled for up to a maximum of three eligibility months if sufficient amount of hours are in his or her Reserve Hour Bank (e.g., If you transfer from UA Local 342 into UA Local 111 effective February 1st, your Reserve Hour Bank will be cancelled effective July 1st. This is because you last worked in January [March eligibility] and would receive up to a maximum of three eligibility months, April, May and June [the maximum amount of hours in your Reserve Hour Bank]) or up until the date the Participant obtains Health and Welfare coverage through his or her new Local Union’s Trust Fund, if earlier. The Trust Fund Office will use the 1st day of the month in which you transferred as your transfer effective date, if your transfer occurs on or between the 1st through the 19th of the month (e.g., transfer occurred on January 6th, use January 1st as transfer effective date). The 1st day of the month following the month in which you transferred will be used as your transfer effective date, if your transfer occurs on or between the 20th through the last day of the month (e.g., transfer occurred on January 27th, use February 1st as transfer effective date).

If additional time is needed to obtain Health and Welfare Coverage through the new UA Local Union, the Participant can provide the Trust Fund Office with a letter with requesting the option to continue coverage and a copy of new UA Local Union’s Trust Fund eligibility requirements. If the Participant meets Plan rules, they may be eligible to make Active Subsidized Self-Payments and/or COBRA payments, until he or she is eligible for Health and Welfare coverage through his or her new UA Local Union’s Trust Fund.

VI. ENROLLMENT

A. **ENROLLMENT PROCEDURES**

You must complete and submit an Enrollment/Change Form to the Trust Fund Office with sufficient documentation to establish the eligibility of any Dependent you list on the Form (such as a certified marriage certificate, certified birth certificate(s) which names the Natural Parents, and/or Court Adoption Order(s), etc.). **Full completion and return of the Enrollment/Change Form is mandatory for all Participants to be enrolled in the Health and Welfare Plan or to make any type of enrollment, address, or informational change.** In addition, an updated Enrollment/Change Form is required when requested by the Trust Fund Office. Failure to complete and return the Enrollment/Change Form within 30 days of the request may affect your and/or your Dependents’ eligibility and/or future benefits. Once you have gained Initial Eligibility and completed an Enrollment/Change Form, the Trust Fund Office will send you a letter with your ISITE username and password.

You are also required to complete a new Enrollment/Change Form when you have any changes in life
circumstances (e.g., marriage, separation in any form, divorce, spouse no longer residing with you, new Dependents, Dependent status changes, Qualified Medical Child Support Order (QMCSO), National Medical Child Support Notice (NMSN), and/or Court Orders, address changes, etc.). You must fully complete a new Enrollment/Change Form and include any/all necessary documentation. **Failure to notify the Trust Fund Office within 30 days of a Dependent’s change in Eligibility status may be considered fraud and you will be required to repay the Plan for any overpayments, including any attorney’s fees and costs incurred by the Plan in recovering such amounts.**

Initial Eligibility begins on the first day of the month in which you initially qualify for benefits based on the initial Eligibility requirements or when you regain eligibility for benefits, as long as the Trust Fund Office has received your completed Enrollment/Change Form in the same month in which you have gained initial eligibility or regained eligibility.

If your fully completed Enrollment/Change Form and all Plan required documentation is received by no later than the 20th of the month, coverage for you and/or your eligible Dependent(s) is generally effective the first day of the following month. If you fail to submit an Enrollment/Change Form, you will be unenrolled and will have no coverage. Retroactive coverage may be limited due to the Carriers retroactive limitations/rules.

**B. HOW TO MAKE/CHANGE YOUR HEALTH PLAN SELECTION**

You are given the opportunity to make your Health Plan selection (Kaiser or Blue Shield) by completing the applicable Enrollment/Change Form when you first become eligible for benefits under the Plan. Timely submission of the Enrollment/Change Form is imperative.

The Plan rules allow an eligible Participant to change his or her Health Plan Selection once in any 12-month period. However, a Participant must be eligible for Health Plan coverage and remain in the selected Plan for the next 12 months, unless the Participant moves out of the Plan’s service area. If special circumstances exist a change may be approved.

Generally, if your fully completed Enrollment/Change Form is received by no later than the 20th of the month, changes will be effective the first of the month following receipt of the Form and any Plan required documentation. A Plan change notification letter may be sent to the Plan Participant by the Trust Fund Office when this occurs.

**C. ENROLLING / RE-ENROLLING NEW DEPENDENT(S)**

If you wish to add a new eligible Dependent, including a new spouse, newborn, adopted child, or stepchild, you must complete and submit an Enrollment/Change Form along with any other Plan required Forms and appropriate documentation establishing the Dependent’s eligibility within 30 days of the birth, adoption, marriage, etc.

Your spouse or eligible Dependent child becomes eligible as of the date of marriage, birth, or adoption provided that within 30 days of the date of marriage, birth, or adoption you have submitted an updated Enrollment/Change Form adding your Dependent along with all Plan required documents (e.g., copy of certified marriage certificate, copy of certified birth certificate naming the Natural Parents). If an updated Enrollment/Change Form and proper documentation is not received within 30 days, enrollment in the Plan for your eligible Dependent will not be effective until the first of the month following receipt of your Enrollment/Change Form and all other Plan required documents.

**D. DESIGNATION OF BENEFICIARY**

You must complete and return a Beneficiary Form for the payment of any death benefits. You may be asked to complete and return a Beneficiary Form at the time of initial Enrollment or if you have a change in life circumstances (e.g., marriage, separation, divorce etc.). To change your Beneficiary at any time, you
must complete and return a new Beneficiary Form. You may change your Beneficiary at any time. If you are married and wish to designate someone other than your spouse, your spouse must consent in writing before a notary to the Beneficiary designation. If you get married or re-married, any previous Beneficiary designation other than your current spouse is invalid. Similarly, if you divorce, any previous designation of your former spouse as Beneficiary is automatically revoked and is no longer valid.

If you are not certain who you have designated as your Beneficiary, you should complete a new Beneficiary Form. The Trust Fund Office is unable to give you information over the phone regarding your designated beneficiary(s).

If you fail to designate a Beneficiary or no designated Beneficiary survives you, distribution of any benefits will be made to:
1. your spouse, if any;
2. if no spouse, in equal shares to your child(ren) (natural or adopted);
3. if no spouse or child(ren), in equal shares to your parents;
4. if no spouse, child(ren), or parents, then in equal shares to your brothers and sisters; or
5. if none of the above, then finally to your estate.

VII. ELIGIBLE DEPENDENTS

A. DEPENDENT ELIGIBILITY

When you have eligible Dependents, each Dependent must be enrolled in accordance with the Plan's enrollment procedure (outlined below). Upon enrollment, a Dependent will be eligible when a Participant's eligibility is effective and/or when he or she qualifies as an eligible Dependent.

A Dependent's eligibility will terminate when the Participant's coverage terminates, or when the individual ceases to be an eligible Dependent; for example, if your spouse no longer resides with you, your spouse’s coverage will terminate.

You must immediately notify the Trust Fund Office when an eligible Dependent ceases to meet the definition of an eligible Dependent. When completing an Enrollment/Change Form, you are indicating that the Dependents listed meet all of the Plan’s Dependent enrollment requirements. Failure to notify the Trust Fund Office within 30 days of a Dependent’s change in eligibility status may be considered fraud and could result in requests for reimbursement of any overpayments and/or loss of certain extensions of coverage (e.g., COBRA) for the ineligible Dependent(s). The Participant and ineligible Dependent(s) may also be responsible for attorney’s fees or other associated costs incurred by the Plan as a result of maintaining an ineligible Dependent(s).

A Participant who fails to repay the Plan any amounts owed as a result of maintaining an ineligible Dependent (even if such amounts are discharged in United States Bankruptcy Court or another Court) will not be permitted to enroll and/or maintain enrollment of any Dependents other than on a Participant’s natural child(ren) who has not reached age 26.

The Plan reserves the right to periodically request supporting documentation or written verification that an enrolled Dependent continues to meet Plan Dependent requirements (e.g. written confirmation and/or documentation that a spouse still resides with you).
B. LAWFUL SPOUSE

An eligible Dependent includes the Participant’s lawful spouse (including opposite-sex and same-sex spouses) who resides (principal residence) with the Participant and is not separated from the spouse in any form (such as a divorce or legal separation or unofficial separation where you no longer live with your covered spouse) except as provided below. If required (such as for Retirees), the Participant must timely remit the monthly premium payment to cover a Dependent spouse.

A spouse becomes eligible as of the date of marriage, provided that you have submitted an updated Enrollment/Change Form adding your spouse along with a copy of your certified marriage certificate within 30 days of the date of marriage. If an updated Enrollment/Change Form and proper documentation is not received within 30 days of the date of marriage, enrollment in the Health and Welfare Plan for your spouse will not be effective until the first of the month following receipt of the required documentation.

California law and this Plan do not recognize a common law marriage; however, you and your partner may qualify as Domestic Partners. Please refer to Section C below for additional information regarding Domestic Partner eligibility and benefits.

A former spouse is NOT eligible for coverage as a Dependent under the Plan, and a Participant may not enroll a former or Separated Spouse, even if he/she is legally required to maintain coverage, except as required by COBRA. Please be aware that a Separated Spouse or former spouse is NOT eligible as a Dependent under the Plan, even if you are required to maintain coverage pursuant to a Court Order. Your Separated Spouse or former spouse may, however, be or eligible to continue medical, prescription drugs, dental, and vision coverage under either the Plan’s Separated Spouse Continuation of Coverage or COBRA Continuation of Coverage. You may be required to pay a monthly premium under COBRA.

It is the obligation of the Plan Participant and Separated Spouse to notify the Trust Fund Office in writing within 30 days of the date of any form of separation. For Administration purposes, the Plan will consider the date of separation to be the earlier of:

(a) The date that a Participant and his spouse separate by joint decision regardless of whether they still reside at the same physical residence; or
(b) The date that a Participant and his spouse no longer reside on a full-time basis at the same physical address; or
(c) The separation date listed on any court filing for Marital Dissolution or Legal Separation.

Coverage for a Separated Spouse will be allowed for only four (4) months after the date of separation as determined by the Plan (e.g., if the Plan recognizes the date of separation as occurring in July, the coverage termination date will be November 30th).

Provided the Trust Fund Office was notified in writing within four (4) months of the date of separation, as defined by the Plan, after a Separated Spouse’s coverage terminates, he/she may be allowed the opportunity to purchase coverage at an unsubsidized rate, determined by the Board of Trustees, that is offered to such spouses for up to six (6) months. An offer of Separated Spouse Continuation of Coverage will be forwarded to the most recent address on file for the Separated Spouse. The Separated Spouse is required to elect coverage within 60 days of the date on the offer letter. If the Separated Spouse elects this continuation coverage, payment is due within 45 days after the date the coverage is first elected. If there is a court filing for legal separation or dissolution of marriage while a Separated Spouse is covered under the Separated Spouse Continuation of Coverage, the Separated Spouse may further extend coverage for a total period not to exceed 36 months pursuant to COBRA (including the first six months of purchased coverage). If there is no court filing for legal separation or dissolution of marriage while a Separated Spouse is covered under the Separated Spouse Continuation of Coverage, no additional coverage is extended.
C. DOMESTIC PARTNER AND DOMESTIC PARTNER’S CHILD(REN) (ACTIVE PARTICIPANTS ONLY)

1. Domestic Partner Eligibility Requirements. The term “Dependent” includes the Domestic Partner of an eligible Active Participant who resides with the Participant. A Domestic Partner would need to meet all of the conditions described in the Northern California Pipe Trades Trust Fund “Affidavit of Domestic Partnership”.

2. A Domestic Partner under the Laws of a country other than the United States is not a lawful Dependent unless such person independently qualifies as a Domestic Partner as provided in the Plan’s “Affidavit of Domestic Partnership.” A Domestic Partner shall not include a former spouse of a Participant, regardless of whether this former spouse meets all the conditions described in the Northern California Pipe Trades Trust Fund “Affidavit of Domestic Partnership”.

3. Domestic Partner’s Child(ren) Eligibility Requirements. The term “Dependent” under the Plan’s Domestic Partner Provision includes both a Domestic Partner of an Active Participant and an enrolled Domestic Partner’s unmarried natural Child(ren) through age 25. If the Dependent Child(ren) of the Domestic Partner is also the natural Child(ren) or adopted Child(ren) of the Active Participant, the eligibility requirements of this section do not apply. Instead, refer to Article VI, Section D for Eligibility requirements of Participant’s Dependent Child(ren).

In order to qualify for coverage, the Child(ren) of an Active Participant’s Domestic Partner must meet all of these qualifications:

(i) The Child(ren) must be the natural Child(ren) of an Active Participant’s eligible and enrolled Domestic Partner; and
(ii) The Domestic Partner (Child[ren]’s natural parent) must meet all Plan requirements and be enrolled as a Domestic Partner in the Plan.

4. Enrollment. Enrollment of a Domestic Partner and, if applicable, the Domestic Partner’s Child(ren) would be subject to Enrollment procedures as outlined under Article VI of the Plan, including completion of an Enrollment/Change Form and submission of all other Plan required documents/information. In addition, the Plan requires a notarized “Affidavit of Domestic Partnership” Form signed by both the Participant and Domestic Partner acknowledging that the Domestic Partner and, if applicable, Domestic Partner’s Child(ren), qualifies for enrollment under Plan rules. The Board of Trustees, or the Boards’ delegate, has the absolute discretion to determine whether an individual would qualify as a Domestic Partner and/or Domestic Partner’s Child(ren) under the Plan.

5. Imputed Income Taxes. The Plan Participant is responsible for monthly payment in full of imputed income taxes for coverage of a Domestic Partner and a Domestic Partner’s Child(ren). The full payment of imputed income taxes is due one month in advance of the month eligibility is provided. Failure to pay the imputed income taxes in full by the due date may result in the immediate termination of Domestic Partner coverage on the last day of the month in which the full imputed income tax payment is not received. Rates are subject to change and payment amounts received in excess of the current coverage month’s imputed income tax payment will not be accepted and may be refunded to the payee. Partial payments and/or credits under $10.00 and/or erroneous payments may not be refunded. If the Plan Participant and Domestic Partner marry, a refund of the imputed income tax payment made for the month in which the marriage occurred will not be eligible for a refund.

Since the value of Domestic Partner Plan benefits is considered imputed income, it must be reported to the Internal Revenue Service and the Plan will issue a W-2 in January of the following year reflecting the taxable value of Plan benefits for the year and the total amount in tax payments paid during the year.
6. **Domestic Partner No Longer Qualifies.** It is the Participant’s responsibility to notify the Trust Fund Office once a Domestic Partner no longer meets the Plan’s Domestic Partner eligibility requirements. Eligibility of a Domestic Partner shall terminate on the date that the Domestic Partner no longer meets the Plan’s eligibility requirements including lack of timely payment of the imputed income taxes. A Participant who fails to notify the Trust Fund Office within 30 days of the date that a Domestic Partner has a change in eligibility status will be legally responsible for any payments or premiums made by the Plan from the date the Domestic Partner became ineligible for coverage.

7. **Domestic Partner’s Child(ren) No Longer Qualifies.** It is the Participant’s responsibility to notify the Trust Fund Office once a Domestic Partner’s Child(ren) no longer meets the Plan’s Domestic Partner’s Child(ren)’s eligibility requirements. Eligibility of a Domestic Partner’s Child(ren) shall terminate on the date the Domestic Partner no longer meets the Plan’s eligibility requirements or the date the Domestic Partner’s Child(ren) no longer meets the Plan’s eligibility requirements (such as the Child(ren) aging out of the Plan). This would include lack of timely payment of the imputed income taxes. A Participant who fails to notify the Trust Fund Office within 30 days of the date that a Domestic Partner’s Child(ren) has a change in eligibility status will be legally responsible for any payments or premiums made by the Plan from the date the Domestic Partner’s Child(ren) became ineligible for coverage.

8. **Proof of Continuing Eligibility.** The Plan, in its sole discretion, may require proof of continuation of such status prior to the payment of any claim or premium. It shall be the responsibility of the Participant to immediately notify the Trust Fund Office of the dissolution of any Domestic Partnership recognized by the Plan.

9. **Termination of Domestic Partner.** A Domestic Partner and/or Domestic Partner’s Child(ren) who loses coverage through either termination of the Domestic Partnership or failure to pay the imputed income tax, will not be allowed back into the Plan as a Domestic Partner and/or Domestic Partner’s Child(ren) at any time in the future.

10. **Domestic Partner Opt-Out of Coverage.** If coverage for a Domestic Partner terminated, for any reason, the Participant is not allowed to re-enroll the Domestic Partner and/or Domestic Partner Child(ren) in the Plan. However, an enrolled Domestic Partner and/or Domestic Partner’s Child(ren) may opt out (disenroll) from the Plan and be permitted to opt back into the Plan under the following conditions:

    i. The Domestic Partner and/or Domestic Partner’s Child(ren) acquire other Group Health Plan coverage and the Participant notifies the Trust Fund Office in writing that disenrollment is due to enrollment in another Group Health Plan; **and**

    ii. The Participant re-enrolls the Domestic Partner and/or Domestic Partner’s Child(ren) within 90 days of the date the other Group Health Plan coverage terminates and provides proof of such termination of prior coverage.

11. **No Continuation of Coverage.** A Domestic Partner and/or Domestic Partner’s Child(ren) is not entitled to continuation coverage under the Federal COBRA program if loss of coverage is due to: (a) failure to meet the Plan’s definition of a Domestic Partner/ Domestic Partner’s Child(ren); or (b) failure to timely pay imputed income tax; or (c) opting out due to other Group Health Plan coverage.

D. **CHILD(REN) THROUGH 25 YEARS OF AGE**

A Participant’s Dependent Child(ren) through age 25 who meets all other Plan requirements is eligible to enroll and be maintained as a Dependent regardless of whether the Dependent Child(ren) is eligible for coverage under another employer-sponsored group health plan through his or her own employment or through his or her Spouse’s employment. Benefits for Dependent Child(ren) are subject to timely remittance of any required monthly premium payment or imputed tax payment to cover a Dependent
child(ren). **Failure to pay any required premium or imputed income tax (for Domestic Partner coverage) by the due date may result in the immediate cancellation of coverage as of the last day of the month in which the premium or imputed income tax payment is not received.**

Enrollment of a Dependent Child(ren) would be subject to Enrollment procedures as outlined under Article VI of the Health and Welfare Plan, including completion of an Enrollment/Change Form and submission of all other Plan required documents/information.

**Dependent Child(ren) include the Participant's:**

1. **Natural Child(ren).**

2. **Stepchild(ren).** The Plan requires that before a stepchild(ren) can be enrolled in the Plan, any legal documents, must be timely submitted to the Trust Fund Office. The Plan has no obligation to continue coverage for a stepchild(ren) once the stepchild(ren)’s natural parent (Participant’s Spouse) separates*, in any form, from a Plan Participant.

3. **Legally Adopted Child(ren) by the Plan Participant and/or Lawful Spouse.** If a Participant has not legally adopted a child(ren), the Plan has no obligation to continue coverage for a child(ren) once the Spouse who legally adopted the child separates*, in any form, from a Plan Participant.

4. **Child(ren) for whom the Participant and/or Lawful Spouse has Court-Appointed Legal Guardianship of the Person.** The Plan might consider a child(ren) for whom the Participant’s Lawful Spouse has been court appointed as sole legal guardian of the person, provided the child(ren) is related to the Participant by blood or marriage. If the Participant is not named as a Court-Appointed Legal Guardian, the Plan has no obligation to continue coverage for a child(ren) once the Participant’s Spouse separates*, in any form, from the Participant.

   * For Administration purposes, the Plan would consider the date of separation to be the earlier of: (a) Date that a Participant and his or her spouse no longer reside on a full-time basis at the same physical address; or (b) Separation date listed on any court filing for Marital Dissolution or Legal Separation. Coverage termination date is based on Plan rules for a Lawful Spouse.

In order to enroll and maintain enrollment of a Dependent Child(ren), the Participant is required to provide the Trust Fund Office with a copy of any legal documents establishing a Dependent Child(ren) relationship to the Participant. In addition, the Plan may require documentation that establishes a Participant’s obligation to provide Health coverage. This includes, but is not limited to, birth certificates, decree of adoption, court ordered legal guardianship papers or a Qualified Medical Child Support Order for a natural child(ren) who does not reside in the Participant’s home. Child(ren) for whom the Participant has Court-Appointed Temporary Legal Guardianship, the Plan will require status updates every six months until permanent guardianship has been obtained and permanent guardianship papers have been submitted to the Trust Fund Office.

**E. DISABLED DEPENDENT CHILD(REN)**

An unmarried Disabled Natural Child(ren) of an Active or Retired Participant whose coverage would otherwise terminate solely due to attainment of age 26 may continue to be eligible for Plan coverage as an eligible Dependent provided that:

1. The Dependent Child(ren) was continuously covered as an eligible Dependent prior to attainment of age 26; and

2. The Dependent Child(ren) became totally and permanently disabled and incapable of self-sustaining employment by reason of mental retardation or physical handicap prior to age 26 while covered
(3) The Dependent Child(ren) also meets ALL of the following requirements:

(i) The Dependent Child(ren) is the Participant’s Natural Child(ren); and
(ii) The Dependent Child(ren) is unmarried; and
(iii) The Participant and/or Dependent Child(ren) has taken action prior to attainment of age 26 to obtain governmental benefits that are available and submits proof that the Disabled Dependent Child(ren) has applied for Social Security Disability Benefits and either:
   1. Submits a copy of the Social Security Administration Disability Award Letter; or
   2. If the Social Security Administration has denied the Disabled Dependent Child(ren)’s application, an Outside Independent Medical Review Organization will need to certify that the Disabled Dependent Child(ren)’s disabling condition(s) are total and permanent. The Participant/Disabled Dependent Child(ren) would be required to sign an Authorization to Release Medical Records in order to initiate such a review; and
(iv) The Dependent Child(ren) remains totally, permanently, and continuously disabled as determined by the Plan; and
(v) The Participant submits certification of total and permanent disability from a licensed physician to the Trust Fund Office within 30 days of the Dependent Child's 26th birthday and thereafter as determined by the Board of Trustees; and
(vi) The Participant has current eligibility under the Plan and, if required, has submitted the full monthly premium to cover Dependent Child(ren).

The Board of Trustees may charge a higher rate of premium for Disabled Dependent Child(ren) over age 26, at any time. The Board reserves the right to set an age limit on Plan coverage for Disabled Dependent Child(ren) in the future and may terminate such coverage at any time.

The Participant must be able to furnish proof to the Trust Fund Office periodically and upon request that the Dependent Child(ren) meets all Plan requirements including the Dependent's continued disability.

F. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)/NATIONAL MEDICAL SUPPORT NOTICE (NMSN)

The Plan will comply with a court order or National Medical Support Notice (NMSN) that requires the Plan to provide coverage for a Participant’s Child(ren) if it meets the standards of a QMCSO; however, no such order may require the Plan to provide benefits to someone who would not otherwise meet the Plan definition of an eligible Dependent Child(ren), nor can such an order require the Plan to provide benefits in excess of benefits provided under the Plan or to provide coverage to a Child(ren) who resides outside of the Plan’s Health Plan service areas.

The Participant must timely provide the Trust Fund Office with a copy of any court order or NMSN that establishes the Participant’s legal obligation to maintain coverage on a Dependent Child(ren), including a QMCSO. A QMCSO recognizes an eligible Child(ren)’s right to receive Plan benefits as a beneficiary of an eligible Plan Participant. The Child(ren) must meet the Plan requirements of an eligible Dependent Child(ren) and will be covered through age 25. **Coverage may terminate earlier than age 26 if the QMCSO and/or NMSN states such.**

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

1. The Participant must provide the Trust Fund Office with a copy of the court order (or NMSN) and/or QMCSO.
2. Within thirty (30) days of receipt of the QMCSO and/or NMSN, the Trust Fund Office or the Plan's Legal Counsel will notify the Participant in writing if the court order (or NMSN) and/or QMCSO is
acceptable to the Plan.

3. If the Plan determines that the court order (or NMSN) and/or QMCSO is not acceptable or if additional information is required, the Participant will be notified in writing by the Plan or by the Plan’s Legal Counsel.

   a. **If a QMCSO and/or NMSN is denied.** The notice will describe the reasons for denial and your right to appeal, along with a summary of the Plan’s appeal procedures. In most instances however, you will simply be asked to revise the order in such a way that it is a QMCSO and/or qualified NMSN.

   b. **If additional information is required.** The notice will describe what is needed. There will be sixty (60) days to respond.

The Plan requires that the Participant and all of his eligible Dependents be enrolled under only one Health Plan option. Therefore, if a Participant’s classification allows him a choice in Health Plan options, he must select and enroll in a Health Plan option whose coverage service area is available to the Participant, the child(ren) covered under the QMCSO and/or NMSN, and to the Participant’s other eligible Dependents based on each individual’s place of residence. If a Participant has a choice in Health Plan options and enrolls in a Plan that would not be available to the Child(ren) covered under the QMCSO and/or NMSN because the Child(ren) resides outside of the Plan’s service area, the Participant is required to enroll in another Health Plan option that would cover the child(ren). The Plan will follow the requirements of the QMCSO and/or NMSN, and may without the consent of the Participant, enroll/change enrollment of the Participant and all of his Dependents into a different Plan option that would cover the Child(ren) named in the QMCSO and/or NMSN.

If a Participant has not enrolled in a Health Plan option and the Plan receives a QMCSO and/or NMSN, the Plan will enroll the Child(ren) for coverage, independent of the Participant, in the Kaiser Plan (assuming the Child[ren] resides in a Kaiser area). If the Child(ren) resides outside of a Kaiser service area and the Participant’s classification allows him a choice in Health Plan options, the Plan has the power and the discretion to enroll the Child(ren) using its best judgment in the interpretation of a QMCSO and/or NMSN. Please be aware that if the Child(ren) covered under a QMCSO and/or NMSN was enrolled in the Plan independent of the Participant, neither the Participant nor any other Dependents would be considered enrolled in the Plan until such time as the Participant has completed all Enrollment Procedures. Under such circumstances, the Participant may only enroll himself and any other eligible Dependents in the same Health Plan option as that of the Child(ren) covered under the QMCSO and/or NMSN.

**G. TERMINATION OF DEPENDENT ELIGIBILITY**

A Dependent's eligibility terminates when the Participant's coverage terminates or when the individual ceases to meet the Plan definition of an eligible Dependent. Eligibility for a Dependent Spouse, Domestic Partner, and Domestic Partner’s Child(ren), will also terminate if a Participant fails to repay the Plan any amounts owed as a result of maintaining an ineligible Dependent (even if such amounts are discharged in United States Bankruptcy Court or another Court).

**H. DEATH OF AN ACTIVE PARTICIPANT**

If a Participant dies, however, his or her Surviving Dependent’s coverage may continue until the Reserve Hour Bank is exhausted. After exhausting the deceased Active Participant's Reserve Hour Bank, Surviving Dependents may continue coverage at rates established by the Board of Trustees. A Dependent’s right to benefits under this Plan will terminate if:

1. A Surviving Dependent Spouse remarries.
2. A Surviving Dependent Child(ren) no longer meets the definition of an eligible Dependent child.

After exhausting the deceased Active Participant’s Reserve Hour Bank, Surviving Spouse/Child(ren) Continuation of Coverage is available to eligible Surviving Dependents under the Retiree Health and
Welfare Plan subject to the Participant having met the Plan rules prior to death. Retiree Plan benefit eligibility would be subject to timely receipt of required monthly premiums. (See Article XIII.)

A Surviving Spouse/Child who loses coverage because of remarriage or no longer meets the definition of an eligible Dependent child would not be eligible to continue coverage through COBRA if he or she exceeded 36 months of continuous coverage as a Surviving Spouse/Child(ren).

VIII. BLUE SHIELD

For information regarding Blue Shield’s Medicare provisions, please refer to Article XIII.

1. **Enrolling in Blue Shield:** Blue Shield provides both HMO and PPO options. The Participant’s place of residence will determine the Blue Shield Plan coverage available to the Participant and all of his or her eligible enrolled Dependents. If the Participant’s place of residence is within a Blue Shield HMO service area, the Participant and each eligible Dependent would need to select a contracting IPA/Medical Group and Primary Care Physician located within a 30 mile radius of the Participant’s residence. Under the Blue Shield HMO Plans, in order to qualify for coverage, medical services would need to be authorized by your selected IPA/Medical Group and the services themselves would need to be provided by one of the IPA/Medical Group’s panel providers.

Your Blue Shield ID Card will identify the Blue Shield Plan option that you are covered under and if your coverage is under the Blue Shield HMO option, your ID card will also provide the name of your Primary Care Physician and the name, address and telephone number of your selected IPA/Medical Group. You would need to contact your selected IPA/Medical Group directly concerning authorization for any medical services.

You should refer to your Blue Shield Evidence of Coverage (EOC) for information about your Blue Shield Plan. However, please be aware that some services listed in your Evidence of Coverage (EOC) may not be available under all of the Blue Shield HMO Physician Group Plans. Some services listed in your EOC which are not covered by some IPA/Medical Group Plans include: family planning; contraceptive services, including emergency contraception; sterilization, tubal ligation at the time of labor and delivery; infertility treatments; or abortion. In order to determine whether services listed in the EOC are available under a specific IPA/Medical Group Plan, you may contact your doctor, medical group, independent practice association or clinic or the Member Services Department at (800) 642-6155 to obtain specific information on coverage for health care services.

2. **Contacting Blue Shield:** For Participants residing in the Blue Shield HMO service areas, questions should be addressed to Blue Shield's Member Services at (800) 642-6155. Participants can also access the Blue Shield website located at www.blueshieldca.com for panel provider information. Participants who reside outside of Blue Shield's HMO service area may also contact Blue Shield Member Services at (800) 642-6155. However, be aware that different levels of benefits apply.

IX. KAISER

1. **Enrolling in Kaiser:** If you reside in a Northern California Kaiser Service Area, you have the option to enroll yourself and your eligible Dependents in the Kaiser Permanente Health Plan option “Kaiser”. Kaiser does not provide benefits for Participants residing outside of the Northern California Kaiser Service area. Kaiser members must receive all covered care from Providers at Northern California Kaiser Plan Facilities,
except in emergency situations. Kaiser's medical care program provides access to services such as routine care with your own personal Plan Physician, hospital care, laboratory, pharmacy services, and many other benefits described in the Kaiser Disclosure Form and Plan booklet. At most Northern California Kaiser Plan Facilities, you can usually receive all of the covered services you may need, including specialty care, pharmacy, and lab work. For information regarding Kaiser Senior Advantage, please refer to Article XIII.

Office visits and many of the services you receive at Kaiser are subject to a co-payment, which is due at the time of service.

You should refer to your Kaiser EOC for information about your Kaiser HMO Plan.

2. **Contacting Kaiser:** Kaiser's Member Services can be reached at (800) 464-4000 to answer questions about your benefits, available services, and the facilities where you can receive care. You can also contact Kaiser through their website at www.kp.org.

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### X. CONTINUATION OF COVERAGE (Active Participants Only)

#### A. ACTIVE SUBSIDIZED SELF-PAY

If your Active Participant coverage terminates due to (1) disability, or (2) unemployment, or (3) you have returned to work and are working short hours, you may be eligible for certain benefits and life insurance at a subsidized rate as determined by the Board of Trustees through the Plan’s Active Subsidized Self-Pay Coverage. Participants who are eligible for Active Subsidized Self-Pay Coverage make premium payments directly to the Plan, with the first payment to be received by the bank by the 20th day of the month following the date coverage would otherwise terminate and each month thereafter, if applicable. **This amount is subject to change and may increase in the future, at the Board of Trustees’ discretion.** Partial payments and/or credits under $10.00 and/or erroneous payments may not be refunded.

**NOTE:** Active Subsidized Self-Pay Coverage includes Medical, Prescription Drugs, Life Insurance, and Accidental Death and Dismemberment benefits only. **It does not cover Dental, Orthodontia, Hearing Aid, and Vision.**

You may receive an Active Subsidized Self-Pay enrollment and billing statement on or around the 1st of the month in which Plan coverage/eligibility terminated. You should also expect to receive a COBRA notification. Payment for coverage is due by no later than the 20th day of the coverage month. After your first full payment is received and processed by the bank, eligibility will be retroactively reinstated to the first of the coverage month (listed on your billing statement). Please be aware that timely payments are required to maintain coverage under Active Subsidized Self-Pay. **Important: Your eligibility and/or benefits cannot be verified until after full payment has been received and processed by the bank.** This may take several business days. You cannot choose a coverage month and coverage must be continuous from your initial loss of coverage or payments will be returned to you. For example, if your loss of coverage is July 1st, you must pay for July coverage in order to make any subsequent Self-Payments.

A Participant is responsible for monitoring his or her hours. When you know and/or determine that your Reserve Hour Bank is low, you should contact the Trust Fund Office to determine if you are eligible to make Active Subsidized Self-Payments.

1. **Active Subsidized Self-Pay Coverage is available only to Participants who meet ALL of the Following Plan rules:**

   (i) Must be a member in good standing with UA Local 342; **and**
(ii) Is not (and has not) performed non-covered work in the Pipe Trades Industry; and

(iii) Must be either: (1) disabled; or (2) unemployed and on the out of work list and available for work; or (3) have returned to work and are working short hours; and

(iv) Must have been covered under the Plan for at least twelve (12) consecutive months preceding the loss of employment based on: (a) hours worked in Covered Employment; and/or (b) Reserve Hour Bank; and/or (c) months of extended coverage due to disability; and/or (d) Active Subsidized Self-Payment (excluding COBRA coverage) or the Participant worked a minimum of 1500 hours in Covered Employment during the 24 months immediately preceding the coverage termination date; and

(v) A Participant and/or his current or former spouse and/or other Dependent does not owe any money (unless on an approved payment plan) to the Northern California Pipe Trades Health and Welfare Plan, the Northern California Pipe Trades Pension Plan, the Northern California Pipe Trades Supplemental 401(k) Retirement Plan or any other entity administered by the Northern California Pipe Trades Trust Fund Office; and

(vi) Must have their monthly payment(s) received by the bank no later than the 20th day of the coverage month.

Participants may be eligible for up to a maximum of twelve (12) consecutive months of Active Subsidized Self-Payments. Participants may receive an overall maximum of eighteen (18) months of Active Subsidized Self-Payments in any consecutive thirty-six (36) month period commencing with Active Subsidized Self-Payments made for eligibility on or after June 1, 2010. After exhausting Active Subsidized Self-Payments, the eighteen (18) month COBRA continuation period will be reduced by the number of Active Subsidized Self-Payments made. For example: If you are eligible to make twelve (12) months of Active Subsidized Self-Payments, you may continue to make COBRA payments for up to an additional six (6) months. After exhausting Active Subsidized Self-Payments, if you choose to continue coverage through COBRA, you will only be eligible to elect the Core Coverage option (Medical and Prescription Drug coverage) for the remaining six (6) months.

2. **Special Plan Rules for Residential and Tradesman/Serviceman, and Other Special Contract Employees to be eligible to make Active Subsidized Self-Payments:**

   (1) Must be a member in good standing with UA Local 342; and

   (2) Is not (and has not) performed non-covered work in the Pipe Trades Industry; and

   (3) Must be either: (a) disabled; or (b) unemployed and on the out of work list and available for work; or (c) have returned to work and are working short hours; and

   (4) Must have been covered under the Plan for at least twelve consecutive months preceding the loss of employment based on: (a) hours worked in Covered Employment; and/or (b) Reserve Hour Bank; and/or (c) months of extended coverage due to disability; and/or (d) Active Subsidized Self-Payment (excluding COBRA coverage) or the Participant worked a minimum of 1500 hours in Covered Employment during the 24 months immediately preceding the coverage termination date; and

   (5) A Participant and/or his current or former spouse and/or other Dependent does not owe any money (unless on an approved payment plan) to the Northern California Pipe Trades Health and Welfare Plan, the Northern California Pipe Trades Pension Plan, the Northern California Pipe Trades Supplemental Pension Plan or any other entity administered by the Northern California Pipe Trades Trust Fund Office; and

   (6) Must have their monthly payment(s) received by the bank no later than the 20th day of the coverage month.

Participants may be eligible for up to a maximum of four (4) consecutive months of Active Subsidized Self-Payments. Participants may receive an overall maximum of six (6) months of Active Subsidized Self-Payments in any consecutive thirty-six (36) month period commencing with Active Subsidized Self-Payments made for eligibility on or after June 1, 2010. After exhausting Active Subsidized Self-Payments, the eighteen (18) month COBRA continuation period will be reduced by the number of Active Subsidized Self-Payments made. For example: If you are eligible to make four (4) months of Active
Subsidized Self-Payments, you may continue to make COBRA payments for up to an additional fourteen (14) months. After exhausting Active Subsidized Self-Payments, if you choose to continue coverage through COBRA, you will only be eligible to elect the Core Coverage option (Medical and Prescription Drug coverage) for the remaining fourteen (14) months.

3. **Non-Bargaining and Subscription Agreement Employees:** Non-Bargaining and Subscription Agreement Employees are not eligible to make Active Subsidized Self-Payments.

4. **Non-Payment of Active Subsidized Self-Payments:** Once you cease making Active Subsidized Self-Payments and/or complying with the Payment Plan, you automatically forfeit your right to make Active Subsidized Self-Payments until you re-qualify for this type of coverage as required above.

**B. DISABILITY EXTENSION**

1. **Eligibility for Coverage:** You may be eligible for an extension of your Health and Welfare coverage under the Plan if, at the time of your disability claim effective date and throughout your disability, you continue to meet **ALL** of the following requirements:

   (1) You are a member in good standing with UA Local 342; **and**
   (2) You are current in paying Union dues; **and**
   (3) You are **not** working in non-covered employment in the Pipe Trades Industry; **and**
   (4) You have **not** paid, been charged or owe a reinstatement fee to UA Local 342 during the 3 months immediately preceding your claim effective date; **and**
   (5) You have **not** been notified of any monies owed to the Northern California Pipe Trades Health and Welfare Plan and/or related Trust Funds administered by the Trust Fund Office - **or** - You have entered into a repayment agreement with the Plan for any monies you owe - **or** - The Trust Fund Office is not pending additional documentation to determine if you do owe any monies; **and**
   (6) You have at least 11 consecutive months (12 months total including eligibility in the month disability began) of Active eligibility through Hours Worked and/or your Reserve Hour Bank and/or Disability Extension and/or Active Subsidized Self-Payments (excluding COBRA) immediately preceding your claim effective date; - **or** - You have at least 1 month of Active eligibility through Hours Worked and/or your Reserve Hour Bank and/or Disability Extension and/or Subsidized Self-Payments (excluding COBRA) immediately preceding the Participant’s claim effective date in the 3 month period prior to your claim effective date **AND** have at least 1000 hours worked in Covered Employment during the 36 months immediately preceding your claim effective date; and
   (7) You are unable to work for at least 14 consecutive days in 1 calendar month and are receiving either Workers’ Compensation Benefits or State Disability Insurance Benefits; **and**
   (8) You are not receiving Retirement benefits from the Northern California Pipe Trades Pension Plan unless you are on an approved return-to-work list; **and**
   (9) Your application is submitted within 90 days of your claim effective date (date of disability) and is approved by the Plan. If your application is not submitted within 90 days of your claim effective date special rules may apply. (e.g., the Plan may include a 90 day look back period for eligibility, provided you are currently disabled.); however, the Plan may deny an application and/or modify a claim effective date on an application received beyond the carrier’s retroactive enrollment limitations.

2. **Lag Month Rule Applies:** The Plan’s lag month eligibility rule applies.

   **EXAMPLE:** If a Participant submits proof of disability for August 1st through August 20th, coverage may be granted for October eligibility (based on the August work month providing October eligibility). If the Participant submits proof of disability for August 1st through August 5th, disability coverage would not be granted for October eligibility.

3. **Lifetime Maximum:** A Participant may receive up to a maximum of 24 months of the Disability
Extension for any/all Disability Extensions (effective for all Disability Extensions granted on or after January 1, 2007).

4. **Maximum:** A Participant who is eligible to receive the Disability Extension Benefit may be entitled to receive a maximum of 12 months per period of disability but not to exceed the Plan’s 24 month Disability Extension Lifetime Maximum. **If a Participant is classified as disabled beyond 12 months in a period of disability by a Governmental Entity or Workers’ Compensation Carrier subject to all other Plan provisions and limitations, the Participant may qualify for up to the 24 month lifetime maximum during this period of disability.**

5. **Exclusions:** Residential, PG&E, MLA Helper, Non-Bargained, Some Tradesman/Serviceman and certain other special Contract Employees are not eligible for this particular benefit.

If a Participant was covered under a classification excluded from the Disability Extension of Benefits on his or her disability claim effective date, the Participant may still qualify for this Benefit if he or she meets all other Plan requirements under a classification that would otherwise qualify the Participant for the Disability Extension of Benefits.

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**XI. COBRA CONTINUATION COVERAGE**

**A. ELIGIBILITY FOR COBRA**

A federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), requires group health plans offer terminated Employees and their Dependents the opportunity to continue their plan health coverage that would otherwise be terminated (called "COBRA Continuation Coverage" or "COBRA") in certain instances (called "qualifying events"). To receive this continuation coverage, the Employee, Spouse and/or Dependent(s) must make timely monthly payments (including the billing statement) directly to the Bank.

When you no longer have sufficient hours in your Reserve Hour Bank, your COBRA coverage will run concurrently with any continuation of coverage described in Article X, Section A. **In other words, your COBRA extension period is reduced by the number of months under Active Subsidized Self-Pay coverage.**

Even if you do not elect COBRA continuation coverage, your Spouse and each of your eligible Dependents have a separate right to elect it. You, your Spouse and your eligible Dependents should all read this section of your benefit booklet.

**A qualifying event is any of the following:**

1. The death of the Participant;
2. The Participant’s termination of employment (except for gross misconduct);
3. A reduction in the Participant’s hours;
4. The divorce or legal separation (e.g., obtained final divorce decree or no longer residing together) of the Participant and his or her spouse; or
5. A child no longer meets the definition of a Dependent.
6. Participant becomes entitled to Medicare.

To receive this COBRA coverage, a Participant and/or his eligible Dependents must: (1) timely notify the Trust Fund Office of his/her Qualifying Event, (2) file a timely application following the Qualifying Event and, (3) make monthly self-payments in an amount determined by the Board of
Trustees directly to the Bank Depository (designated by the Trust Fund Office), including the payment stub.

B. COBRA RULES

1. Upon payment of the required monthly premium (which is usually set at 102% of the applicable cost of medical coverage), you and/or your Dependent(s) may elect COBRA Continuation Coverage as follows:

   (a) Termination of Employment or Reduction in Hours. A Participant or Dependent may elect COBRA for medical benefits and prescription drug coverage only (core), or medical, prescription drug, dental and vision coverage (core and non-core benefits) for a period of up to 18 months if you lose your health coverage due to a termination of your Covered Employment or a reduction in hours (including having used all hours in your Reserve Hour Bank), unless such termination is due to your Gross Misconduct. This 18 month period is reduced by the number of months of Active Subsidized Self-Pay described in Article X, Section A above.

   By electing COBRA Continuation Coverage, you will be electing to maintain benefits on behalf of you and/or your eligible Dependents. If you do not elect COBRA Continuation Coverage, your spouse may independently elect such coverage on behalf of himself or herself and eligible Dependents if applicable and pay the required premium.

   (b) Disability-Extended Coverage for 29 Months. For an additional premium and subject to certain notice provisions, an Employee or other eligible Dependent may elect continuation coverage for up to an additional 11 months if the Employee or eligible Dependent is determined by the Social Security Administration to be totally and permanently disabled within sixty days of the date of the Employee's termination of employment or reduction in hours (e.g., the qualifying event which invoked COBRA coverage). You pay 150% of the applicable premium for the additional 11 months of coverage. To qualify for this special extended COBRA eligibility, you must report the Social Security Disability determination to the Trust Fund Office before the initial 18 months of COBRA coverage expires (and within 60 days after receipt of the Social Security Disability determination). This disability extension ends immediately if the disabled individual fully recovers from the disabling condition.

2. Thirty-Six Month COBRA Coverage for Dependents: A Dependent spouse or child who would otherwise lose health coverage will be eligible for COBRA continuation coverage for up to 36 months as a result of one the following qualifying events:

   (1) the death of the Employee; or
   (2) divorce or legal separation of the Employee and spouse; or
   (3) a child ceases to meet the Plan's definition of an eligible Dependent.

3. Multiple Qualifying Events: An 18 month period of COBRA continuation coverage may be extended for up to 36 months for your spouse or Dependent child if a second qualifying event occurs (such as your death or divorce, or your child no longer qualifies for coverage, or you become entitled to Medicare) within the first 18 month period. In no event, however, will such coverage extend beyond 36 months from the date coverage was first lost due to the initial qualifying event.

   EXAMPLE: A Participant’s Spouse is on COBRA continuation coverage due to the Participant’s termination of employment. The Participant passes away after 12 months of coverage during the 18 month period. His or her death is a second “qualifying event”, which entitles the spouse to the remaining balance of 24 months (36 month maximum minus the 12 months that has already been covered).

The period of coverage under this section is reduced by any period in which the Employee or Dependent was provided coverage through the Plan’s Active Subsidized Self-Pay provisions.
C. ELECTION OF COBRA COVERAGE

The Trust Fund Office will provide you with COBRA coverage and enrollment information within 45 days of receiving written notification of a qualifying event entitling you and/or your Dependent(s) to COBRA coverage. You and/or your Dependent(s) must elect COBRA coverage within 60 days after your Plan coverage ends or the date you receive the election form, whichever is later. Anyone electing COBRA coverage must pay for it retroactive to the date he or she lost coverage under the Plan. Payment for this retroactive coverage is due within 45 days after the date COBRA coverage is first elected. After this first premium, there is a 30-day grace period for making future COBRA payments. No benefit claim will be honored unless the Trust Fund Office has received the required payment for the period in which the claim was incurred. If you elect COBRA, you will be entitled to the same health coverage that is provided to Active Employees and Dependents in the Plan. Therefore, if there are any changes to the Plan for Active Employees, your benefits will also change.

Active Subsidized Self-Pay For Coverage. If your loss of coverage is due to a reduction in hours of termination of employment and you were eligible for coverage under the Active Subsidized Self-Pay Plan provisions prior to your loss of coverage, you may be eligible to make Active Self-Payments to the Plan at a rate determined by the Board of Trustees. Please note the time period for your COBRA continuation coverage will be reduced by your months of Active Subsidized Self-Pay. You have the option of electing one of the following COBRA Plans and paying the designated premiums:

1. **CORE COVERAGE** - Provides coverage for medical and prescription drugs only.
2. **CORE AND NON CORE COVERAGE** - Provides coverage for medical, prescription drugs, dental, orthodontia, vision and hearing aid.

The premiums for COBRA will increase each year. You have the option of changing Medical Plans while covered under COBRA, subject to residing within the HMO’s service area, and remittance of the applicable COBRA payment for the Medical Plan you have elected.

D. YOUR OBLIGATION TO NOTIFY THE TRUST FUND OFFICE

You or your eligible Dependents are required to notify the Trust Fund Office if (1) you become divorced or legally separated (including an unofficial separation where you no longer live with your covered spouse) or (2) your separated spouse obtains sole custody of his/her Dependent child(ren) or (3) you or your Dependent enrolls in Medicare Part A or B, after electing COBRA continuation coverage, or (4) if there are any other changes in life circumstances that may affect your or a Dependent's eligibility for Plan benefits.

Plan Participants are also required to immediately notify the Trust Fund Office if your spouse or certain enrolled Dependents no longer reside with you. Once your Dependent spouse no longer resides in your home, that Dependent would no longer meet the definition of an eligible Dependent and consequently would not qualify for coverage under the Plan. Please be aware that a spouse no longer residing in the Participant’s home, resulting in an unofficial separation by joint decision, is a basis for termination of the separated spouse’s coverage and a COBRA qualifying event under the Plan provided the Trust Fund Office is notified within 120 days of the date of a separation (legal or by joint decision). A spouse who no longer resides in your home will be allowed the opportunity to purchase coverage at an unsubsidized rate determined by the Board of Trustees for up to six months after the date of separation through the Plan’s Separated Spouse Coverage. If, within the 6-month period, you file for a legal separation or obtain a final divorce decree, coverage may be extended for a total period not to exceed 36 months (including the first six months of purchased coverage). Please note that any time allowed under the Separated Spouse Coverage will be reduced by the COBRA continuation coverage period.
E. TERMINATION OF COBRA COVERAGE

COBRA continuation coverage will end before the 18-, 29- or 36-month continuation coverage period expires if:

1. **Failure to Timely Pay Premium:** You and/or your Dependent(s) fail to pay the required contribution on time; or
2. **Coverage Under Other Plan:** You or your Dependent(s) become covered by another group health plan after your COBRA election; or
3. **Medicare Entitlement:** You or your Dependent(s) become entitled to Medicare after having elected COBRA; or
4. **No Longer Disabled:** You or your Dependent(s) qualified for 29-month maximum continuation period based on disability, but are no longer disabled; or
5. **Employer No Longer Contributes:** The Employer who was making Plan contributions on your behalf ceases to be a Contributing Employer or withdraws from the Collective Bargaining Agreement; or
6. **No Active Plan:** The Trust Fund and your Employer cease to maintain any health plan for Active Employees or Retirees.

F. CALIFORNIA CONTINUATION BENEFITS REPLACEMENT ACT (Cal-COBRA)

Under the California Continuation Benefits Replacement Act (“Cal-COBRA”), Small Employers with 2 to 19 employees are required to offer terminated Employees and their Dependents the opportunity to continue health insurance coverage. Cal-COBRA is the California program that is similar to Federal COBRA. If applicable, once you have exhausted Federal COBRA Continuation Coverage which generally lasts for up to 18 months, Cal-COBRA may extend continuation coverage for an additional 18 months, up to a combined total of 36 months. However, Employers with over 20 or more employees are subject to Federal COBRA. Please contact the Plan’s Carriers (Kaiser and Blue Shield) for Cal-COBRA eligibility questions.

XII. Patient Protection and Affordable Care Act

A. **Grandfathered Plan**

The Board of Trustees believes this Plan is a “Grandfathered health plan” under the federal law known as the Patient Protection and Affordable Care Act of 2010 (“ACA”). As permitted by the ACA, a Grandfathered health plan can preserve certain basic health coverage that was already in effect when the ACA was enacted. Being a Grandfathered health plan means that the Plan is not required to include certain consumer protections of the ACA that apply to other plans, for example, requiring the provision of preventive health services without any cost sharing. Grandfathered health plans must comply, however, 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 please visit [www.Healthcare.gov/glossary/essential-health-benefits](http://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 Fund Manager. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor (DOL) at 1–866–444–3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans. Implementation of the ACA’s provisions began with the July 1, 2011, Plan Year.
B. **No Pre-Existing Condition Exclusions for Any Individual.**

The ACA prohibits insurance plans in the individual and group markets from imposing pre-existing condition exclusions on any individual for Plan Years beginning after January 1, 2014, except for Grandfathered individual policies. This ban includes both benefit limitations (e.g., an insurer or employer health plan refusing to pay for chemotherapy for an individual with cancer because the individual had the cancer before getting insurance) and outright coverage denials (e.g., when the insurer refuses to offer a policy to the individual because of the individual’s pre-existing medical condition).

C. **Dependent Child Coverage Through Age 25**

In accordance with the ACA, the Plan will permit a Participant’s eligible Child(ren) to be enrolled and maintained as a Dependent through the end of the month in which the Child(ren) attains age 26, regardless of whether the Child(ren) are eligible for coverage through his or her own employer-sponsored group health plan (or his or her Spouse’s plan) and regardless of the Child(ren)’s marital status, student status, financial dependency, residency, or employment status.

D. **Individual Mandate & Minimum Essential Coverage**

With certain exceptions, the ACA requires you and your Dependents to have health coverage that qualifies as minimum essential coverage or pay a penalty for noncompliance. Minimum essential coverage includes jointly-sponsored coverage such as this Plan. The ACA also establishes a minimum value standard of benefits for health plans. Minimum value means coverage under a health plan (such as this Plan) meets the minimum value standard if the plan’s share of the total allowed costs of benefits provided is 60% or greater. If you are covered under the Plan, you meet the individual mandate. The Board of Trustees believes this Plan provides minimum essential coverage and meets the minimum value standard for the benefits it provides.

E. **Availability of Summary of Benefits & Coverage**

The ACA requires health insurers to provide a Summary of Benefits and Coverage, also known as the “SBC”, to Participants and their Dependents. The SBC is a standard format, written in easy-to-understand language, summary of what the Plan covers and what it costs. It is intended to help you understand and compare the different benefits and coverage options available to you under the Plan. Under the ACA, you also have a right to request and receive within 7 business days a copy of the Plan’s SBC in paper form, at any time and free of charge. If you want a copy of the Blue Shield of California HMO and/or PPO Plan SBC, please contact Blue Shield at 800-642-6155. If you want a copy of the Kaiser HMO Plan SBC, please contact Kaiser Permanente at 800-464-4000.

F. **Elimination of Lifetime and Annual Limits on Essential Health Benefits**

The ACA prohibits both grandfathered and non-grandfathered health plans from imposing lifetime and annual dollar limits on Essential Health Benefits. In accordance with the requirements of the ACA, this Plan does not impose any lifetime and annual dollar limits on its Essential Health Benefits. However, the Plan is permitted to impose annual limits on certain non-Essential Health Benefits.

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**XIII. RETIREE HEALTH AND WELFARE PLAN**

The Board of Trustees has established the Retiree Health and Welfare Plan on the basis that Employer Contributions for Active Participants will, if continued, partially maintain this Plan for Retirees. You will be required to pay a portion of the cost of coverage for Retiree Health and Welfare Benefits. It is recognized that the
benefits provided by this Plan can be paid only to the extent that the Plan has available adequate resources for those payments. **Benefits under this Plan are not vested, and can be changed or eliminated at any time. Monthly premium payments/deducts for Retirees are likely to increase.**

**ALERT**

YOU WILL NOT BE ELIGIBLE FOR RETIREE HEALTH AND WELFARE BENEFITS IF THE EMPLOYER CONTRIBUTION RATE NEGOTIATED WITH UA LOCAL 342 DOES NOT ALLOW FOR CONTRIBUTIONS TO PROVIDE RETIREE COVERAGE.

All retirees eligible for Retiree Health and Welfare coverage entitled to a gross monthly pension of $1,000 or greater from what the Retiree would be entitled to at Normal Retirement age at a single life annuity benefit (e.g., 60 month guarantee) from the NCPT Pension Plan, prior to any reduction in the pension as a result of the Election of a benefit option, Early Retirement, Qualified Domestic Relations Order ("QDRO") , Tax Lien or for any other reason, are required to pay a monthly premium to the Health and Welfare Plan as determined by the Board of Trustees. The above rule also applies to any current Retiree whose benefit was reduced to under $1,000 as a result of a QDRO. The Board of Trustees has the total and absolute discretion to establish the premium amount. **Monthly premiums may increase at any time at the discretion of the Board of Trustees without a formal Plan amendment.**

It is also possible that Retirees with a gross monthly Retirement Benefit under $1,000 may, in the future, be required to pay a monthly premium in order to maintain Retiree Health and Welfare coverage.

The Retiree Health and Welfare coverage includes medical, prescription drugs, dental, hearing aid, and vision care for the Retiree and/or his or her eligible enrolled Dependent(s).

To maintain coverage under the Northern California Pipe Trades Health & Welfare Plan, once a Retiree or Retiree's Dependent(s) becomes eligible for Medicare coverage, **enrollment in both Medicare Parts A and B is mandatory.** Currently Medicare Part D (Prescription Drug benefits) is part of your Medical Plan and no action is necessary by you at this time. If you earn a higher income, Federal Law also requires that you pay an additional premium, known as the Income-Related Monthly Adjustment Amount ("IRMAA") for your Medicare Part D Prescription Drug coverage to the Social Security Administration ("SSA"). The SSA will provide you with a Notice if it determines that the additional IRMAA premium applies to you. If your income level requires that you pay the additional IRMAA premium, you do not pay the premium to the Plan. Instead, you pay the premium directly to Medicare through (1) an automatic deduction from your Social Security Benefits or (2) direct billing by the Centers for Medicare and Medicaid services for individuals who do not receive Social Security Benefits or their benefit amount is not enough to cover the premium owed. For more information on the additional premium or Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227) or visit [www.medicare.gov](http://www.medicare.gov). TTY users should call 1-877-486-2048.

If an individual does not enroll in Part B when he or she becomes entitled to Medicare coverage, he or she may lose coverage under his or her Medical Plan option (Kaiser or Blue Shield of California) and additional premium amounts would be applicable to continue participation in the Retiree Health and Welfare Plan. **FAILURE TO NOTIFY THE TRUST FUND OFFICE REGARDING YOUR AND/OR YOUR DEPENDENT(S) MEDICARE ELIGIBILITY MAY IMPACT YOUR COVERAGE.** In addition, it is also your obligation to notify the Trust Fund Office in writing when your Dependent(s) no longer meets the definition of an eligible Dependent. You will be required to complete a new Enrollment/Change Form.

**A. ELIGIBILITY RULES**

1. **General Requirements:** To be eligible for Retiree Health and Welfare coverage, a Participant must:

   (1) Have been eligible through hours worked (including maintaining the minimum amount of hours in the Reserve Hour Bank, Active Subsidized Self-payment, or Disability Extension (excluding COBRA payments and Incoming Reciprocity) under a classification that permits Retiree Health and Welfare Benefits (based on Employer Contributions paid) through the Northern California Pipe Trades Health and Welfare Active Plan (“NCPT Active Plan”):
a. Have been eligible under the NCPT Active Plan for at least 12 of the last 18 consecutive months immediately preceding his or her Date of Retirement in a classification that provides for and contributes the required amount of Employer Contributions to the Retiree Health and Welfare Plan; or

b. Have been eligible for at least one (1) month in the 18 month period immediately preceding his or her Date of Retirement, providing the Participant has earned at least 25 years of Benefit Credits and 25 years of Vesting Credits (excluding Pro Rata Reciprocal Credits and Contiguous Service Vesting Credits) and has not had a gap in coverage in the Active Plan of more than 36 continuous months in the 10 year period immediately preceding his or her Date of Retirement; or

c. Have worked at least 1500 hours in Covered Employment in a classification that provides for and contributes the required amount of Employer Contributions to the Retiree Health and Welfare Plan in the 24 month period immediately preceding his or her Date of Retirement; and

ALERT: Contact the Trust Fund Office if you have a questions or concerns as to whether your Employer is contributing the required contribution to the Retiree Health and Welfare Plan. This issue will arise more if you are having funds reciprocated from another UA Local Health and Welfare Plan that has lower contribution rates and/or you are working under an Agreement, such as the Residential Agreement (and others), that does not provide for the required contributions to the Retiree Health and Welfare Plan.

(3) Have at least 15 years of Benefit Credits and 15 years of Vesting Credits at any age or at least 13 years of Benefit Credit and 13 years of Vesting Credit for Participants age 55 or over, exclusive of (a) Pro Rata Reciprocal Credits and/or (b) Vesting Credit for Contiguous Service as defined in the Northern California Pipe Trade Pension Plan, and Retiree Health and Welfare contributions have been made for the same years of required Benefit Credits (15 years or 13 years excluding COBRA payments and Incoming Reciprocity)

If a Participant was on an authorized leave of absence due to Military Service in the Armed Forces of the United States or was in the Reserves and drafted to Active Duty, in accordance with the Veterans’ Readjustment Assistance Act, the Uniformed Services Employment and Reemployment Rights Act of 1994, and/or other applicable Federal Law, the Plan will allow up to a maximum of five (5) years of Military Service Credits toward eligibility for Retiree Health and Welfare Benefits assuming the Plan Participant met the Eligibility Requirements for Military Service Vesting Credits and Benefits Credits. Only service in the Armed Forces of the United States for which Military Service Credit is required under the above-referenced Federal Laws will be considered under this subsection.

Military Service Credits (Benefit Credits and Vesting Credits) will not apply toward Retiree Health and Welfare Benefits when Military Service is voluntary or for enlistment in the Reserves.

(3) Be a Member in Good Standing with UA Local 342; and

(4) Be receiving a monthly Retirement Benefit from the Northern California Pipe Trades Pension Plan and (no longer be working in the Plumbing and Pipe Trades Industry unless pre-approved by the Board of Trustees); and

(5) Not have worked in Non-Covered Employment in the Plumbing and Pipefitting Industry at any time after becoming a member of UA Local 342 unless approved by the Board of Trustees; and

(6) Submit timely monthly retiree premiums for such coverage (if applicable). NOTE: The Board has the authority to charge higher premium amounts for Retiree Health and Welfare coverage if the Board has evidence that an eligible Retired Participant has committed fraud against the Plan (such
as enrolling ineligible Dependents) and failed to repay amounts owed to the Plan as a result. Any such Participant who has enrolled and/or maintained an ineligible Dependent and failed to repay such amounts (or make arrangements to pay such amounts over time) will be required to pay an additional premium for Retiree Health and Welfare Coverage, which is currently $500 per month. This fee can be changed in the future by motion of the Board of Trustees.

(7) For any Participant retiring under this Plan, the 12 out of the last 18 consecutive months requirement is waived for certain government work provided the Participant worked continuously in such Government Employment from the time he left Covered Employment (unless he was on the UA Local 342’s "out of work" list between such work and his Covered Employment) to his Date of Retirement or later. Such government work must be work that is in the Plumbing and Pipefitting Industry as determined by the Board of Trustees, with input from UA Local 342. The Participant must provide proof of such government work from his Employer as requested by the Trust Fund Office and otherwise must cooperate with the Trust Fund Office for any request for documentation of such work.

(8) If the Retired Participant owes any amount to the Plan as a result of having enrolled and/or maintained an ineligible Dependent and the Retired Participant fails to repay such amount (or any amounts owed to the NCPT Pension and/or Supplemental 401(k) Retirement Plan), irrespective of whether such amount was discharged in U.S. Bankruptcy Court or any other Court, then any Surviving Dependents will no longer qualify for Surviving Dependent Health and Welfare coverage. In addition to the regular premium amount, the Retired Participant would be required to pay an additional $500/per month.

(9) A Retiree may return to Covered Employment once, and not forfeit his or her Retiree Health and Welfare Benefits. Thus, upon reinstatement of the Retiree’s Retirement Benefits, the Plan will allow a one-time only reinstatement of Retiree Health and Welfare Coverage.

Any subsequent termination of a Retiree’s Health and Welfare Coverage due to return to Covered Employment will result in a permanent termination of Retiree Health and Welfare Coverage. Also see Warning about Re-employment for additional information (Subsection 9 below).

The Trustees have established eligibility rules but retain their right to amend those rules as they deem necessary. The Board may change these rules at any time in the future. Some classifications may not be entitled to certain benefits. Eligibility for Retiree Health and Welfare Benefits is determined based on Plan Rules at the time of Retirement. Health and Welfare Benefits are not vested.

2. **Timely Receipt of Retiree Health and Welfare Benefit Application:** An eligible Participant, in addition to meeting the “General Requirements” above, must timely submit a Retiree Health and Welfare Benefit Application and Enrollment/Change Form (including required documentation) to the Trust Fund Office. An eligible Participant may become eligible on the later of, the Date of Retirement under the Northern California Pipe Trades Pension Plan or the first of the month following receipt of notification that his or her Application for Retirement Benefits has been approved and subject to receipt of the Retiree Health and Welfare Application.

3. **Loss of Union Membership:** If you lose your UA Local 342 Union Membership and/or are no longer considered a member in good standing, you will lose Retiree Health and Welfare Coverage effective the 1st of the following month after the Trust Fund Office receives notification from UA Local 342.

**EXAMPLE:** If the Trust Fund Office receives notification from UA Local 342 stating that you are no longer a member in good standing effective January 15th, coverage would terminate effective February 1st. Loss of Union membership and/or being a member in good standing resulting in the termination of coverage is NOT considered a COBRA qualifying event. Therefore, you will not be eligible for COBRA coverage.
4. **Reinstatement of Coverage after Reinstating Union Membership:** If you once again become a member in good standing with UA Local 342 and previously lost Retiree Health and Welfare coverage, you may have coverage reinstated effective the 1st day of the following month after the Trust Fund Office receives notification from UA Local 342.

   **EXAMPLE:** If the Trust Fund Office receives notification from UA Local 342 stating that you are once again a member in good standing effective January 15th, coverage would be reinstated effective February 1st.

Reinstatement of coverage is contingent upon your timely submission of any Retiree Health and Welfare premiums due, if applicable.

5. **Disability Extension removed due to Retirement:** A Participant is not eligible for Disability Extension benefits beyond the Date of Retirement, because Active Benefits cannot be provided during a period of Retirement. If a Disability Extension has been granted and a Participant retires retroactively, the Disability Extension will be removed and the Reserve Hour Bank will be used to provide eligibility, if a Reserve Hour Bank is available. A Retired Participant may be covered under the Active Plan’s Disability Extension Benefit for those months that the Participant qualified for the benefit while covered under the Active Plan.

   **EXAMPLE:** A Participant is covered under the Active Plan and qualifies for the Disability Extension Benefit in May and June (qualification for May disability would provide July eligibility and qualification for June disability would provide August eligibility). If the Participant were to retire and commence receiving a Pension effective July 1st, the Participant will be allowed to remain in the Active Plan coverage under the Disability Extension Benefit for the months of July and August. **Note:** The maximum that can be allowed under the Plan’s eligibility rules would be one month of Active Plan coverage under the Disability Extension Benefit after a Participant’s Date of Retirement under the Northern California Pipe Trades Pension Plan.

Please refer to Article X, Section B for a detailed explanation of the Disability Extension Benefit.

As a reminder, if your Retirement Benefits under the Northern California Pipe Trades Pension Plan are retroactive, Supplemental Disability Benefits (through UA Local 342) will be required to be repaid (Contact UA Local 342 for information on Supplemental Disability Benefits).

6. **Retiree Coverage for Individual Employers / Associations / Related Groups:** Retiree coverage may be maintained for Non-Bargaining Unit Employees and Owner/Manager Employees and their eligible Dependent(s) or their eligible Surviving Dependents at the same monthly premium rate as other eligible Retirees or Surviving Dependents under the Retiree Health and Welfare Plan, who satisfy at least three (3) of the following five (5) conditions:

   (1) The Participant/Retiree is a UA Local 342 Member in good standing;
   (2) The Participant/Retiree has a minimum of five (5) years of Vesting Service Credit with contributions from UA Local 342 Employers (e.g., not by way of Pro Rata Reciprocal Credits);
   (4) The Participant/Retiree is 58 years of age or older;
   (5) The Participant/Retiree has a minimum of fifteen (15) years in which contributions (exclusive of COBRA) have been made to the Northern California Pipe Trades Health and Welfare Plan; and
   (6) The Participant/Retiree served as a Trustee and/or Alternate Trustee and/or was employed at a related entity for a minimum of ten (10) years (120 months) with at least six (6) months of Active Health and Welfare coverage in the twenty-four (24) months immediately preceding Retiree Health and Welfare coverage.

In addition, Surviving Dependent coverage will apply under the same criteria as other Surviving Dependents.
7. **Surviving Spouse/Dependent Coverage:** When the Retiree passes away and you are eligible for and you elect Surviving Dependent Health and Welfare Benefits (which are the same as Retiree Health and Welfare Benefits), the Plan provides for one additional month of Retiree Health and Welfare coverage for eligible Dependents at the Retiree monthly premium rate.

**EXAMPLE:** A Retiree paid $110 during March 2014 and subsequently passes away on March 29, 2014. The Surviving Dependent of the Retiree chooses to elect Surviving Dependent coverage. The Surviving Dependent will pay the monthly premium for April 2014 at the same rate as that paid by the Deceased Retiree for his/her last month of coverage ($110). Therefore, the Surviving Dependent will pay the premium rate of $110. However, effective May 1, 2014, the Surviving Dependent’s premium rate would be based on the Surviving Dependent premium current rate of $220/month for a Surviving Dependent with Medicare coverage. Monthly premiums are subject to increase at any time at the discretion of the Board of Trustees without formal Plan Amendment.

If the Retired Participant’s Surviving Spouse and/or Surviving Dependent Child(ren) were eligible and enrolled as Dependents under the Participant’s Retiree Health and Welfare Plan at the time of the Participant’s death, the Surviving Spouse and/or Surviving Dependent Child(ren) may continue coverage offered at rates determined by the Board or Trustees. Surviving Spouses who remarry lose coverage immediately (effective the date of the marriage). The new spouse and/or any newborn child(ren) from the new marriage are also excluded from Retiree Health and Welfare Coverage. In addition, any Surviving Dependent Child(ren) would only be eligible to continue coverage providing that they continue to meet all other Plan requirements for Dependent Child(ren) including age requirements. Please refer to Article VII, Sections D, E, F and G. **Please be aware that for Surviving Dependent Child(ren), when reviewing the Eligibility Requirements Section, the term “Participant” should be substituted with either “Surviving Natural Parent” or “Legal Guardian”, whichever is applicable.**

Surviving Spouse and/or Dependent Child(ren) continuation of coverage as described above is provided in lieu of COBRA continuation coverage. Refer to the COBRA Article XI. As a result, please be aware that if a Surviving Spouse and/or Dependent Child(ren) no longer qualify for this continuation of coverage and have been covered for 36 or more months, COBRA benefits would not be available. However, if a Surviving Spouse and/or Dependent Child(ren) lose eligibility but have been covered for less than 36 months, the Surviving Spouse and/or Dependent Child(ren) would be eligible to continue coverage under COBRA for a total period not to exceed 36 months (including months of coverage purchased for Surviving Spouse and/or Dependent Child(ren) coverage).

If the Surviving Spouse and/or Dependent Child(ren) have alternate coverage at the time he or she is eligible for the continuation of coverage, he or she may choose to delay the Retiree Health and Welfare coverage until termination of the alternate coverage, provided that he or she notifies the Trust Fund Office in writing within a reasonable time prior to the other coverage’s termination date and subject to proof of such termination of prior coverage.

If the Participant’s Surviving Spouse and/or Dependent Child(ren) owes any amount to the Plan as a result of the Participant having enrolled and/or maintained an ineligible Dependent in the Plan and fails to repay such amount irrespective of whether such amount was discharged in U.S. Bankruptcy Court or any other Court, then the Surviving Spouse and/or Dependent Child(ren) do not qualify for Surviving Spouse/Dependent Health and Welfare coverage.

A Surviving Spouse and/or Surviving Dependent Child(ren) of a deceased Active Participant may be offered Surviving Dependent Continuation Coverage under the Retiree Health and Welfare Plan providing the deceased Participant met **ALL** of the following requirements:

1. The Surviving Dependent Spouse and/or Surviving Dependent Child(ren) were eligible for Pre-Retirement Death Benefits at the time of the Active Participant’s death; and
2. The Surviving Dependent Spouse and/or Surviving Dependent Child(ren) were eligible and enrolled as Dependents under the Participant’s Active Health and Welfare Plan at the time of the Participant’s death; and
3. The Surviving Dependent(s) meets the Plan definition of an eligible Dependent(s) under the Retiree Health and Welfare Plan (Article VII), however, no Domestic Partner coverage is available; and
4. At the time of the Participant’s death he or she had accrued a minimum of at least ten (10) years of Benefit Credits and ten (10) years of Vesting Credits, exclusive of Pro Rata Reciprocal Credits, without a Permanent Break in Service under the Northern California Pipe Trades Pension Plan; and
5. The Participant had Active eligibility through hours worked, Reserve Hour Bank, Disability Extension of Benefits, or Subsidized Self-Payments (excluding COBRA payments) under the Northern California Pipe Trades Health and Welfare Active Plan for at least 12 of the last 18 consecutive months immediately preceding his or her month of death in a classification requiring contributions to the Retiree Health and Welfare Plan; and
6. The Participant worked at least 1000 hours in Covered Employment during the 36 months immediately preceding the Participant’s month of death.

8. Termination of Coverage: Eligibility for Retiree/Surviving Dependent Health and Welfare benefit coverage will terminate if:

   (1) The required Retiree contributions (if applicable) are not made in a timely manner in accordance with the rules adopted by the Board of Trustees; and/or
   (2) The Retiree discontinues timely payment of the full required UA Local 342 Union dues (this is not applicable to Surviving Dependent Spouses/Surviving Dependent Child(ren)); and/or
   (3) The date Retirement benefits from the Northern California Pipe Trades Pension Plan terminate, including the return to Covered Employment.
   (4) If the Participant and/or the Participant’s current or former spouse or other Beneficiary owes any amount to the Plan as a result of the Participant having enrolled and/or maintained an ineligible dependent or for any other reason, and fails to repay such amount to the Plan irrespective of whether such amount was discharged in U.S. Bankruptcy Court or any other Court. As a result, the Participant and/or the Participant’s current spouse or other surviving Dependent no longer qualify for Retiree Health and Welfare coverage.

9. Warning about Re-employment:

   (a) A Retiree may return to Covered Employment one time without becoming ineligible for Retiree Health and Welfare Benefits. **Thereafter**, if a Retiree returns to Active Employment within the Pipe Trades Industry (“Industry Service”) that is not pre-approved by the Board of Trustees, the Retiree shall **immediately upon such reemployment become ineligible for Benefits and shall thereafter be ineligible for Retiree Health and Welfare Benefits**, even if he or she terminates such Industry service. As a result, before engaging in any employment in the plumbing and pipefitting industry after retirement that might in any way be considered “Industry Service”, a Retiree should submit a written request to the Trust Fund Office for guidance as to whether such employment might adversely affect his or her Retiree Health and Welfare Benefits.

   (b) If a Retiree returns to Covered Employment within the Pipe Trades Industry, which is pre-approved by the Board of Trustees of the Northern California Pipe Trades Pension Plan, such employment will not adversely affect his or her Retiree Health and Welfare Benefits. For Retirees who have obtained pre-approval by the Board to return to Covered Employment within the Pipe Trades Industry, Health and Welfare Benefits would be handled as follows:
Retiree and eligible Dependents with Medicare

- You will be allowed to maintain coverage under the Retiree Health and Welfare Plan until such time as you gain Active Health Plan coverage.
- Initial eligibility requirements for Active Health Plan coverage are waived. You are required to complete a new Active Enrollment/Change Form.
- If you or any enrolled Dependent has Medicare, once you gain Active Health Plan coverage, Medicare will be secondary payer. As a result, the Medicare eligible individual(s) will need to immediately complete a Blue Shield Medicare D Disenrollment Form or Kaiser Senior Advantage Plan (“KPSA”) Disenrollment Form.
- You will be enrolled in the Active Health Plan under your current Health Plan option (Blue Shield or Kaiser).
- You will be eligible for all Active benefits in accordance with the Health and Welfare Plan rules.
- You will not be required to pay monthly premiums if you work a minimum of 125 hours per month. As a reminder, eligibility is skip-month, so hours worked in May, will provide July eligibility; so premiums would not be due for July.
- You can accumulate excess hours up to a maximum of 6 months (750 hours) in a Reserve Hour Bank.
- If you do not have Eligibility, you qualify for Active Subsidized Self-Pay for a month in which you do not gain eligibility through hours worked.
- Once you cease working and have exhausted Active Health and Welfare eligibility, you are permitted to re-enroll in the Retiree Health Plan and will be responsible for payment of premiums, if applicable. You will be required to complete a new Retiree Health and Welfare Plan Enrollment/Change Form.
- If you or any enrolled Dependent has Medicare, once you re-enroll in the Retiree Health and Welfare Plan coverage, Medicare will be the primary payer. The Medicare eligible individual(s) will need to immediately complete a Blue Shield Medicare D Enrollment Form or Kaiser Senior Advantage Plan (“KPSA”) Enrollment Form.

Non-Medicare Retirees and Retirees without Retiree Health and Welfare Coverage

- Initial eligibility requirements are waived.
- You will be required to enroll in an Active Health Plan option (Blue Shield or Kaiser). You are required to complete a new Active Enrollment/Change Form.
- You will be eligible for all Active benefits in accordance with the Health and Welfare Plan rules.
- You will not be required to pay monthly premiums if you work a minimum of 125 hours per month. As a reminder, eligibility is skip-month, so hours worked in May, will provide July eligibility; so premiums would not be due for July.
- You can accumulate excess hours up to a maximum of 6 months (750 hours) in a reserve hour bank.
- If you do not have Eligibility, you qualify for Active Subsidized Self-Pay for a month in which you do not gain eligibility through hours worked.

At the time the Retiree ceases working and all known contributions are received, after exhausting any Reserve Hour Bank, Retiree Health and Welfare premium deductions (if applicable) will be implemented. Please be aware that if you remain employed beyond the time pre-approved by the Board, it may adversely affect your entitlement to Retiree Health and Welfare benefits. As a reminder, if you were not eligible for Retiree Health and Welfare benefits prior to this Return to Covered Employment, you will not be later eligible for Retiree Health and Welfare benefits in the future.

B. MEDICARE COORDINATION (YOU ARE REQUIRED TO ENROLL)

Medicare is our country’s federal health insurance program for people who worked at least ten 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 effective date. ALERT: If
you are not a citizen or permanent U.S. Resident, you may not be eligible for certain or all of the medical coverage under the Plan.

Under the Medicare program, the hospital insurance portion is called Medicare Part A, and the medical insurance portion, such as for the cost of physicians, is called Medicare Part B.

Currently, Medicare Part A is financed by payroll taxes, and, if you are eligible to receive it 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 Part B coverage. Most working people are entitled to Medicare Part A when they reach age 65 because either they or a spouse paid Medicare taxes while working.

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 must enroll in both Medicare Part A and Part B, as soon as you are eligible for Medicare. If you 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. Medicare Part D is also applicable to your participation in the Retiree Health and Welfare Plan.

**IMPORTANT NOTICE: ENROLL IN MEDICARE**

To be eligible for Retiree Health and Welfare benefits under this Plan you and/or your eligible Dependent(s) are required to formally and timely enroll in both Medicare Parts A and B and pay all the required applicable premiums for Part B and D as soon as you and/or your eligible Dependent(s) are entitled to coverage. Note: You and/or your eligible Dependents can only enroll in one Medicare Plan.

It is important that you enroll in Medicare Part B when you first become eligible. If you do not, Medicare generally imposes penalties which will significantly increase your Part B premium once you do enroll. If a person declines Part B when first eligible, the cost of enrolling in Part B at a later date may be increased by 10% for each full 12-month period that they should have had Part B. The Part B penalty can be waived if a person is still actively employed or their spouse is actively employed and the person has health insurance coverage under an employer/union group Health and Welfare Active Plan (the employer must have more than 20 employees) subject to Medicare changes.

For enrollment and eligibility information, you should call Social Security at (800) 772-1213. You can also find Medicare information on the internet at [www.medicare.gov](http://www.medicare.gov). To avoid loss of protection, you (or your Dependents) must enroll in Parts A and B of the Federal program during the three months before the month in which you (or your Dependents) will become eligible for Medicare. Social Security will automatically enroll you in Medicare Parts A and B. Moreover, if you and/or your Dependent are under age 65 but eligible for Medicare, you and/or your Dependent must also enroll for Parts A and B. Proof of Medicare status is required to maintain your coverage and avoid penalties in premiums.

Retirees and/or Dependents who are Medicare eligible but fail to enroll in Medicare Parts A and/or B are subject to an additional monthly premium to help offset the additional costs imposed on the Plan for Medicare eligible individuals who elected not to enroll. Please be aware that the rate of this additional premium is determined by the Board of Trustees and will likely increase in the future.

In addition, please be aware that if a Retiree and/or a Retiree's Dependent is currently covered under another Medical Plan he or she would not be eligible to enroll in either the Kaiser or Blue Shield Medical Plans.

The prescription drug benefits offered by the Kaiser Plan option and the Blue Shield Plan option are, on average, expected to pay out as much as standard Medicare Prescription drug coverage pays and is therefore considered "Creditable Coverage". Therefore, because your existing coverage is Creditable Coverage, if at
some later date you choose to enroll in Medicare Part D, you will not be charged a late penalty (higher premium) for delayed enrollment. If you decide to join a Medicare drug plan and drop your current Plan coverage, be aware that you and your dependents will not be able to get coverage with the Plan back.

C. KAISER PERMANENTE SENIOR ADVANTAGE (“KPSA”) AND BLUE SHIELD MEDICARE OPTIONS

The Kaiser Permanente Senior Advantage (“KPSA”) and Blue Shield PPO Plans are available to Retired Participants and their eligible Dependents who are enrolled in Medicare Part A and Part B and who reside in a Northern California Kaiser or Blue Shield Service Area. Retirees with Medicare must enroll in Kaiser or the Blue Shield PPO Plan. Please be aware that one requirement to qualify for enrollment in the Blue Shield HMO Plan is that neither the Early Retiree nor any Enrolled Dependents can be Medicare eligible. Once an Early Retiree or any Enrolled Dependent is Medicare eligible, you must select another Health Plan option, currently either the Blue Shield PPO option or Northern California Kaiser option (available only if the individual resides in a Northern California Kaiser Permanente Senior Advantage Service Area). The Trust Fund Office will send you and/or your Medicare Eligible Dependents the required Forms to enroll. These forms are also available on the Plan’s website at www.ncpttf.com. Please be aware that the Participant and all eligible Dependents can only be enrolled in one Health Plan option; therefore, a Dependent’s eligibility to enroll in these Plans would depend on the Health Plan option selected by the Participant.

Important Information you should be aware of:

1. You MUST enroll in Medicare Part A and Part B as soon as you are eligible to enroll in Medicare.
2. You MUST continue to pay your Medicare Part B coverage premiums.
3. If you elect KPSA coverage, you MUST transfer the administration of your Medicare benefits to KPSA.
4. Participants, Spouses, and Dependents enrolling in KPSA MUST receive all of their medical care from Kaiser Service Providers, except for emergency care, and urgent out-of-the-area medical care. KPSA will not be reimbursed by Medicare or Kaiser for non-Kaiser medical care.
5. If you enroll in KPSA and then move outside of the Northern California Kaiser service area, you cannot continue to have KPSA. You must dis-enroll in KPSA and then change your health plan to the Blue Shield PPO Plan option.

If you have any questions regarding the Kaiser Permanente Senior Advantage (KPSA) Program, or require any additional information, please call a Kaiser Customer Services Representative at (800) 464-4000.

If you have any questions regarding the Blue Shield Plan or require any additional information, please call Blue Shield at (855) 256-9404.

D. DELAYING OR OPTING OUT OF/INTO THE RETIREE HEALTH AND WELFARE PLAN

1. Delaying or Opting Out. If you are eligible for Retiree Health and Welfare Plan Benefits, you may wish to opt out or delay enrollment in the Plan. If you wish to opt out or delay enrollment, you must submit a written request to the Trust Fund Office. Please be aware that you may only opt out of or delay enrollment in the Retiree Health and Welfare Plan one time. If you opt out or delay enrollment in the Retiree Health and Welfare Plan Benefits, this will terminate all Retiree Benefits including Medical, Prescription Drug, Dental, Vision, and Hearing Aid benefits.

If you are not currently eligible for Medicare Benefits, you will be dis-enrolled the first of the following month after your request has been received and processed by the Trust Fund Office. If you are eligible for Medicare Benefits and are currently enrolled in the Northern California Kaiser or Blue Shield Medicare programs, you will be dis-enrolled as described below:
(i) **Northern California Kaiser (Senior Advantage).** In addition to your written request, you must sign a Kaiser Disenrollment Form. Provided that your request is submitted in a timely manner, you will be dis-enrolled the first of the following month after you sign and submit the Disenrollment Form.

(ii) **Blue Shield.** In addition to your written request, you must sign a Blue Shield Disenrollment Form. Provided your request is submitted in a timely manner, you will be dis-enrolled the first of the following month after you sign and submit the Disenrollment Form.

PLEASE NOTE: Because Medicare requires time to process your disenrollment request, failure to dis-enroll on a timely basis may result in a lapse in utilizing your Medicare Benefits. Please contact the Trust Fund Office if you need assistance.

2. **Limited Exceptions.** Please be aware that if you opt out of or delay enrollment for Retiree Health and Welfare Benefits, you are only permitted to opt back into the Plan one-time and you will not be permitted to opt back into the Plan except under the following limited conditions:

   (1) In accordance with Plan rules, you may delay/opt out of your Retiree Health and Welfare Benefits for yourself and/or your Dependent spouse until you/or your spouse becomes Medicare eligible. Please be aware that if you delay/opt out of Retiree Health and Welfare Benefits, you will not be permitted back into the Plan until you become Medicare eligible. After you become Medicare eligible, you may opt back into the Plan at any time subject to proof of enrollment in parts of Medicare, including, but not limited to, Parts A and B. Also, please be aware that in order for a spouse to be eligible to opt back into the Plan based on Medicare eligibility, the Retiree would have to already be eligible for and enrolled in Retiree Health and Welfare Benefits.

   (2) Plan rules also provide that if you and/or your Dependent(s) are eligible for coverage under another plan, you may also delay/opt of out of your Retiree Health and Welfare Benefits for yourself and/or eligible Dependents until: (a) your/their coverage under the other plan terminates, provided that you notify the Trust Fund Office in writing within 30 days of the date the other coverage terminates and submit proof of such termination of prior coverage (such as a copy of a HIPAA certificate of creditable coverage applicable through December 31, 2014, or notice/letter of termination after December 31, 2014) and re-enroll in the Plan within a reasonable period of time, as determined by the Plan, after this prior coverage has terminated; or (b) at any time that this other group health plan coverage is still in effect subject to proof from the other carrier that the coverage is still in force.

E. **RETIREE AND SURVIVING DEPENDENT DISENROLLMENT PROCEDURES DUE TO CHANGE IN HEALTH PLANS**

If you are planning to move, you should contact the Trust Fund Office in advance to obtain information regarding how your new address may affect your Retiree Health and Welfare Benefits. You will be required to submit a new Enrollment/Change Form.

1. **Non-Medicare Eligible Participants.** If you are not currently eligible for Medicare Benefits, you will be dis-enrolled the first of the following month after your request has been received and processed by the Trust Fund Office.

2. **Medicare Eligible Participants.** If you are eligible for Medicare Benefits and are currently enrolled in the Kaiser or Blue Shield program and you move out of the Northern California Kaiser or Blue Shield Service Area, or you wish to switch from the Northern California Kaiser Medicare Plan to the Blue Shield Medicare Plan, or vice versa, you need to be dis-enrolled as described below:

   (i) **Northern California Kaiser (Senior Advantage).** In addition to your written request, you must sign a Kaiser Disenrollment Form. Provided that your request is submitted in a timely manner, you
will be disenrolled the first of the following month after you sign and submit the Disenrollment Form.

(ii) Blue Shield. In addition to your written request, you must sign a Blue Shield Disenrollment Form. Provided your request is submitted in a timely manner, you will be disenrolled the first of the following month after you sign and submit the Disenrollment Form.

PLEASE NOTE: Because Medicare requires time to process your request for disenrollment, failure to disenroll on a timely basis may result in a lapse in utilizing your Medicare Benefits. Please contact the Trust Fund Office if you need assistance.

F. PAYMENT OBLIGATIONS - By the 20th Day of the Month Prior to the Coverage Month

If you are eligible for Retiree Health and Welfare Coverage either as a Retiree and/or Surviving Spouse/Dependent Child(ren) you are encouraged to elect to deduct premiums from your monthly retirement benefit. If you elect not to deduct premiums from your monthly Retirement Benefit, payment for the required premium must be made accordingly and may cause delays in eligibility:

1. All payments must be made by check, cashier’s check, or money order. Cash and/or credit cards cannot be accepted as a method of payment.
2. Checks, cashier’s checks and/or money orders should be made payable to: NCPTTF
3. Payments must be received by the due date requested, generally by the 20th day of the month prior to the coverage month. Refer to your billing statement for your due date. Failure to timely submit the required payment(s) may cause a delay and/or termination of coverage indefinitely. Furthermore, the Trust Fund Office will NOT have eligibility and/or benefits verified until the payment has been received and processed by the bank.
4. You must submit both your payment and the top portion of your billing statement directly to the bank as follows:

   NCPTTF
   PO Box 55606
   Hayward, CA  94545-0606

5. The Trust Fund Office can only accept up to three (3) months of pre-paid self-payments. Payments received for more than three (3) months will be refunded to the payee.
6. Payments must be made timely and consecutively (when applicable).

As a courtesy, the Trust Fund Office may send monthly billing statements and/or warning letters. It is the responsibility of the Plan Participant and/or Dependent to submit payments when due. Once coverage has been terminated due to non-payment, the Plan Participant and/or Dependent may not be allowed to reinstate coverage.

XIV. PRESCRIPTION DRUGS

Prescription Drug coverage is provided through your selected Health Plan (Kaiser or Blue Shield) in the amounts stated in each of those programs. You should consult your selected Health Plan’s Evidence of Coverage (EOC) or contact your selected Health Plan directly if you have questions about your prescription drug coverage.
Effective for Dental and Orthodontic services incurred on or after January 1, 2015, the Board of Trustees has contracted with Delta Dental of California (“Delta Dental”) to provide Dental and Orthodontic Benefits to eligible Participants and their Dependent(s). Please refer to Delta Dental’s “Evidence of Coverage” (Group Number 17422).

1. **Eligibility Rules:** Participants and Dependents must meet the eligibility rules described in the Summary Plan Description and any subsequent Notifications of Material Modifications to the Plan. Retirees and their Dependents are not eligible for Orthodontic Benefits. In addition, Active Participants whose coverage is based on Active Subsidized Self-Payments or COBRA CORE Coverage are not eligible for Dental or Orthodontic Benefits.

2. **Dental Plan Benefits for Active and Retired Participants:** Under the Dental Plan, a Participant and his/her eligible enrolled Dependents can go to any licensed dentist for necessary dental care. The Plan will cover up to the Usual, Customary and Reasonable (“UCR”) amount for eligible dental expenses, not to exceed the amount you are charged.

   a. **Dental Maximums.** The Plan provides the following Calendar Year Maximums:

      Actives. The dental maximum is $4,000 per calendar year for each eligible individual. There is no deductible. **Dental Benefits are not available to Participants and their Dependents whose coverage is through Active Subsidized Self-Payment or COBRA CORE Coverage.**

      Retirees. The maximum Dental Benefit is $3,000 per calendar year for each eligible individual. There is no deductible. **In any year when a Participant is covered under both the Active and Retiree Plan, the maximum payable under both the Active and Retiree Plans combined is never more than the maximum allowed for an individual under the Active Plan for that year.**

   b. **Diagnostic and Preventive Services.** The Plan provides payment of 100% of UCR for Active Participants (and their eligible Dependents) and 50% of UCR for Retirees (and their eligible Dependents) on diagnostic and preventive services. The Plan defines diagnostic and preventive services to be:

      (1) Diagnostic Services: routine oral examination (including periodontal exam) and x-rays;
      (2) Preventive Services: prophylaxis (cleaning of teeth) and fluoride treatments; and
      (3) Biopsy/Tissue Examinations.

   c. **Basic Services.** The Plan provides payment of 80% of UCR for Active Participants (and their eligible Dependents) and 50% of UCR for Retirees (and their eligible Dependents) for Basic Services. The Plan defines basic services to be:

      (1) Analgesia or pre-medication when administered by a licensed dentist in performance of covered dental services for patients under age 6. Analgesia and pre-medication for patients age 6 and over would not be covered by the Plan except in lieu of general anesthesia for a covered oral surgery procedure;
      (2) Consultation by a Specialist;
      (3) Emergency treatment;
      (4) Endodontic treatment. Treatment of the tooth pulp including, but not limited to pulpal therapy and root canal procedures for the treatment of diseased teeth;
      (5) General Anesthesia / IV Conscious Sedation when administered by a licensed dentist for a covered oral surgery procedure;
(6) Implants or the surgical removal of implants;
(7) Oral Surgery. Surgical extraction of diseased or accidentally injured teeth and certain other surgical procedures, including pre and post-operative care;
(8) Periodontics. Treatment of the gums and bones supporting the teeth, including, but not limited to, root planting and periodontal procedures that include cleanings;
(9) Restorative Treatment. Treatment of tooth decay or fracture with amalgam, synthetic plastic or resin restorations. Crowns and cast restorations will be provided only when amalgam, synthetic, plastic or resin restorations will not suffice;
(10) Sealants. Topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing dental decay. Sealant benefits include the application of sealants to all permanent teeth with no decay, with no restorations, and with the occlusal surface intact. Sealant benefits do not include the repair or replacement of a sealant on any tooth within 3 years of its application. Sealants are limited to eligible Dependent Child(ren) under age 14;
(11) Space Maintainers; and
(12) Study Models.

**d. Prosthodontic Services.** The Plan provides payment at 80% of UCR for Active Participants (and their eligible Dependents) and 50% of UCR for Retirees (and their eligible Dependents) on prosthodontic services. The Plan defines prosthodontic services to be those procedures for construction or repair of fixed bridges, partial dentures, and complete dentures.

**e. Orthodontic Services (ACTIVE Participants and their Eligible Dependents ONLY).** The Orthodontic Lifetime Maximum is $3,500 for each eligible individual. Eligible individuals are defined as the Participant and all eligible enrolled Dependents, including Pediatric Dependent Child(ren). The orthodontic lifetime maximum is independent of the dental maximum.

Retirees and their Dependents are not eligible for Orthodontic Benefits. In addition, Orthodontic Benefits are not payable during any month that an Active Participant’s eligibility is under Active Subsidized Self-Payments or COBRA CORE Coverage.

Orthodontic procedures that are dentally necessary are covered at 50% of the UCR fees. The Plan may, at any time, request supporting proof of clinical reports, charts, x-rays, and other documentation.

On approved active phase orthodontia treatment plans, if the treatment is less than $500, Delta Dental will pay the treatment plan in one lump sum at the date of banding.

On approved active phase orthodontia treatment plans greater than $500, providing the individual is eligible under the Plan on the date of banding, Delta Dental will pay 50% of the lesser of: (a) 50% of the orthodontia treatment plan charges; or (b) the Orthodontic Benefit available under this Plan on the date of banding, provided the individual remains eligible, the remainder of treatment plan fees will be paid 12 months later with benefit payment being 50% of the lesser of: (a) 50% of the orthodontia treatment plan charges; or (b) the Orthodontic Benefit available under this Plan will be paid 12 months later.

Orthodontic Benefits are payable only during those months that the Participant has Dental Benefit eligibility. If the claim is for a Dependent, in addition to eligibility requirements, Orthodontia Benefits are payable only during those months that the individual qualified as an eligible Dependent.

**f. Service and Limitations.** Dental Benefits are subject to the following limitations:
1. Supplementary bitewing (individual) x-rays are covered no more than twice in a calendar year.

2. Coverage for replacement crowns and cast restorations will be allowed only after 5 years (60 consecutive months) have elapsed.

3. One extraoral radiograph is covered once in a 5 year period (60 consecutive months). This limitation would not apply to complete extraoral radiographs covered under the Plan’s Orthodontic Benefit.

4. Complete intraoral mouth x-rays (full mouth) are covered only once in a 5-year period (60 consecutive months), unless special need is shown and approved by Delta Dental.

5. If the Plan covers an onlay or inlay any subsequent crown or cast restoration for that tooth would be allowed only after 5 years (60 consecutive months) have elapsed.

6. Coverage on occlusal guards/night guards is subject to review. On covered occlusal guards/night guards, the Plan pays 80% of UCR for Active Participants (and their eligible Dependents) and 50% of UCR for Retirees (and their eligible Dependents). On covered occlusal guards/night guards replacement would be allowed only after 5 years (60 consecutive months) have elapsed.

7. Coverage for routine oral examinations is allowed only twice in a calendar year.

8. Prophylaxis (cleanings) and fluoride treatments are covered no more than 4 times in a calendar year.

9. Coverage for replacement prosthodontic appliances (including but not limited to fixed bridges and partial or complete dentures) will be allowed only after 5 years (60 consecutive months) have elapsed, except when Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissues that the existing appliance cannot be made satisfactory. The Plan considers the placement date/delivery date and not the preparation date to be the date of service for prosthodontic appliances.

10. Coverage on dental veneers would be subject to review. Dental veneers placed to improve the aesthetics of a tooth would not be covered by the Plan.

g. **How to Use the Dental Plan.** During your first appointment, provide the dentist with your Delta Dental Identification Card which identifies you as participating in the Delta Dental of California PPO Plan (Group Number 17422). **Before treatment is started, be sure to discuss with the dentist the total amount of his or her fee and the portion that will be your responsibility. Have your dentist submit the Dental Claim Form to Delta Dental.**

h. **Preauthorization of Dental Services-Recommend if $300 or More.** Preauthorization of benefits is not a requirement under the Plan; however, to learn about your Plan benefits in advance, or any time your dentist recommends $300 or more in dental work, you may want to have your dentist submit a preauthorization of benefits. (Please be aware that even though your benefits are ‘preauthorized’, you must also remain eligible for coverage.) Delta Dental will notify your dentist of the Plan’s UCR allowance for the procedures and whether there are any alternative treatments available.

i. **Covered Fees.** The Plan will cover up to the Usual, Customary and Reasonable (“UCR”) amount for eligible dental expenses, not to exceed the amount you are charged.

A Usual fee is the amount which an individual dentist regularly charges and receives for a given service or the fee actually charged, whichever is less.

A Customary fee is within the range of usual fees charged and received for a particular service by dentists of similar training in the same geographic area.
A Reasonable fee schedule is reasonable if it is Usual and Customary. Additionally, a specific fee to a specific Participant/Dependent is reasonable if it is justifiable considering special circumstances, or extraordinary difficulty of the case in question.

**j. Dentally Necessary.** Only dentally necessary services will be covered under the Plan. Dentally necessary expenses are defined by the Plan as those expenses which are:

1. Necessary for your dental care; **and**
2. Prescribed by a licensed dentist or licensed dental surgeon; **and**
3. The appropriate type, level, amount and frequency of care necessary to treat a dental condition; **and**
4. Consistent with generally accepted United States dental standards of practice; **and**
5. Within the Plan’s scheduled limits; **and**
6. Covered by the Plan.

Some services may require review by an outside independent dental consultant.

**l. Exclusions.** The Plan will **not** provide coverage on:

1. Analgesia or premedication except in connection with covered services provided to an eligible Dependent child under age 6.
2. Anesthesia. Charges for anesthesia, except for general anesthesia or IV Sedation provided by a licensed dentist for oral surgery services and select endodontic and periodontic procedures.
3. Application of antimicrobial agents in affected mouth tissues.
4. Services for purely cosmetic reasons or cosmetic surgery.
5. Services associated with employment related injuries or conditions or charges which could be reimbursable under Workers’ Compensation or other Employer Liability laws.
6. Experimental procedures.
7. Extra Oral Grafts. Extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
8. Services provided to the eligible patient by any Federal or State Government Agency or are provided without cost to the eligible patient by any municipality, county or other political subdivision, except as provided in Section 12432.5 of the California Government Code.
9. Hospital. Hospital costs and any additional fees charged by the dentist for hospital treatment.
10. Investigational procedures.
11. Procedures which are not considered necessary for your dental care; or which are not prescribed by a licensed dentist or licensed dental surgeon; or which are not the appropriate type of care necessary to treat a dental condition; or which are not consistent with generally accepted United States dental standards of practice.
13. Prescription drugs.
14. Services for which a third party may be liable or legally responsible.
15. Services performed by a person who lives in your home or is related to you by blood or marriage.
16. Prosthetic services or any single procedure started prior to the date you or your Dependent(s) became eligible for such services under this Plan.
17. Replacement of lost or stolen dental appliances.
18. Services for restoring tooth structure lost from wear, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing teeth. Such services include, but are not limited to, equilibration and periodontal splinting.
(19) Charges for services associated with the treatment of disturbances of the jaw joints (temporomandibular joints, or “TMJ”) or associated muscles, nerves or tissues.

(20) Charges which exceed this Plan’s usual, reasonable and customary guidelines.

XVI. VISION CARE BENEFITS

The Vision Service Plan (VSP) (Group No. 12005611) covers each eligible Participant and Dependent for a regular examination and lenses and frames when necessary for proper visual function or correction. Please refer to your VSP Evidence of Coverage booklet for more details.

1. **To obtain services:** To obtain services of a Panel Doctor, an eligible Participant and/or Dependent is requested to contact a VSP participating doctor to make an appointment. Make sure you identify yourself as a VSP member; give your Social Security Number and the group name. The doctor's office will verify eligibility and benefits. If you need to locate a VSP participating doctor, call VSP at (800) 877-7195, or find one at www.vsp.com.

   VSP will pay the doctor directly. Except as otherwise provided in this section, you are responsible only for the applicable co-payment and any additional costs for items only partially covered or not covered.

   If you use a doctor from the VSP network, this assures direct payment to the doctor and guarantees quality and cost control; however, if you decide to use the services of a doctor who is not a VSP Panel Member, you should pay the doctor his or her fee. You will later be reimbursed in accordance with the VSP reimbursement schedule by VSP.

2. **Services and Materials (Obtained with VSP Network Provider):**
   a. **One Vision Examination per 12 month period.** Comprehensive examination of your visual functions once every 12 months, including the prescription of corrective eyewear where indicated are Covered in Full after $25.00 Copayment.
   b. **Necessary Lenses and Frames.** If the vision examination indicates that new lenses or frames or both are necessary for the proper visual health of an eligible Participant or Dependent, the Plan provides the following:
      (1) **Lenses - available once every 12 months** for eligible Participant or Dependent if a prescription change is warranted.
         - Single Vision Covered in Full after $25.00 Copayment.
         - Bifocal Lenses Covered in Full after $25.00 Copayment.
         - Trifocal Lenses Covered in Full after $25.00 Copayment.
         - Lenticular Covered in Full after $25.00 Copayment
      (2) **Frames - available once every 12 months** (for eligible Retired Participant and Dependent) and **24 months** (for eligible Active Participant and Dependent) if replacement is necessary; frames of your choice are covered up to Plan Allowance of $120.00 plus 20% off any out-of-pocket expenses.
   c. **Lens Options.** Tints/Photochromic and adaptive transitions lens enhancements are Covered in Full.
   e. **Low Vision Benefits.** The Plan provides the following professional services obtained for severe visual problems that are not corrected with regular lenses:
1. **Supplemental Testing**- includes evaluation, diagnosis and prescription of vision aids where indicated are Covered in Full and subject to Overall Low Vision Maximum benefit of $1,000 every two (2) years.

2. **Supplemental Aids** - Covered up to 75% of cost and subject to Overall Low Vision Maximum benefit of $1,000 every two (2) years.

3. **Contact Lenses Care (Obtained with VSP Network Provider):**

   a. **Necessary Contact Lenses.** If the vision examination indicates that contact lenses are necessary for the proper visual health of an eligible Participant or Dependent, the contact lens exam (fitting and evaluation) and contact lenses are Covered in Full after a maximum $60.00 Copayment and is available once every 12 months.

   b. **Elective Contact Lenses.** When an eligible Participant or Dependent chooses contacts instead of glasses, contact lens exam (fitting and evaluation) is Covered in Full after a maximum $60.00 Copayment. This exam is in addition to the VISION exam to ensure proper fit on both Standard and Premium wear and is available once every 12 months. Eligible Participants or Dependents are also covered up to a $120.00 allowance on contact lenses and this is available once every 12 months.

4. **Extra Discounts and Savings:**

   a. **Prescription Glasses.** Up to 35-40% savings on lens extras such as scratch resistant and anti-reflective coating and progressives. There is also a 30% discount off second pair glasses if purchased on the same day of your vision eye exam, otherwise you receive a 20% discount off additional prescription glasses and sunglasses within 12 months of your last eye exam.

   b. **Contacts.** 15% off cost of contact lens exam (fitting and evaluation) available from the same VSP doctor who provided your eye exam within the last 12 months

5. **Your Copayment (subject to change):**

   - Exam and Prescription Glasses: $25.00
   - Contacts Lens Exam: $60.00 (capped)
   - Contacts: No co-pay applies

6. **Out-of-Network (Non-VSP):** If you choose to receive vision care services and materials from a doctor who is not a panel member of VSP or from a dispensing optician, you will be reimbursed in accordance with the following schedule:

   1. **Professional Fees**
      - Vision Examination: $50.00
      - Low Vision Supplemental Testing: $125.00

   2. **Materials**
      - Single Vision Lens, up to: $50.00
      - Bifocal Lenses, up to: $75.00
      - Trifocal Lenses, up to: $100.00
      - Lenticular Lenses, up to: $125.00
      - Frames, up to: $70.00
      - Tints, up to: $5.00
      - Low Vision Supplemental Aids: 75% of cost
Elective Contact Lenses up to $105.00

Necessary Contact Lenses up to $210.00

These amounts may change at any time. Please call VSP for vision care request forms at (800) 877-7195 prior to visiting your provider or at www.vsp.com.

7. **VSP Grievance Procedures:** If a Participant has a complaint/grievance (hereafter ‘grievance’) regarding VSP service or claim payment, the Participant may communicate the grievance to VSP by using the form which is available by calling VSP Customer Service Department’s toll free number (800) 877-7195 Monday through Friday 5:00 a.m. to 8:00 p.m. Pacific Standard Time. Grievances may be filed at www.vsp.com or in writing within 180 days with VSP at 3333 Quality Drive, Rancho Cordova, CA 95670. If you are dissatisfied with the results after exhausting VSP’s grievance procedures, you may file a written appeal with the Plan’s Board of Trustees, as provided in the Claims and Appeals Procedures described in Article XXIV, Section B.

The California Department of Managed Health Care (“Department”) is responsible for regulating health care service plans and receiving complaints regarding VSP (and similar programs). If you need the Department’s help with a complaint involving an emergency grievance or with a grievance that has not been satisfactorily resolved by VSP, you may call the Department’s help center toll-free at 800-466-2219. The hearing and speech impaired may use the California Relay Service’s toll-free telephone number 1-877-688-9891 (TDD) to contact the Department. Health plan complaint forms and instructions are available online at the Department’s website, http://www.dmhc.ca.gov/dmhc_consumer/pc/pc_complaint.aspx.

**NOTE:** VSP’s grievance process and the Department’s complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

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**XVII. HEARING AID BENEFITS**

1. **General:** The Plan provides coverage for medically necessary hearing aids. After a $100 deductible for each hearing device, the Plan provides coverage at 80% of Covered Charges for medically necessary hearing aids, up to a maximum of $1500 per hearing device, for one device per ear in any four year period (48 consecutive months). No payment would be made under this benefit for any other hearing related services such as hearing exams or testing. **Claims are paid by the Trust Fund Office as this is a Self-funded benefit provided through the Trust Fund Office.** If you have any questions concerning the Plan’s Hearing Aid Benefit, please call the Trust Fund Office at 1-800-780-8984.

2. **Replacement of Hearing Device:** The Plan will allow replacement of a hearing device after at least two years (24 consecutive months) have elapsed between replacements, provided that a licensed physician certifies that replacement of aids is medically necessary as a result of hearing deterioration being directly related to a traumatic illness (e.g. cerebrovascular accident), injury (e.g. automobile accident), or surgical procedure that occurred after the last hearing device was dispensed.

3. **Hearing Aid Repair:** The Plan will cover medically necessary hearing aid repair. Benefits for hearing aid repair would only be payable if less than $1,500 was issued in benefits for purchase of the aid being repaired within the preceding four year (48 month) period and would be limited to only the difference between $1,500 and the amount previously issued for purchase of the device. In addition, any benefits payable for subsequent purchase of a hearing device in that ear within the next 4 years (48 consecutive months) would be decreased by any amount paid by the Plan for the repair. If benefits are available, after a $100 deductible per device being repaired, the Plan provides coverage at 80%.
4. **Hearing Aid Provider Network (HearPO):** The Plan has contracted with a Hearing Aid Provider Network (HearPO) with over 2,700 locations nationwide to provide hearing aids at discounted rates to eligible Participants and Dependents. While you can continue to choose any hearing aid provider, you also have the option of using the HearPO network to reduce your out-of-pocket costs. If you access the HearPO Network and do not already have a valid prescription from a licensed provider for a hearing aid, you will be charged $56.00 consultation fee for an exam and testing. This consultation fee is not reimbursable under the Plan’s Hearing Aid Benefit. Please also keep in mind, the Plan’s deductible, percentage of benefit payment, dollar maximum, and replacement limits will apply regardless of whether you use a HearPO Network Provider. However, since HearPO Network providers offer lower prices on hearing aid devices, in most situations, this should reduce your out-of-pocket costs.

To access the HearPO Network, please call HearPO at 1-888-408-5947. A HearPO representative will explain the process and assist you in locating and making an appointment with a contracted Hearing Aid Provider in your area.

5. **Exclusions:** No payment will be made under this benefit for:

   (i) Any other hearing related services such as hearing exams, testing, or batteries. (You should contact your selected Health Plan (e.g., Kaiser or Blue Shield) for information on any coverage that they may offer on hearing exams and testing.)

   (ii) Replacement of a lost, stolen, or damaged device.

   Please be aware that any coverage that might be available for hearing exams would be exclusively through your selected Health Plan option.

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**XVIII. JURY DUTY (Certain Active Participants Only)**  
(Not Applicable for Those Working under the Residential, PG&E, Helper, Non-Bargained, Tradesmen/Servicemen and Certain Other Agreements)

The Plan provides Jury Duty Benefits to Participants except for those working under the Residential Agreements, those working the capacity of Helper, PG&E, Non-Bargained or Tradesman/Serviceman and certain other special Contract Employees. Moreover, only limited benefits are provided to First and Second Period Apprentices. Participants making Active Subsidized Self-Payment (excluding COBRA) may be eligible for this benefit. The rules are:

1. **Eligibility Requirements:** To be entitled to “Jury Duty” Benefits, an Employee, at the time of Jury Duty, must:

   (i) Be a member of a collective bargaining unit represented by UA Local 342; **and**

   (ii) Be a current member of UA Local 342; **and**

   (iii) Be eligible to receive Health and Welfare Benefits in the month that Jury Duty begins (excluding COBRA); **and**

   (iv) Meet all Plan requirements under a classification that qualifies for Jury Duty Benefits; **and**

   (v) Meet either a) or b) of the following requirements:

   a) The Participant must:

      (i) Be actively employed under a UA 342 Collective Bargaining Agreement or registered on UA Local 342’s out-of-work list for employment or actively employed on a travel card **and**

      (ii) Credited with at least 1000 hours worked in Covered Employment reported during the 36 work months immediately preceding the month listed on the Jury Duty Summons (e.g., Jury Duty summons date lists February; therefore the 36 look month period would begin with December work hours reported in January); **or**
b) Be disabled from Covered Employment under a UA Local 342 Collective Bargaining Agreement but be eligible for Health and Welfare Benefits based on the Disability Extension due to: (1) an occupational disability for which State Disability Insurance is being received or (2) receipt of Worker’s Compensation by reason of an injury suffered while working in Covered Employment for an Employer signatory to a Collective Bargaining Agreement with UA Local 342.

2. **Amount of Jury Duty Benefits:** Benefits are calculated at an amount equal to the Master Labor Agreement Building Trades Journeyman rate for each day, half day or other period of Jury Duty Services. A full day is eight hours (even if your Jury Duty lasts longer than eight hours or your recent work was more than eight hours). A half day is four hours. **An Employee who is eligible for Jury Duty Benefits may be entitled to a maximum of 30 calendar days during a Plan Year (July 1st through June 30th), regardless of the number of days served on a Jury or required to be present at Court.**

   **Please note:** Based on your classification, Jury Duty Benefits may include Health and Welfare, HRA, Dues, Pension and Mandatory Supplemental Pension contributions. **Certain classifications and exclusions may apply. Please refer to your dispatch for further clarification.**

   The Benefits paid include:

   a. **Reimbursement for Lost Wages.** An amount equal to the Master Labor Agreement Building Trades Journeyman rate for each full day, half day or other period of Jury service (including payment of Union dues), reduced by any allowance from any source (including Unemployment Insurance, State Disability Insurance, Workers’ Compensation benefits or Court reimbursements/payments) received for such Jury Duty service (exclusive of travel pay).

   b. **Contributions to NCPT Pension Plan.** A contribution to be paid to the Northern California Pipe Trades Pension Plan in lieu of Employer Contributions lost by reason of Jury Duty service, for the same number of hours for which wages are paid under (a) above. **First and Second Period Apprentices are excluded.**

   c. **Contributions to NCPT 401(k) Retirement Plan.** A contribution to be paid to the Northern California Pipe Trades Supplemental Pension Plan in lieu of Employer contributions lost by reason of Jury Duty service, for the same number of hours for which wages are paid under (a) above. **First and Second Period Apprentices are excluded.**

   d. **Health and Welfare and/or HRA Benefits.** A contribution to be paid to the Northern California Pipe Trades Health and Welfare Plan in lieu of Employer Contributions lost by reason of Jury Duty service, for the same number of hours for which wages are paid under (a) above.

3. **File Application within 30 days, W-4 (Federal) Form and DE4 (California State) Form:** Jury Duty Benefits Applications are processed by UA Local 342; however, payment is issued by the Trust Fund Office on behalf of the Plan. An Application for benefits (including all other required documentation) must be received by the UA Local 342 Office within thirty (30) days after completion of any Jury Duty service. Any Employee seeking Jury Duty benefits must timely submit any information requested by UA Local 342 and/or the Trust Fund Office. The Plan has total and absolute discretion in making determinations hereunder. In addition, you must also timely complete, sign and return the Form W-4 Federal Income Tax Withholding Form to the Trust Fund Office. Under IRS and State tax rules, the Jury Duty Benefit is a wage and considered taxable income. Failure to complete the Form W-4 will result in taxes being withheld using the single and zero deductions withholding under IRS and State tax rules. There is also a DE4 Form for California state taxes which is not mandatory but may also be completed if the exemptions are to be different from your Federal exemptions. **To obtain an Application, please contact the UA Local 342 Office at (925) 686-5880.**

4. **Payment:** Timely filing of the application is required and other Plan requirements apply. Checks are generally mailed on the 15th of each month (unless the 15th falls on a weekend or holiday) on any approved Jury Duty claims for which an application and all other Plan required documents were received by UA
Local 342 the prior month. In order to receive a check, your information must be submitted to UA Local 342 by no later the last business day of the prior month.

**EXAMPLE:** An approved Jury Duty Benefit Claim with an application and all other Plan required documents is received in March. Benefit payment on this claim will be issued on the 15th of the following month (April 15th).

Amounts paid to you or amounts to which you are entitled by a court or other government entity for such Jury Duty services (including any reimbursement of expenses except for travel expenses) are offset against what you are entitled to receive under this Plan. In order to receive payment, you must return the Application along with all other required documents to the address below:

UA Local 342 Jury Duty Benefits  
935 Detroit Avenue  
Concord, California 94518-2501

5. **Benefits Improperly Paid:** Any benefit paid to persons not entitled thereto, including any benefits paid to them for a period when they are not entitled to Jury Duty Benefits (or in excess of what they are entitled to receive) shall be owed by him or her to the Fund and repaid immediately, but in any event, within 30 days. In addition, if it is later determined that you received more benefits from the Plan than you were entitled to receive, you will be **required to make restitution of the amount of any such overpayment within 30 days of any demand.** You must agree that if you do not make such restitution and the Plan institutes legal action to collect any sums owed to it, you will be liable to the Fund not only for such sums, but also for all costs and expenses, including attorney’s fees. Any such amounts owed to the Plan may be deducted from other benefits you may be due under this Plan. **Please further note you are required to notify the Trust Fund Office immediately if any additional payment for time served on Jury Duty is received from another source (such as current or former Employer, Unemployment Insurance, Workers’ Compensation, State Disability Insurance, etc.).** Jury Duty Benefit payments may be reduced by these additional payments.

6. **Availability for a Court Appearance:** Coverage is also provided for the reporting date listed on a Jury Duty Summons to Participants required to be available for possible Jury Duty Service on such reporting date. The Plan will accept the Jury Duty Summons as proof of availability for a court appearance for the reporting date listed on the Summons.

To qualify, a Participant must meet all Plan requirements under a classification that qualifies for this benefit and on the date of the court appearance must be:

(i) Actively employed under a UA Local 342 Collective Bargaining Agreement or actively employed on a travel card or registered on UA Local 342’s out-of-work list for employment; and

(ii) Available for Covered Employment; and

(iii) Credited with at least 1000 hours worked in Covered Employment during the 36 work months immediately preceding the month listed on the Jury Duty Summons (e.g., Jury Duty Summons lists December; therefore eligibility would be based on October work hours reported in November); and

(iv) The Participant must have been unable to work for all or part of the reporting date listed on a Jury Duty Summons in order to be available for a possible court appearance that day. The Plan will cover up to a maximum of one full work day (maximum of eight hours) for the reporting date listed on the Jury Duty Summons; and

(v) The Plan will cover only one such availability for Jury Duty claim in any 12 month period; and

(vi) The Plan will accept the Jury Duty Summons as proof of availability for a possible Court appearance for the reporting date listed on the Summons only.

Participants who are eligible to receive Health and Welfare Benefits but are unable to work due to a disability for which they receive benefits from Workers’ Compensation or State Disability Insurance, would only be eligible for the Jury Duty Benefit for dates on which they “actually” serve as a Juror. These
Participants are **not** eligible for the Availability for a Court Appearance Provision.

7. **Exclusions:** Residential, Helper, Non-Bargained, PG&E, Tradesman/Serviceman and certain other special Contract Employees are not eligible for this particular benefit.

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**XIX. DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (Active Participants Only)**

1. **Life Insurance Benefit for Active Employees:**

   a. **Basic Death Benefit.** A $25,000 death benefit is payable to the designated beneficiary of a Covered Employee in the event of the Employee’s death from any cause-on the job or off-while the Employee is eligible for benefits under this Plan or otherwise eligible as provided below. The Board of Trustees is authorized to enter into an agreement with a life insurance company or other entity to provide such benefits or to self-fund such benefits directly from the Plan. (**This benefit is not applicable for Retirees.**)

   b. **Exclusions.** On self-funded benefits, no benefits would be payable if the loss results from:

   (1) Suicide or intentional self-inflicted injury, while sane or insane;
   (2) War, or an act of war, whether or not declared;
   (11) Participation in the commission of a felony or being engaged in *any* illegal activity. No criminal conviction is required for this exclusion to apply; or
   (12) Insurrection or riot.

   For any benefits provided by a life insurance company or other entity, there may be additional exclusions as prescribed in any agreement entered into between the life insurance company or other entity and the Board of Trustees.

   c. **Coverage While Disabled.** On self-funded benefits, there is no extension of coverage while disabled. For any benefits provided by a life insurance company or other entity, if an eligible Employee while insured and under age 60, coverage may continue for the Employee only until the Employee recovers or turns age 65, whichever occurs first. In order to apply for this extension of Life Insurance Benefits, the Employee or Employee’s representative must independently complete and submit Plan required Forms, proof of Total Disability, along with a written request for this extension to the life insurance company or other entity within 90 days of the Employee’s coverage termination date. If an extension is approved, the Employee or his or her representative must submit proof of continued Total Disability when requested.

   d. **Total Disability Means.** For benefits provided by a life insurance company or other entity, Total Disability is defined as:

   (1) A disability resulting from an accidental bodily injury or disease which prevents the Participant, solely by reason of such disability, from engaging in any type of work; **and**
   (2) A disability which has existed continuously for a period of at least nine (9) months; **and**
   (3) A disability which has prevented the Participant from engaging in *any* type of work / employment for wages or profit; **and**
   (4) A disability supported by medical evidence satisfactory to the life insurance company or other entity for insured benefits or Board of Trustees for self-funded benefits.

   e. **No Extension of Coverage may be Granted.** No extension by the insurance company or other
entity may be granted if:

(1) The Employee was not continuously disabled for a period of at least nine (9) months prior to termination of coverage; or
(2) The disability resulted from suicide or intentional self-inflicted injury, while sane or insane; or
(3) The disability resulted from war or act of war; or
(4) The disability resulted from voluntary participation in an assault, felony, criminal activity, or being engaged in any illegal activity. No criminal conviction is required for this exclusion to apply; or
(5) The disability resulted from insurrection or riot; or
(6) If the Employee is outside the United States for six (6) or more months.

f. **Termination of Coverage While Disabled.** If an application for continuation of coverage while disabled has been approved by the insurance company or other entity, coverage for the disabled Employee will automatically terminate at the earliest of:

(1) At the end of the month in which he or she ceases to be totally disabled;
(2) When the Employee turns age 65;
(3) Upon failure of such Employee to submit to an examination by a physician designated by the Trust Fund Office in accordance with the requirements of the Plan; or
(4) The date this Trust Fund terminates.

g. **Facility of Payment.** If, in the opinion of the Trustees, any person who is eligible to receive payments under this Plan is legally, physically, or mentally incapable of personally signing and acknowledging any such payment, the Trustees may direct payments to such other person, persons or institutions, who have been duly appointed guardian or other legal representative of such payee. Such payments, to the extent thereof, will constitute a full discharge of the liability of the Trust Fund and of the Trustees under the Plan.

h. **Conversion Features.** For any benefits provided by a life insurance company or other entity, you may be eligible for conversion to an individual policy, without proof of good health, due to termination of employment, retirement, or moving to a class not eligible for group life coverage. The Employee or Employee’s representative must submit the application and a minimum of one quarterly premium to the insurance company or other entity within 31 days after the date your coverage terminates.

i. **Beneficiary Designation.**

(1) Any person(s) may be named by the eligible Employee as the Designated Beneficiary and the designation may be changed at any time by completing the proper form. If a Beneficiary card has not been filed with the Trust Fund Office, or if the Employee wishes to change his or her Beneficiary, he or she must obtain a Beneficiary Form and submit it to the Trust Fund Office.

(2) If no Beneficiary is designated or the Beneficiary predeceases the Employee, payment will be made to the first surviving class of the following classes of successive preference:

   (i) The Employee's Spouse;
   (ii) The Employee’s Surviving Child(ren);
   (iii) The Employee's Surviving Parent(s);
   (iv) The Employee's Surviving Brothers and Sisters; or
   (v) The Employee's Estate.

2. **Life Insurance for Dependents of an Active Employee Only:**

a. **Coverage.** For an Employee’s eligible Dependent to be entitled to life insurance coverage, the
Dependent must be eligible and enrolled for coverage in the month of the Dependent’s death. The Board of Trustees is authorized to enter into an agreement with a life insurance company or other entity to provide such benefits or to self-fund such benefits directly from the Plan.

Eligible Dependents include an Employee’s Lawful Spouse, Employee’s Domestic Partner, and Employees Child(ren) from live birth to age 26. An Employee’s eligible Dependent Child(ren) is defined as the Employee’s Natural Child(ren), Employee’s Step-Child(ren), Child(ren) for whom the Employee or Employee’s Legal Spouse has legal guardianship; Legally Adopted Child(ren) of the Employee or Employee’s Spouse; Employee’s or Employee’s Spouse’s Foster Child(ren); and Child(ren) of an Employee’s Enrolled Domestic Partner. An Active Employee’s Disabled Dependent Child(ren) may be covered over age 26 provided the Disabled Dependent Child(ren) was eligible and enrolled for coverage in the Plan on the date of death.

If an eligible enrolled Dependent dies, effective for deaths occurring on or after September 1, 2014, the following amount of insurance on the life of that Dependent will be paid to the Employee as Beneficiary:

<table>
<thead>
<tr>
<th>Dependent Type</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lawful Spouse/Domestic Partner</td>
<td>$2,000</td>
</tr>
<tr>
<td>Child(ren) (from live birth through Plan’s maximum age)</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

If the Employee loses eligibility for benefits from the Plan (such as retirement or termination of employment), this benefit will terminate.

b. **Conversion.** For any benefits provided by a life insurance company or other entity, upon termination of your Dependent Spouse’s coverage, your Spouse may be eligible for conversion to an individual policy, without proof of good health. Your Spouse must submit the application and a minimum of one quarterly premium to the insurance company or other entity within 31 days after the date his/her coverage terminates.

c. **Exclusions.** On self-funded benefits, no benefits would be payable if the loss results from:

1. Suicide, or intentional self-inflicted injury, including attempted suicide, while sane or insane;
2. War, or an act of war, whether or not declared;
3. Participation in the commission of a felony or being engaged in an illegal occupation (no criminal conviction is necessary for the exclusion to apply); or
4. Insurrection or riot; or
5. Stillbirth.

For any benefits provided by a life insurance company or other entity, there may be additional exclusions as prescribed in any agreement entered into between the life insurance company or other entity and the Board of Trustees.

### 3. Accidental Death and Dismemberment for Active Employee Only:

a. **Basic Coverage.** An eligible Employee is insured for up to $25,000 against Accidental Death or Dismemberment in an accident, on the job or off while the Employee is eligible for benefits under this Plan. The Board of Trustees is authorized to enter into an agreement with a life insurance company or other entity to provide such benefits or to self-fund benefits directly from the Plan.

1. **Loss of Life.** If an Employee is killed in an accident or dies within 90 days as a result of an accident, his or her beneficiary will be paid $25,000 in addition to the $25,000 to be paid under the Basic Death Benefit, or
(2) **Loss of Both Hand/Feet/Sight.** If an Employee accidentally suffers the loss of both hands, or both feet, or the sight of both eyes, or one hand and sight of one eye, or one foot and sight of one eye, or one hand and one foot within 365 days (or 12 consecutive months) of the accident, a benefit of $25,000 will be paid to the Employee, or

(3) **Loss of One Hand/Foot/Sight.** If an Employee accidentally suffers the loss of one hand or one foot or the sight of one eye within 365 days (or 12 consecutive months) of the accident, a benefit of $12,500 will be paid to the Employee; or

(4) **Loss of Thumb and Index Finger on the Same Hand.** If an Employee accidentally loses the thumb and index finger on the same hand within 365 days (or 12 consecutive months) of an accident, a benefit of $6,250 will be paid to the Employee.

b. **Exclusions.** On self-funded benefits and any benefits provided by an insurance company or other entity, unless required by state or Federal Law, there are no benefits paid for losses resulting from:

1. Willful self-injury or self-destruction, while sane or insane; or
2. Disease or the treatment of disease; or
3. War, or an act of war; or
4. Voluntary participation in an assault, felony, criminal activity, insurrection, or riot; or
5. Participation in flying, ballooning, parachuting, parasailing, bungee jumping or other aeronautic activities, except as a passenger on a commercial aircraft or as a passenger or crew member in a Policyholder-owned or leased aircraft on company business; or
6. Duty as a member of a military organization; or
7. The use of alcohol if, at the time of injury, the Employee’s blood alcohol concentration exceeds the legal limit allowed by the jurisdiction where the injury occurs; or
8. The operation by the Employee of a motor vehicle or motor boat if, at the time of the injury, the Employee’s blood alcohol concentration exceeds the legal limit allowed by the jurisdiction where the injury occurs; or
9. The use of any drug, narcotic, or hallucinogen not prescribed for the Employee by a licensed Physician.

For any benefits provided by a life insurance company or other entity, there may be additional exclusions as prescribed in any agreement entered into between the life insurance company or other entity and the Board of Trustees.

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**XX. MILITARY SERVICE**

1. **Called to Active Military Duty:** If a Participant is called to active military duty for a period of 30 days or longer, the Participant may elect either of the following options:

   a. To have his or her Reserve Hour Bank frozen effective the first day of the month following the commencement of Active Service, which will terminate eligibility for the Employee and/or any Dependents; or

   b. To continue eligibility for the Employee and/or any Dependents using the Participant’s Reserve Hour Bank until it is exhausted.

If a Participant elects option a (above), the Participant and/or his or her Dependents will immediately be eligible for COBRA Continuation Coverage under the Plan’s rules governing that form of coverage. If a Participant fails to make an election, the Participant shall be deemed to have elected option b (above).
2. **Eligibility Rules for USERRA:** To qualify for re-employment rights under the Uniformed Service Employees Reemployment Rights Act ("USERRA"), including certain limited health care benefits (summarized below), a Covered Employee must meet the following requirements:

a. **Purpose of Leave:** The Employee had to leave civilian employment for the purpose of entering a "Uniformed Service." Uniformed services includes the Army, Navy, Air Force, Marine Corp, Coast Guard, National Guard (full time duty), Commissioned Corps of Public Health Service and anyone else designated as Covered by the President of the United States during time of war or National Emergency.

b. **Employee Provided Prior Notice of Service:** An Employee leaving for uniformed service has to provide prior notice that his or her absence will be due to uniformed service. Written notice is not required. You are strongly urged to notify the Union Dispatch Office so that the uniformed service may be noted on the dispatch rolls, by your Employer, and the Trust Fund Office so the Plan is aware of your situation.

c. **Assert Military Rights for no More than Five Years (with certain exceptions):** You may assert USERRA Benefits for military absence not to exceed five years. There are limited exceptions to the five year rule so if you are close to that period, you may contact the Trust Fund Office to determine if your situation may meet an exception to the five year rule.

d. **Employee must be honorably discharged from Service:** The Employee must have been honorably discharged from the military service.

e. **Return to Covered Employment within a Specified Period:** You must return to your same Employer or another Employer that contributes to the Plan within a specified period of time, depending upon the length of time you are absent for military service. The rules for return to employment are:

   1. **Service of Less than 31 Days.** If your period of military service is less than 31 days, you must be available for Covered Employment (which means registering at UA Local 342's dispatch office) on the next calendar day (so long as you had at least eight hours rest after returning home by normal transportation methods) following the end of service.

   2. **Service of More than 30 and Less than 181 Days.** If your military service lasts longer than 30 days but less than 181 days, you must be available for Covered Employment no later than 14 days after completion of military service.

   3. **Service of More than 180 Days.** If your leave from Covered Employment for military service exceeds 180 days, you must be available for Covered Employment no later than 90 days after you have completed your military service.

3. **Right to Certain Health Care Benefits under the Plan:**

a. **Less than 31 Days of Service-One Month of Free Coverage:** If you are absent from Covered Employment as a result of military service for less than 31 days, you may elect to continue your coverage with the Plan at the expense of the Plan.

b. **Absent for More than 30 Days:** If you are absent from Covered Employment as a result of military service for more than 30 days, you may elect to purchase COBRA-like coverage for up to 24 months (the first month of which is free). Typical rights under COBRA are for 18 months, rather than the longer 24 month periods. After the first 30 days you will be required to pay a premium which is 102% of the Plan's cost of the coverage. USERRA continuation requirements are similar but not identical to COBRA requirements. Your absence for service in the uniformed services will trigger rights under both statutes, and you are entitled to protection under the law that provides the most favorable benefit.
EXAMPLE: If you last worked sufficient hours in January, you would have March eligibility. Coverage for April would be provided at the Plan’s expense. If you wish to continue coverage for up to the additional 23 months after April, you would do so by electing and paying COBRA-like payments to the Trust Fund Office. After you return to Covered Employment (with proper notice and documentation), your Reserve Hour Bank may be reinstated (if applicable) in accordance with the Plan rules.

c. Twenty-Four (24) Month COBRA Continuation Coverage: The Participant and/or Dependent(s) may be eligible for pay for a Continuation of Coverage for up to 24 consecutive months. Coverage under the Participant’s Reserve Hour Bank may recommence after discharge from active military service if the Employee returns to work for a Contributing Employer or becomes available to work for a Contributing Employer as shown by registration on the Union's out-of-work list provided the Employee returns to work or registers within the period set forth in Section 2.e above.

XXI. GENERAL PROVISIONS

A. CLAIM FORMS

All claims for benefits shall be filed on forms provided by the Plan, which are available from the Trust Fund Office. The Plan, upon receipt of a written notice of claim, will furnish such forms to a claimant.

B. PROOF OF LOSS – within 180 days

Written proof of loss must be furnished to the Plan for any claim for any benefits payable under the Plan within 180 days after the beginning date of such loss. A proof of loss shall be considered to have been furnished as soon as a claim is received at the Trust Fund Office, provided the claim is substantially complete, with all necessary documentation required by the form. If the form is not substantially complete, or if required documentation has not been furnished, the claimant will be notified as soon as possible of what is necessary to complete the claim. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if the Trustees determine it was not reasonably possible to give proof within such time, provided, except in the absence of the claimant's legal capacity, it is later than one year from the time proof is otherwise required.

C. PLAN HAS RIGHT TO REQUEST PHYSICAL EXAMINATION

The Plan, at its own expense, has the right and opportunity to have a physician or provider of its choice examine any individual whose injury or sickness is the basis of a claim, when and as often as it may reasonably require.

D. CONSTRUCTION

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

E. NO VESTED RIGHT TO BENEFITS, COVERAGE, PAYMENTS AMOUNTS OR ANY OTHER ASPECT OF THE PLAN

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

F. FACILITY OF PAYMENT

Any Death Benefit payable to a minor may be paid to the legally appointed guardian of the minor, or if there is no such guardian, to such adult or adults as have complied with the requirements of California or other applicable law for receipt of such benefit on behalf of the minor, after which the Plan shall have no further obligations with respect to such minor.

G. AVAILABLE ASSETS FOR BENEFITS

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

If at any time the Fund does not have sufficient assets to permit continued payments hereunder, nothing contained in this Plan shall be construed as obligating any Contributing Employer or any UA Local to make benefit payments or contributions in order to provide for such benefits. Likewise, there shall be no liability upon the Board of Trustees, individually or collectively, or upon any Contributing Employer, the Union, signatory association or any other person or entity of any kind to provide the benefits established hereunder if the Fund does not have sufficient assets to make such benefit payments.

H. INCOMPETENCE OR INCAPACITY

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

I. GENDER AND NUMBER

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

J. COORDINATION OF BENEFITS

The Plan’s Coordination of Benefits rules in this section apply only to the extent that Kaiser, Blue Shield, Vision Service Plan, Delta Dental and/or any other administrator/insurer of benefits does not contain their own applicable coordination of benefits provision(s).

Members of a family are often covered by more than one group health insurance Plan. As a result, two or more Plans are paying for the same claim. To help control costs, your health Plan provides a Coordination of Benefits provision. This provision affects all of your different benefits under the Plan.
If a Participant or eligible Dependent is entitled to benefits from another plan, the total amount received from all Plans will never be more than 100% of “Allowable Expenses.” Benefits are reduced to prevent any person from making a profit.

“Allowable Expenses” are any Reasonable and Customary expenses for medical or dental services, treatment or supplies covered by one or more of the Plans under which you or your Dependents are covered.

A “Plan” is considered to be any group Plan providing coverage for medical treatments or services on an insured or uninsured basis. This includes Labor-Management Trustee Plans, Union Welfare Plans, Employer Plans, any coverage under government programs and any coverage required or provided by law, including Mandatory State No-Fault Auto Insurance.

When a person is covered by two or more plans, the primary plan is the Plan that will issue benefits first. If a plan is a secondary plan, it means that it will determine benefits only after the primary plan has issued their benefit payment. The secondary plan would then issue benefits in such a way that the combined benefits paid by all plans do not exceed 100% of the allowable expenses.

1. **Rules:** There are special rules, listed below, for determining the order of benefit payment by the Plans:

   (1) The benefits of a plan that covers an individual as an Employee shall be determined before the benefits of a plan that cover an individual as a Dependent.

   (2) The benefits of a plan which covers a person as an Active Employee (or as that Employee's Dependent) are determined before those of a plan which covers that person as a laid-off or Retired Employee (or as that Employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

   (3) For a Dependent child whose parents are married or living together, whether or not they have ever been married;

      (i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

      (ii) If both parents have the same birthday (month and day), the plan that has covered the parent the longest is the primary plan.

   (4) For a Dependent child whose parents are divorced, separated, or are otherwise not living together, whether or not they have ever been married, benefits are determined in this order:

      (i) If a court decree states that one of the parents is responsible for the Dependent Child’s health care expenses or health care coverage, the order of benefits would be:

          (a) First, the plan of the parent having responsibility for health care expenses would be the primary plan;

          (b) Then, the plan of the parent not having responsibility for health care expenses;

          (c) Finally, the plan of the spouse of the parent with physical custody of the child.

      (ii) If a court decree states that the parents have joint physical custody of the Dependent Child but either does not specify that one parent has responsibility for health care expenses/health coverage or fails to assign responsibility for health care expenses/health coverage to both parents, the order of benefits would be:

          (a) First, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan;

          (b) Then, the plan of the parent whose birthday falls later in the calendar year.
If a court decree states that one parent has primary physical custody of the Dependent Child and assigns responsibility for health care expenses/health coverage to both parents, the order of benefits would be:

(a) First, the plan of the parent with physical custody of the child;
(b) Then, the plan of the parent not having physical custody of the child;
(c) Finally, the plan of the spouse of the parent with physical custody of the child.

If a court decree states that one parent has primary physical custody of the Dependent Child and does not specify that either parent has responsibility for the health care expenses/health coverage, the order of benefits would be:

(a) First, the plan of the parent with physical custody of the child;
(b) Then the plan of the spouse of the parent with physical custody of the child;

If none of the above rules determines the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

If a covered Employee or Dependent is entitled to benefits from another plan and the rules listed above do not determine which plan is primary, the benefits provided hereunder shall be paid in accordance with the standardized coordination of benefits provisions of the National Association of Insurance Commissioners.

2. Allowable Expense: The term “Allowable Expense” is defined as any Reasonable and Customary expenses for medical or dental services, treatment or supplies covered by one or more of the Plans under which you or your Dependents are covered. The maximum “allowable expense” that would be covered under this Plan would never exceed the lesser of:

(1) The normal charge billed for the expense by the provider.
(2) The contractual rate for such expense under a preferred provider contract between the provider and this Plan.
(3) The contractual rate for such expense under a preferred provider contract between the provider and the plan with which this Plan is coordinating benefits.
(4) The maximum usual, reasonable and customary allowance permitted under this Plan.
(5) The maximum usual, reasonable and customary allowance permitted under the Plan with which this Plan is coordinating benefits.

In some instances, a charge billed for a service that is covered by both this Plan and another plan may exceed the usual, reasonable and customary amount allowed under either Plan. Providing this occurrence is not a result of a preferred provider agreement, when this Plan is secondary payer, this Plan can cover any difference between the charge billed and this Plan’s usual, reasonable and customary allowance from any amount available in the individual’s Coordination of Benefits Calendar Year Credit Reserve Bank (benefits that would have been payable in the same calendar year in the absence of the other coverage that were not issued due to Coordination of Benefits). However, in no event would this Plan’s benefit payment ever exceed any amounts available in the individual’s Coordination of Benefits Calendar Year Credit Reserve Bank.

3. Another Plan: The term "Another Plan" means any program with a coordination of benefits provision providing benefits or services for or by reason of medical care or treatment. The term "Other Plan" shall include but not be limited to the following, providing they meet the previously described requirements:

(1) Group Insurance Plans,
(2) Group Hospital or Medical Service Plans and other group Pre-Payment Plans,
(3) Labor-Management Trusteed Plans, Union Welfare Plans, Employer Organization Plans,
4. **Coordination with Medicare:** The coordination of benefits provision in the applicable Plan document for Kaiser or Blue Shield will apply to claims covered by such HMOs. This provision applies to any other benefits provided under this Plan.

Coverage under any Medical Plans offered will be secondary if you are eligible for Medicare and you are a Retired Participant or a Dependent of a Retired Participant.

Medical Coverage under this Plan will be primary if you are eligible for Medicare and you are:

1. An Active Participant performing Covered Employment and over age 65;
2. A Dependent, over age 65, and your spouse is an Actively Employed Participant.

In each situation, where this Plan continues as the primary carrier, the Plan will pay first and Medicare will pay second; however, you and your spouse have the option of electing Medicare as primary. **Please note: If Medicare is elected as primary, coverage under this Plan will cease as required by Federal Law.**

6. **Medicare Benefits Due to Total Disability:** You or your Dependent may become entitled to Medicare benefits prior to age 65 due to total disability or end stage renal disease. The following rules apply with respect to coordination of medical benefits with Medicare due to total disability or end stage renal disease prior to age 65. Upon attainment of age 65, the rules for coordination of benefits with Medicare at age 65 apply.

This Plan will be a primary Plan to Medicare during any waiting period for Medicare benefits due to total disability or end stage renal disease. After meeting the Medicare waiting period and you or your Dependent are entitled to Medicare benefits, this Plan will be secondary to Medicare, for an Actively employed member or his or her Dependent who is entitled to Medicare benefits due to total disability for other than end stage renal disease, the Plan will remain primary to Medicare. Last, the Plan will be secondary to Medicare for an Active member or his or her Dependent who is entitled to Medicare benefits due to end stage renal disease.

7. **Right to Obtain or Release Information:** The Plan may obtain or release any information necessary to implement these provisions. You must declare your coverage under other group Plans. The Plan can pay to another paying organization amounts warranted to satisfy the intent of this provision and, to the extent of such payment, be discharged from liability for that claim. The Plan can also recover amounts that are overpaid under this provision from the Participant, from an insurance company, or from another organization. The Trust Fund Office will require certain information from you for the administration of this provision at the time a claim is submitted. Payment of the claim may be delayed if the required information is not provided.

K. **SUBROGATION RIGHTS/THIRD PARTY LIABILITY**

The subrogation third party liability provision in the applicable Evidence of Coverage booklet for Kaiser or Blue Shield will apply to claims covered by such PPO or HMO. This provision applies to any other benefits provided under this Plan.

This Plan does not cover any illness, injury, disease or other condition for which a third party is or may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation on the part of that third party. Charges incurred by a Participant or Dependent for which a Third Party is liable or responsible are not covered charges under any benefits provided in this Plan; however, payments on otherwise eligible expenses might be advanced to an otherwise eligible Participant or Beneficiary, if the conditions of this section are met.

In requesting any advances from the Plan on account of an illness, injury, or other condition for which a
third party (or their respective insurers) may be liable or legally responsible, you and your Dependent must agree that as a condition precedent to being advanced any Plan benefits, you and your Dependent will notify the Trust Fund Office within 30 days if any claims incurred under the Plan are the result of an accident, injury, disease or other condition for which a third party is OR MAY BE liable or legally responsible, by reason of negligence, an intentional act or breach of any legal obligation on the part of that third party. You must furnish any information or assistance and execute any documents that the Board of Trustees or the Board's delegate may require or request to facilitate enforcement of their rights under this Section and take no action that may prejudice or interfere with the Plan's rights under this Section.

Participants are required to reimburse the Plan immediately for any proceeds received by way of a court judgment, settlement or otherwise (including receipt of proceeds under any uninsured motorists coverage or other insurance) arising out of any claims for damages by the individual or his heirs, parents or legal guardians, to the extent of the payments made or to be made by the Plan for which the third party may be responsible. Any Participant and/or a Dependent who accepts payments from the Plan agrees that by doing so he or she is making a present assignment of his or her rights against such third party to the extent of the payments made by the Plan. These rules are automatic, but the Plan may require that any Participant sign an Agreement to Reimburse and/or Assignment of Recovery in such form or forms as the Plan may require. Any Participant and/or Dependent who refuses to sign an Agreement to Reimburse and/or Assignment of Recovery in a form satisfactory to the Plan shall not be eligible for Plan benefit payments related to the injury involved. Any Participant and/or Dependent who receives benefits and later fails to reimburse the Plan as set forth above will be ineligible for any future Plan benefit payments until the Plan has withheld an amount equal to the amount which the Participant has failed to reimburse, including reasonable interest in such unpaid funds.

By accepting payments from the Plan, any Participant and/or Dependent agrees that the Plan may intervene in any legal action brought against the third party or any insurance company, including the Participant's own carrier for uninsured motorists’ coverage. By accepting payments from the Plan, the Participant and/or Dependent agrees that a lien shall exist in favor of the Plan upon all sums of money recovered by the Participant and/or Dependent against the third party. The lien may be filed with the third party, the third party's agents, or the court. The Participant and/or Dependent shall do nothing to prejudice the Plan's rights as described above without the Plan's written consent.

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

L. WORK RELATED CONDITIONS

The work-related claims provisions in the applicable Kaiser or Blue Shield Evidence of Coverage booklet will apply to claims covered by the PPO or HMO. This provision applies to any other benefits provided under the Plan. This Plan does not pay any claims for condition(s) arising out of or in the course of employment or other occupation for wages or profit, whether or not the individual is covered by Workers’ Compensation insurance.

If you file a claim that your Workers’ Compensation carrier denies as a non-industrial condition(s), the Plan might cover otherwise eligible expenses, providing that you file an appeal of this denial with the Workers Compensation Appeals Board. You must furnish any information or assistance and execute any documents that the Board of Trustees or the Board's delegate may require or request to facilitate enforcement of their rights under this Section and take no action that may prejudice or interfere with the Plan's rights under this Section.
Participants are required to pay to the Plan immediately any proceeds received by way of a court judgment, settlement or otherwise. Any Participant who accepts payments from the Plan agrees that by doing so he is making a present assignment of his rights against such Workers’ Compensation claim. These rules are automatic, but the Plan may require that any Participant sign an Agreement to Reimburse and/or Assignment of Recovery in such form or forms as the Plan may require. Any Participant who refuses to sign an Agreement to Reimburse and/or Assignment of Recovery in a form satisfactory to the Plan shall not be eligible for Plan benefit payments related to the condition(s) involved. Any Participant who receives benefits and later fails to reimburse the Plan as set forth above will be ineligible for any future Plan benefit payments until the Plan has withheld an amount equal to the amount which the Participant has failed to reimburse, including reasonable interest in such unpaid funds.

By accepting payments for the Plan, any Participant agrees that the Plan may intervene in any legal action brought against the third party or any insurance company. A lien shall exist in favor of the Plan upon all sums of money recovered by the Participant against the third party. The lien may be filed with the third party, the third party's agents, or the court. The Participant shall do nothing to prejudice the Plan's rights as described above without the Plan's written consent.

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

M. WOMEN’S HEALTH AND CANCER RIGHTS ACT OF 1998

Under a Federal Law known as the Women's Health and Cancer Rights Act of 1998, Group Health Plans, Insurers and HMOs (such as Kaiser and Blue Shield) that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive breast surgery. For a Participant or beneficiary who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, the law requires coverage in a manner determined in consultation with the attending physician and the patient for (a) reconstruction of the breast on which the mastectomy was performed, (b) surgery and reconstruction on the other breast to produce a symmetrical appearance, and (c) prostheses and physical complications of all stages of mastectomy, including lymphedemas. This coverage is subject to the Plan's annual deductibles and coinsurance provisions.

N. NEWBORNS AND MOTHER’S HEALTH PROTECTION ACT

Group Health Plans, Health Insurance Issuers, and HMOs (such as Kaiser and Blue Shield) generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child less than 48 hours following normal delivery, or less than 96 hours following a cesarean section. (Federal Law does not, however, prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and her newborn earlier than the 48 hours, or 96 hours as applicable.) In any event, Plans and issuers may not, under Federal Law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours or 96 hours as applicable.

O. OUT OF COUNTRY/TEMPORARY STAY

Please refer to your Evidence of Coverage (EOC). Please be aware that covered services under both the Kaiser Permanente Plan and Blue Shield Health Maintenance Organization (HMO) Plans is limited to only those treatments specifically provided for under your Plan’s EOC when rendered by panel providers within your coverage service area. If a covered individual (Plan Participant or Eligible Dependent) temporarily resides outside of the Plan’s coverage service area, only Medically Necessary Emergency Services as defined in your Plan’s EOC might be covered and verification/authorization for such emergency treatments
should be obtained directly from your selected Health Plan.

P. HEALTH REIMBURSEMENT ACCOUNT (HRA)

This Plan includes a Health Reimbursement Account (HRA). The HRA under the Plan uses pre-tax dollars in the account to pay for qualified out-of-pocket medical, dental, visions or prescription drug expenses allowed under the Internal Revenue Code (IRC) and which are otherwise not payable under the Plan, incurred by eligible Participants and Dependents defined in IRC 152 (excluding Domestic Partners). For a complete list of “Qualified Expenses”, which are reimbursable if not otherwise covered by the Plan, please view the IRS publication at [http://www.irs.gov/pub/irs-pdf/p502.pdf](http://www.irs.gov/pub/irs-pdf/p502.pdf). Generally, reimbursements for eligible claims filed by the end of a month with all necessary documentation will be issued by the 15th of the next month. However, if you have an overpayment on file with the Plan, your reimbursement payment may be delayed. The Plan has engaged the services of Kaufmann & Goble to administer its HRA benefits. Please contact Kaufmann & Goble at 1-800-767-1170 for questions about your HRA. Also, for more details on the Plan’s HRA, please refer to Appendix I of this booklet.

XXII. GENERAL EXCLUSIONS

For any self-funded benefits, the following general exclusions would apply:

1. **Employment Related Injuries/Conditions.** Services associated with employment related injuries or conditions or charges which are reimbursable under Workers’ Compensation or other Employer’s Liability laws.

2. **Government Provided Services.** Services provided to the eligible patient by any Federal or State Government Agency or are provided without cost to the eligible patient by any municipality, county or other political subdivision, except as provided in Section 12432.5 of the California Government Code.

3. **Third Party Liability.** Services for which a third party may be liable or legally responsible.

4. **Services Performed by Person Related to.** Services performed by a person who lives in your home or is related to you by blood or marriage.

5. **Charges Patient Not Liable for In Absence of Insurance.** Charges for which the patient would not otherwise be liable for in the absence of insurance.

6. **Services Patient Not Legally Required to Pay.** Charges for services for which the Participant/patient is not legally required to pay.

7. **Charges Plan Not Legally Obligated to Pay.** Charges for which the Plan would not be legally obligated to pay in the absence of this Plan.

8. **Experimental or Investigational Procedures/Treatment.** Any experimental or investigational procedures or treatment; or any course of treatment whether or not prescribed by a physician, for which charges incurred are not the direct result of injury or illness, and any other procedure not recognized to have medical significance or therapeutic value; or any course of treatment making use of drugs or devices not yet approved by the Federal Drug Administration.

9. **Charges Resulting From War, Crime, Participation in Riot/Insurrection.** Any charges resulting from war, declared or not, armed aggression, in the commission of a crime, or participation in a riot or insurrection.
10. **Charges Resulting From Felony/Illegal Activity.** Any charges resulting from participation in a felony or illegal activity (no criminal conviction is necessary for the exclusion to apply).

11. **Cosmetic Surgery.** Services for purely cosmetic reasons or cosmetic surgery.

12. **Investigational Procedures.** Investigational procedures.

13. **TMJ related Services.** Charges for services associated with the treatment of disturbances of the jaw joints (temporomandibular joints, or “TMJ”) or associated muscles, nerves or tissues.

14. **Non-Medically Necessary Charges.** Procedures which are not considered necessary for your health care; or which are not prescribed by a licensed physician or dentist; or which are not the appropriate type of care necessary to treat a medical/dental condition; or which are not consistent with generally accepted United States medical/dental standards of practice.

15. **Exceeds Usual, Customary, and Reasonable Charges.** Charges which exceed this Plan’s usual, reasonable and customary guidelines.

16. **Claims Submitted More than 12 months.** Any claims submitted more than 12 months after the date of occurrence shall not be covered by the Plan.

17. **Non-Covered Out-of-Country Expenses.** Charges incurred out-of-the country are not a covered expense.

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**XXIII. POTENTIAL LOSS OF BENEFITS**

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

A. **PLAN EXCLUSIONS/CO-PAYMENTS/INELIGIBLE FOR COVERAGE**

The Plan and any HMO or PPO contains exclusions and exceptions for coverage. You should be aware of the Plan’s limitations, exclusions, co-payments and other facets of the Plan in which you may not receive full payment on a claim or reimbursement or for which there is a co-payment. In addition, if you or a Dependent are not eligible for benefits based on Plan rules, no benefits will be paid.

B. **INADEQUATE OR IMPROPER EVIDENCE**

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

C. **PROHIBITED EMPLOYMENT IN THE PIPE TRADES INDUSTRY**

If you engage in certain kinds of work in the Pipe Trades Industry, known as Prohibited Employment, you will no longer be entitled to Retiree Health and Welfare Benefits.

D. **SUBROGATION THIRD PARTY CLAIMS**

The Plan does not cover any illness, injury, disease or other condition or claim for which a third party may be liable or legally responsible. See Article XXI, Section K for the rules for Third Party Liability.
E. COORDINATION OF BENEFITS WITH OTHER PLANS

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

F. FAILURE TO ENROLL IN MEDICARE PARTS A AND B

If you are eligible for and fail to enroll in Medicare parts A and B the Plan will not pay many of your claims. Please refer to Article XIII, Section B for additional information.

G. CLAIMS RESULTING FROM WORK-RELATED INJURIES

The Plan is not responsible for paying any claims incurred as a result of a work-related injury. This is so even if you have not filed a claim with Workers’ Compensation.

H. RIGHT TO RECOVER CLAIMS PAID OR OFFSET OF FUTURE CLAIMS

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

I. FAILURE TO FILE COMPLETE APPLICATION

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

J. INCOMPLETE INFORMATION/FALSE STATEMENTS

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

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

K. PLAN TERMINATION

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

L. FAILURE TO MAKE EMPLOYER CONTRIBUTIONS

If the Contributing Employer did not make contributions on your behalf, you will not be eligible for Retiree Health and Welfare Coverage.

XXIV. CLAIMS AND APPEAL PROCEDURE

A. GENERAL RULES

1. Comply with Department of Labor Regulations: The Board of Trustees has established the claims and appeal procedures
with the intent of complying with regulations issued by the Department of Labor ("DOL"). The Plan seriously takes into consideration of abiding by the claims and appeal procedure. It is imperative that you timely file your claims and appeal according to these provisions.

**ALERT--LIMITED APPLICABILITY OF FOLLOWING RULES**

2. **Limited Applicability--Insurance Company PPO and HMO Rules Apply:** The claims and appeals procedures set forth below apply only for non-insured (Blue Shield PPO), non-HMO (Health Maintenance Organization) Benefits. Claims and appeals for insured PPO and HMO benefits are governed by the rules of the specific insurance companies and HMOs, which are available upon written request from the applicable insurance company or HMO.

3. **Kaiser and Blue Shield PPO and HMO Arbitration:** When you apply for coverage with the Plan you will be required to sign a form agreeing to arbitrate your dispute with either Kaiser or Blue Shield. The application will state something similar to the following:

   (1) **Kaiser Binding Arbitration Agreement.** I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

   (2) **Blue Shield Binding Arbitration Agreement.** Blue Shield participating providers may choose to enter into arbitration agreements with Blue Shield plan members, providing the agreement to arbitrate fully complies with California Code of Civil Procedure, Section 1295, including the provision that the patient is permitted to rescind the arbitration agreement in writing within 30 days of signature, even when medical services have already been provided. In addition, Authorization for Disclosure of Personal Information: by signing below, you authorize any "provider of care," insurer, plan, or your Blue Shield of California agent or broker, to disclose to Blue Shield of California or Blue Shield of California Life & Health Insurance Company (individually or collectively referred to as "Blue Shield"), or its representatives, and vice versa, all "medical information" (as those terms are defined in the California Civil Code) regarding you and your applying family members, including medical information regarding substance abuse or mental/emotional conditions. This information may be used for the purposes of evaluating this application, determining eligibility and claims for benefits, quality assurance, peer review, or administrative functions reasonably related to executing and managing this Agreement/Policy. In addition, you authorize Blue Shield of California to obtain personal and medical record information (as those terms are defined in the California Insurance Code) from an institutional source or an insurance support organization that gathers this type of information, for the purposes of determining eligibility for coverage. This authorization will remain valid as follows: (1) for 30 months from the date of authorization for the purposes of processing the application, a policy reinstatement, or a request for change in policy benefits; and (2) for all other activities under the policy, for the term of the coverage or for as long as may be necessary for processing of claims incurred during the term of coverage. You understand that you are entitled to a copy of this form and that a photocopy is as valid as the original.
4. **Discretionary Authority of Board of Trustees**: The Board of Trustees has the discretionary authority to determine eligibility for and the amount of benefits and to construe the terms of any Plan, the Trust Agreement, other documents, and any rules and regulations issued hereunder. The Board of Trustees has the discretionary authority to make all factual determinations concerning any claim or right asserted under or against the Plan.

**B. CLAIMS AND APPEALS PROCEDURES**

1. **Definitions**:

   a. **Adverse Benefit Determination.** An "Adverse Benefit Determination" is any denial, reduction, termination of or failure to provide or make payment for a benefit (either in whole or in part) under the Plan. Each of the following is an example of an Adverse Benefit Determination:

      (1) A payment of less than 100% of a Claim for benefits (including coinsurance or co-payment amounts of less than 100% and amounts applied to the deductible);
      (2) A denial, reduction, termination of or failure to provide or make payment for a benefit (in whole or in part) resulting from any utilization review decision;
      (3) A failure to cover an item or service because the Plan considers it to be Experimental, Investigational, not Medically Necessary;
      (4) A restriction on reimbursement for particular services because they are classified as related to a mental or nervous, rather than a physical, condition; and
      (5) A decision that denies a benefit based on a determination that a claimant is not eligible to participate in the Plan.

   Presentation of a prescription order at a pharmacy, where the pharmacy refuses to fill the prescription unless the Participant pays the entire cost, is not considered an Adverse Benefit Determination (but only to the extent that the pharmacy's decision for denying the prescription is based on coverage rules predetermined by the Plan).

   b. **Claim.** The term "Claim" means a request for a benefit made by a Participant in accordance with the Plan's procedures.

   Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered Claims. Nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered to be a Claim. However, if a Participant files a Claim for specific benefits and the Claim is denied because the individual is not eligible under the terms of the Plan, that coverage determination is considered a Claim.

   The presentation of a prescription order at a pharmacy does not constitute a Claim, to the extent benefits are determined based on cost and coverage rules predetermined by the Plan. If a Physician, Hospital or pharmacy declines to render services or refuses to fill a prescription unless the Participant pays the entire cost, the Participant should submit a Post-Service Claim for the services or prescription, as described under Claim Procedures below.

   A request for precertification or prior authorization of a benefit that does not require precertification or prior authorization by the plan is not considered a Claim. However, requests for precertification or prior authorization of a benefit where the Plan does require precertification or prior authorization are considered Claims and should be submitted as Pre-Service Claims (or Urgent Claims, if applicable), as described under Claim Procedures below. Claims are categorized as Follows:

   (1) **Urgent Claim.** The term "Urgent Claim" means a Claim for medical care or treatment that, if normal Pre-Service standards for rendering a decision were applied, would seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical
condition, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

(2) **Pre-Service Claim.** The term "Pre-Service Claim" means a Claim for a benefit for which the Plan requires precertification or prior authorization before medical care is obtained in order to receive the maximum benefits allowed under the Plan.

(3) **Concurrent Claim.** The term "Concurrent Claim" means a Claim that is reconsidered after an initial approval has been made resulting in a reduction, termination or extension of the previously approved benefit.

(4) **Post-Service Claim.** The term "Post-Service Claim" means a Claim for benefits that is not a Pre-Service, Urgent or Concurrent Claim. This will generally be a claim for reimbursement for services already rendered.

(5) **Disability Claims.** The term "Disability Claim" means any Claim that requires a finding of Total Disability as a condition of eligibility.

c. **Relevant Documents.** "Relevant Documents" include documents pertaining to a Claim if they were relied upon in making the benefit determination, were submitted, considered or generated in the course of making the benefit determination, demonstrate compliance with the administrative processes and safeguards required by the regulations, or constitute the Plan's policy or guidance with respect to the denied treatment option or benefit. Relevant Documents could include specific Plan rules, protocols, criteria, rate tables, fee schedules or checklists and administrative procedures that prove that the Plan's rules were appropriately applied to a Claim.

2. **Claim Procedures:**

(Please refer to your individual Vision Service Plan (VSP), Blue Shield or Kaiser and Delta Dental EOC documents for appeal and grievance procedures).

a. **Urgent Claims.** An Urgent Claim is a request by a Participant or a provider for authorization before medical care is obtained and delay in a decision of up to 15 days would seriously jeopardize the life or health of the claimant.

The Plan will determine whether a Claim is an Urgent Claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, if a Physician with knowledge of the patient's medical condition determines that the Claim is an Urgent Claim, and notifies the Plan of such, it will be treated as an Urgent Claim.

Urgent Claims, which may include requests for Precertification of Hospital Admission and Prior Authorizations of various services and prescription drugs, must be submitted by fax. Urgent Care Claims may not be submitted via the US Postal service.

For properly filed Urgent Claims, the Plan will respond to the Participant with a determination by telephone as soon as possible, taking into account the medical emergencies, but not later than 72 hours after receipt of the Claim. The determination will also be confirmed in writing.

If an Urgent Claim is received without sufficient information to determine whether, or to what extent, benefits are covered or payable, the Plan will notify the Participant as soon as possible, but not later than 24 hours after receipt of the Claim, of the specific information necessary to complete the Claim. The Participant must provide the specified information within two (2) business days. If the information is not provided within that time, the Claim will be denied.

During the period in which the Participant is allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the extension notice until either two (2) business days or the date the claimant responds to the request, whichever is earlier. Notice of the decision will be provided no later than 48 hours after receipt of the specified information or the end of the two (2) business day period given for the
Participant to provide this information, whichever is earlier.

If a Participant improperly files an Urgent Claim to the Trust Fund Office, the Trust Fund Office will notify the Participant as soon as possible but not later than 24 hours after receipt of the Claim, of the proper procedures to be followed in filing an Urgent Claim. The Participant will only receive notice of an improperly filed request for prior authorization of an Urgent Claim if the Claim includes (i) the patient's name, (ii) the patient's specific medical condition or symptom, and (iii) the specific treatment, service or product for which approval is requested. Unless refiled properly, it will not constitute a Claim.

b. **Pre-Service Claims.** A Pre-Service Claim is a Claim for a benefit for which the Plan requires precertification or prior authorization before medical care is obtained as a condition of receiving maximum benefits allowed under the Plan. Under the terms of this Plan, claimants are not required to obtain precertification for any services.

c. **Concurrent Claims.** Any request by a Participant to extend an approved Urgent Claim will be acted upon by the Plan within 24 hours of receipt of the Claim, provided the Claim is received at least 24 hours prior to the expiration of the approved Urgent Claim. A request to continue a plan of treatment that is in progress that does not involve an Urgent Claim will be decided in enough time to request an appeal and to have the appeal decided before the benefit is reduced or terminated.

d. **Post-Service Claims.** A Post-Service Claim must be submitted to the Trust Fund Office in writing, using an appropriate claim form, as soon as possible after expenses are incurred. A claim form may be obtained by contacting the Trust Fund Office. Failure to file a Post-Service Claim within the time required will not invalidate or reduce any Claim if it was not reasonably possible to file the Claim within such time. However, in that case, the Claim must be submitted as soon as reasonably possible, but in no event later than one year from the date the charges were incurred.

A Post-Service Claim is considered to have been filed upon receipt of the Claim by the Trust Fund Office.

Ordinarily, Participants will be notified of decisions on Post-Service Claims within 30 days from the receipt of the Claim by the Trust Fund Office. The Plan may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, the Participant will be notified, before the end of the initial 30-day period, of the circumstances requiring the extension and the date by which the Plan expects to render a decision.

If an extension is required because the Plan needs additional information from the Participant, the Plan will issue a Request for Additional Information that specifies the information needed. The Participant will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the Claim will be denied. During the 45-day period in which the Participant is allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the Request for Additional Information until either 45 days or until the date the Participant responds to the request, whichever is earlier. The Plan then has 15 days to make a decision on the Claim and notify the Participant of the determination.

If the Plan determines that additional information is required from the Participant, and the Participant fails to provide any requested information within 45 days, the Plan will issue a Notice of Adverse Benefit Determination.

e. **Disability Claim.** A Disability Claim must be submitted to the Trust Fund Office within 90 days after the date of the onset of the disability. The Plan will make a decision on the Disability Claim and notify the Participant of the decision within 45 days after receipt of the Claim by the Trust Fund Office. If the Plan requires an extension of time due to matters beyond the control of the Plan, the Trust Fund Office will notify Participant of the reason for the delay and the date by which the Plan
expects to render a decision. This notification will occur before the expiration of the initial 45-day period. The notice of extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

A decision will be made within 30 days of the time the Plan notifies the Participant of the delay. The period for making a decision may be delayed an additional 30 days, provided the Plan notifies the Participant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information from the Participant, the extension notice will specify the information needed. If the information is not provided within the 45-day period, the Claim will be denied. During the 45-day period in which the Participant is allowed to supply additional information, the normal period for making a decision on the Claim will be suspended. The period for making the determination is suspended from the date of the extension notice until the earlier of: (1) 45 days from the date of the notification; or (2) the date the Participant responds to the request. Once the Participant responds to the Plan's request for the information, the Participant will be notified of the Plan's decision on the Claim within 30 days.

For Disability Claims, the Plan reserves the right to have a Physician examine the claimant (at the Plan's expense) as often as is reasonable while a claim for benefits is pending.

f. **Authorized Representatives.** An authorized representative, such as a spouse or an adult child, may submit a Claim or appeal on behalf of a Participant if the Participant has previously designated the individual to act on his or her behalf. An Appointment of Authorized Representative form, which may be obtained from the Trust Fund office, must be used to designate an authorized representative. The Trust Fund Office may request additional information to verify that the designated person is authorized to act on the Participant's behalf.

A health care professional with knowledge of the Participant's medical condition may act as an authorized representative in connection with an Urgent Claim without the Participant having to complete the Appointment of Authorized Representative form.

g. **Notice of Initial Benefit Determination.** The Participant will be provided with written notice of the initial benefit determination. If the determination is an Adverse Benefit Determination, the notice will include:

1. The specific reason(s) for the determination;
2. Reference to the specific Plan provision(s) on which the determination is based;
3. A description of any additional material or information necessary to perfect the Claim and an explanation of why the material or information is necessary;
4. A description of the appeal procedures and applicable time limits and a statement of the Participant's right to bring a civil action under ERISA Section 502(a) following the appeal of an Adverse Benefit Determination;
5. If an internal rule, guideline or protocol was relied upon in deciding the Claim, a statement that a copy is available upon request at no charge;
6. If the determination was based on the absence of Medical Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge;
7. For Urgent Claims, a description of the expedited review process applicable to Urgent Claims (for Urgent Claims, the notice may be provided orally and followed with written notification).
3. **Appeal Procedures:**

a. **Appealing an Adverse Benefit Determination.** If a Claim is denied in whole or in part, or if the Participant disagrees with the decision made on a Claim, the Participant may appeal the decision. Appeals must be made in writing and must be submitted to the Trust Fund office within 180 days after the Participant receives the notice of Adverse Benefit Determination.

   (1) **Urgent Claims.** Appeals of Adverse Benefit Determinations regarding Urgent Claims must be made within 180 days after receipt of the Notice of Adverse Benefit Determination by either:

   (2) Calling the Trust Fund Office and asking to speak to the Utilization Review Representative. All oral requests must be followed by a faxed written request within 24 hours.

   (3) Faxing the request to the attention of the Utilization Review Representative.

   Appeals of Urgent Claims may not be submitted via the US Postal service.

b. **Concurrent Claims.** Appeals of Adverse Benefit Determinations regarding Concurrent Claims must be made in the same manner described for Urgent Claims.

c. **Post-Service and Disability Claims.** The appeal of a Post-Service or Disability Claim must be submitted in writing to the Trust Fund Office within 180 days after receipt of the Notice of Adverse Benefit Determination and must include:

   (1) The patient's name and address;

   (2) The Participant's name and address, if different;

   (3) A statement that this is an appeal of an Adverse Benefit Determination to the Board of Trustees;

   (4) The date of the Adverse Benefit Determination; and the basis of the appeal, e.g., the reason(s) why the Claim should not be denied.

d. **The Appeal Process.** The Participant will be given the opportunity to submit written comments, documents, and other information for consideration during the appeal, even if such information was not submitted or considered as part of the initial benefit determination. The Participant will be provided, upon request and free of charge, reasonable access to and copies of all Relevant Documents pertaining to his or her Claim.

   A different person will review the appeal than the person who originally made the initial Adverse Benefit Determination on the Claim. The reviewer will not give deference to the initial Adverse Benefit Determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by the Participant.

   If the Claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was Investigational or Experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. Upon request, the Participant will be provided with the identification of medical or vocational experts, if any, that gave advice on the Claim, without regard to whether the advice was relied upon in deciding the Claim.

e. **Time frames for Sending Notices of Appeal Determinations.**

   (1) **Urgent Claims.** Notice of the appeal determination for Urgent Claims will be sent within 72 hours of receipt of the appeal by the Trust Fund Office.

   (2) **Concurrent Claims.** Notice of the appeal determination for a Concurrent Claim that involves an extension of an Urgent Care Claim will be sent by the Plan within 72 hours of receipt of an appeal by the Trust Fund Office.
Post-Service and Disability Claims. Ordinarily, decisions on appeals involving Post Service and Disability Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of Participant's request for review. However, if the request for review is received at the Trust Fund Office within 30 days before the next regularly scheduled meeting, the request for review may be considered at the second regularly scheduled meeting following receipt of the Participant's request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of the Participant's request for review may be necessary. The Participant will be advised in writing in advance if this extension will be necessary. Once a decision on review of Participant's Claim has been reached, the Participant will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

If the decision on review is not furnished to the Participant within the time specified in this subsection, Participant's Claim shall be deemed denied upon review. Participant shall be free to bring an action upon his Claim in accordance with Section 4 below.

Content of Appeal Determination Notices. The determination of an appeal will be provided to the claimant in writing. The notice of a denial of an appeal will include:

1. The specific reason(s) for the determination;
2. Reference to the specific Plan provision(s) on which the determination is based;
3. A statement that the Participant is entitled to receive reasonable access to and copies of all documents relevant to the Claim, upon request and free of charge;
4. A statement of the Participant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal;
5. If an internal rule, guideline or protocol was relied upon, a statement that a copy is available upon request at no charge; and
6. If the determination was based on Medical, Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge.

Time of Notice. The notice of denial shall be given within 90 days after a claim is filed (with all pertinent information), unless special circumstances require an extension of time for processing the claim. If such an extension is required, written notice shall be furnished to the claimant stating the special circumstances requiring additional time and the date by which a decision on the claim can be expected. If such notice of denial is not given within the time required and all required information has been furnished to the Plan, the claimant may assume that the claim has been denied and proceed to the review stage.

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

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

**XXV. AMENDMENT AND TERMINATION OF THE PLAN**

A. **AMENDMENTS**

The Plan may be amended in whole or in part at any time by the Board of Trustees and all persons with rights or obligations hereunder shall be bound thereby. Benefit levels and amounts may be changed at any time.

B. **MANDATORY AMENDMENTS**

Amendment of the Trust or Plan shall be mandatory in the following situations:

1. When necessary to assure compliance with ERISA or other applicable laws;
2. When necessary to assure the tax-deductibility of contributions hereto under Federal and State Income Tax Laws;
3. When necessary to assure that this Trust remains tax exempt.

C. **TERMINATION**

The Board of Trustees may terminate the Plan at any time subject to the Trust Agreement and applicable Collective Bargaining Agreements. Upon termination of the Trust, all obligations shall first be satisfied. The Board of Trustees shall thereupon use the remaining Trust assets to provide Plan benefits in such manner as the Plan may provide, or in the absence of a Plan provision, to continue to provide Plan benefits in a manner permitted by ERISA for so long as Trust assets permit.

D. **TRANSFER OF ASSETS TO ANOTHER BENEFIT TRUST/MERGERS AND CONSOLIDATIONS**

Notwithstanding anything above to the contrary, the Board of Trustees may transfer, merge or consolidate, the Trust assets or any portion thereof to the Trustees of any other trust or trusts which provide similar benefits.

**XXVI. ADDITIONAL INFORMATION REQUIRED BY ERISA**

A. **NAME AND TYPE OF PLAN**

The name of the Plan is the Northern California Pipe Trades Health and Welfare Plan ("Plan"). The Plan is a Health and Welfare Plan exempt from income tax under Section 501(c) 9 of the Internal Revenue Code.

B. **PLAN ADMINISTRATOR**

The Board of Trustees is the designated Plan Administrator of the Plan under ERISA. The Board is responsible for the operation and administration of the Plan, including ensuring that information regarding the Plan is reported to governmental agencies and disclosed to Plan Participants and beneficiaries in accordance with ERISA. The Board has designated Kim Biagi to be the Fund Manager for the Plan; you may contact her as follows:
C. AGENT FOR THE SERVICE OF LEGAL PROCESS

The person designated as agent for service of legal process is:

Richard K. Grosboll
Neyhart, Anderson, Flynn & Grosboll
369 Pine Street, Suite 800
San Francisco, CA 94104-3323
(415) 677-9440

Service of legal process may be made upon the above named person and also upon the Fund Manager, any Plan Trustee, or the Board of Trustees, at the addresses listed on Page v of this booklet.

D. PLAN YEAR

The Plan Year commences on July 1st and ends on June 30th.

E. EMPLOYER IDENTIFICATION NUMBER (EIN)

The Internal Revenue Service Employer Identification Number (EIN) for the Northern California Pipe Trades Health and Welfare Plan is 94-3183274, Plan 501.

F. FUNDING CONTRIBUTIONS AND COLLECTIVE BARGAINING AGREEMENTS

The Plan is maintained in accordance with Collective Bargaining Agreements between the UA Local 342 and certain designated Employer associations (and some individual Employers), which require Employers to contribute to the Plan.

The Trust Fund Office will provide you upon written request with information regarding whether a particular Employer for whom you work is contributing to the Plan, if the Employer is a contributor, and the Employer's address.

G. FUND MEDIUM/INVESTMENTS

Assets of the Plan are held in Trust. Plan assets are held in custody by Bank of New York. The Board of Trustees has delegated to Mammini Company, the Plan's Investment Manager, with the responsibility for investing the Plan's assets. The Board may select other Investment Managers in the future.

XXVII. STATEMENT OF ERISA RIGHTS

A. YOUR RIGHTS UNDER ERISA

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

1. Examine, without charge, at the Trust Fund Office and at other specified locations such as work sites and the Union Office, documents governing the Plan, including Collective Bargaining Agreements and the annual report (Form 5500 series) filed with the Department of Labor.

2. Obtain copies of Plan documents and other information required to be furnished by law, upon written request to the Plan. Pursuant to ERISA, the Trust Fund office may require that you pay a reasonable charge for the copies (not to exceed 25 cents a copy).

3. Receive a summary of the Plan’s annual financial report, known as a Summary Annual Report (“SAR”). The Plan is required by law to furnish each Participant with this SAR.

B. PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called “fiduciaries,” have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under ERISA.

C. ENFORCING YOUR RIGHTS

If your claim for a Plan Benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision, without charge, and to appeal any denial, all within certain time limits.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of certain Plan documents (required to be furnished) or the latest annual report (Form 5500) from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the Court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Administrator or the Administrator’s delegate’s control.

If you have a claim for benefits that is denied or ignored in whole or in part, which is upheld on appeal (or ignored), you may file suit in a state or federal court. As summarized earlier in this booklet, any lawsuit must be filed within two years of the denial on appeal or other action, omission or decision which adversely affected you or your benefits.

In addition, if it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. If your lawsuit is unsuccessful, the court may order you to pay these court costs and fees to the prevailing party. No lawsuit may be filed (started) more than two years after services were provided or benefits were partially or totally denied, or an otherwise adverse determination was made against you.

D. ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Trust Fund Office. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor at (866) 444-3272 or writing to the Department’s national office at the following address:
You may also obtain certain publications about your rights and responsibilities under ERISA by calling the EBSA’s Brochure Request Line at (866) 444-3272 or contact the EBSA field office nearest you.

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

APPROVED

Scott W. Strawbridge, Chair

Michael Hernandez, Co-Chair

Dated: ______________________________

Dated: ______________________________
NORTHERN CALIFORNIA PIPE TRADES HEALTH AND WELFARE PLAN

Health Reimbursement Account (HRA) Supplemental Accounts

This Health Reimbursement Account Document shall be considered an Amendment to the Northern California Pipe Trades Health and Welfare Plan (“Plan”) and is an Appendix to the Plan Document.

Article 1. Establishment of Supplemental Accounts

1. Each Active Participant for whom contributions are made under a Collective Bargaining Agreement for the purpose of a Supplemental account will receive Supplemental Account credit for those contributions. These Supplemental Accounts will be separate from, and in addition to, the amounts credited to each Active Participant for the purposes of determining current coverage and accruing a Reserve Hour Bank. Notwithstanding the above:

   a. If a Participant working under a Collective Bargaining Agreement of UA Local Union 342 has reciprocity in effect, he or she shall not have a Supplemental Account in this Plan. Instead, his or her Supplemental Account contributions shall be reciprocated to his or her home Trust Fund, to be allocated at the discretion of the home Trust Fund’s Trustees and are sent as Health and Welfare Contributions. Travelers will not be permitted to participate in the Plan under any classifications above the mandatory amount.

   b. If a participant of UA Local Union 342 is working under a collective bargaining agreement of another UA Local Union which has contributions dedicated to Supplemental Accounts or the equivalent, the participant shall receive credit towards his/her Reserve Hour Bank to give eligibility. The Board has determined that this is more beneficial to participant’s since other UA Local Union plans have lower contribution rates and these supplemental benefits can help maintain his/her eligibility.

2. Supplemental Accounts may be used for any purpose allowed under the Plan rules below and only for such purposes. Nothing in these rules for Supplemental Accounts shall be construed as making Supplemental Accounts vested at any time or subject to use in any manner except as provided herein.

3. Supplemental Accounts that have a year-end balance may be credited (or charged) an amount reflecting the income (or loss) on those Accounts for the Plan Year at the discretion of the Board of Trustees. Regardless of whether income or losses are allocated to Supplemental Accounts, the Board of Trustees reserves the power to assess an administrative charge against Supplemental Accounts. Statements are to be mailed on an annual basis, unless special circumstances prevent such distribution.

4. Eligibility Rules. Effective July 1, 2014, in order to comply with the Patient Protection and Affordable Care Act, IRS Notice 2013 54, and EBSA Technical Release 2013-03 the following eligibility rules apply:

   a. In order to use the HRA for reimbursements, the Active or Retired Participant must be actually enrolled in the Northern California Pipe Trades Health and Welfare Plan or other group health coverage that provides minimum value pursuant to the Internal Revenue Code Section 36B(c)(2)(C)(ii), regardless of whether the other group health coverage is sponsored by the Northern California Pipe Trades Health and Welfare Trust Fund.

   b. Proof of other group health coverage will be required in a manner to be determined by the Board of Trustees. If the Active or Retired Participant does not provide proof of enrollment in other group coverage that provides minimum value, in a manner determined by the Board of Trustees, benefits from the HRA will be limited to reimbursement of co-payments, co-insurance, deductibles, and
premiums, as well as medical care defined under the Internal Revenue Code Section 213(d) that does not constitute essential health benefits.

c. Any Participant who has an HRA account balance is permitted to permanently opt out of and waive future reimbursements from his or her HRA account at least annually.

d. Upon termination of employment, the Participant may elect to either: forfeit his or her HRA account balance or permanently opt out of and waive future reimbursements from his or her HRA account.

Article 2. Use of Supplemental Accounts

1. Retiree Health and Welfare Payments. Supplemental Accounts are intended primarily to be used to make Retiree Health and Welfare payments under this Plan. Once a Participant is receiving a Retirement Benefit from the Northern California Pipe Trades (NCPT) Pension Plan and is enrolled for Retiree Health and Welfare coverage under this Plan, the credits accrued in his or her Supplemental Account may be used to pay the monthly charge set by the Board of Trustees for Retiree Health and Welfare coverage.

2. Qualified Expenses. Any Active or Retired Participant who is eligible for benefits under this Plan may be reimbursed from his or her Supplemental Account for any Qualified Expenses that are not otherwise covered under the Plan. A Retired Participant who is receiving a benefit under the NCPT Pension Plan but who is not covered as a Retiree under this Plan may also be reimbursed for Qualified Expenses. To qualify for payment through a Participant’s Supplemental Account an expense must satisfy all of the following requirements:

   a. The expense must have been for medical care as defined in Internal Revenue Code § 213(d), except as follows: An expense for premiums for medical coverage shall be reimbursable only if:

      (i) A Surviving Spouse or Surviving Eligible Dependent of a Participant is using the Participant’s Supplemental Account to make monthly payments required for Surviving Dependent Health and Welfare Coverage, or to pay premiums for COBRA continuation of Coverage based on the death of the Participant as the Qualifying Event. If the eligible Dependent(s)’ Surviving Dependent Health and Welfare Coverage or COBRA Continuation of Coverage period ends before the Participant’s Supplemental Account is exhausted, that Account may be used to pay for the extended coverage for the Participant’s Dependent(s), at the COBRA Continuation of Coverage rate, until the earlier of the following time (1) the Supplemental Account is exhausted; or (2) other coverage becomes available (including, but not limited to, coverage through Medicare or through another group health plan); or

      (ii) The Participant is using his/her Supplemental Account to make Subsidized Self-Payments or COBRA payments for his/her coverage or covered as a Retiree, and the premium is for coverage of a Dependent under insurance or a group health plan other than this Plan.

      (iii) Surviving Eligible Dependents who are enrolled at the time of a Participant’s death may be eligible to continue to use the remaining Supplemental Account.

   b. The expense must have been incurred once Initial Eligibility was established for HRA Benefits.

   c. The expense must have been incurred by the Participant or by a person who was then either a covered Eligible Dependent of the Participant (Active Participants) or a Dependent within the meaning of Internal Revenue Code § 152. No cash Death Benefit distribution may be made unless permitted by the Internal Revenue Code or lawful regulations issued thereunder.

   d. Domestic Partners and their Eligible Dependents or Dependents covered through legal guardianship are not considered Dependents pursuant to the Internal Revenue Code.

   e. The claim for Supplemental Account Benefits may be made at any time after the expense is incurred.

   f. The expense must have been incurred on or after January 1, 2007.

   g. The Participant or Dependent must provide proof satisfactory to the Board of Trustees that the claim satisfies the requirements under Section 3.
h. Effective July 1, 2014, amounts credited to the Participant’s HRA cannot be used to reimburse premiums or expenses for individual market coverage or individual coverage purchased from the Public or Private Health Insurance Marketplace (also known as the Exchange).

3. **Procedures for Payment of Benefits.**

   a. Benefits will be paid only to a Participant or an Eligible Surviving Dependent. Benefits will be paid only after a Participant or an Eligible Surviving Dependent has incurred a Qualified Expense, and submitted a claim with supporting documents. Assignment of Supplemental Account Benefits is not allowed. If a claim is submitted with incomplete or no supporting information for expenses and a request for more information has been sent, but the Participant or Eligible Surviving Dependent fails to respond, the claim will automatically be denied one (1) year from the date the request for additional information was sent.

   b. Claims may be submitted at any time. Generally reimbursements for claims filed by the end of a month with all necessary documentation will be paid by the 15th of the next month. If a Participant, Retiree, or Dependent is aggrieved by the action on a claim, he or she may appeal that action to the Board of Trustees under the general appeal procedures in the Northern California Pipe Trades Health and Welfare Plan. The Plan has discretion to process claims less often than monthly if necessary, and may require more than 30 days to process claims if deemed appropriate.

   c. Claims for submission are generally the same eligible expenses as determined by the Northern California Pipe Trades Health and Welfare Plan. Exclusions and limitations as noted in that Plan apply.

   d. If a claim has unreimbursed expenses and an entire calendar year has passed without receipt of any HRA contributions the claim will be deemed closed.

4. **Claims and Appeal Rights.** The same claims and appeal rights in the Northern California Pipe Trades Health and Welfare Plan apply to this Plan.

5. **Benefits are not Vested.** The Board of Trustees may amend, reduce, eliminate or otherwise change the Supplemental Plan at any time and may change, reduce, or discontinue any Plan Benefits, in whole or in part, at any time. The Board of Trustees may change the eligibility requirements and any other Plan rules at any time.