NORTHERN CALIFORNIA PIPE TRADES HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION (SPD)
and
PLAN DOCUMENT

FOR MEMBERS OF UA LOCAL 342 (Active and Retired)

Effective July 2023

KEEP THIS BOOKLET FOR FUTURE REFERENCE

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EMPLOYER TRUSTEES

Alex Hall, Co-Chairman
(Northern Cal. MCA)
78 Cernon St, Suite D
Vacaville, CA 95688-2808

LeRoy Ginn
(Northern Cal. MCA)
ACCO Engineered Systems
PO Box 6145
Carmel, CA 93921-6145

Michael Lescure
(UMIC)
Lescure Company, Inc.
2301 Arnold Industrial Way, Suite C
Concord, CA 94520-5376

Don Silva
(Northern Cal. MCA)
San Ramon, CA 94583-9214

EMPLOYER TRUSTEE ALTERNATES

Mike Stirling
(Northern Cal. MCA)
78 Cernon St, Suite D
Vacaville, CA 95688-2808

Michael Vlaming
(UMIC)
447 Georgia St
Vallejo, CA 94590-6004

UNION TRUSTEES

Ché Timmons, Chairman
(UA Local 342)
935 Detroit Ave
Concord, CA 94518-2501

Robbie Nash
(UA Local 342)
935 Detroit Ave
Concord, CA 94518-2501

Chuck Leonard
(UA Local 342)
935 Detroit Ave
Concord, CA 94518-2501

Marc Lopez
(UA Local 342)
935 Detroit Ave
Concord, CA 94518-2501

Randy Loyd
(UA Local 342)
935 Detroit Ave
Concord, CA 94518-2501

UNION TRUSTEE ALTERNATES

Dave Herwat
(UA Local 342)
935 Detroit Ave
Concord, CA 94518-2501

Please note the Trustees are subject to change, for a more recent list of Trustees please contact the Trust Fund Office.

ADVISORS TO THE PLAN

FUND MANAGER Jeanette Null **NCPT Trust Fund Office** Concord, CA	**LEGAL COUNSEL** Richard Grosboll and Lois Chang **Neyhart, Anderson, Flynn, & Grosboll APC** San Francisco, CA
AUDITOR Sun Young Baek **Withum** San Ramon, CA	**BENEFIT CONSULTANTS** Melissa Ramos, Jason Birkle, and Elaine Chan **NWPS Benefits** San Jose, CA

HELPFUL CONTACTS

NORTHERN CALIFORNIA PIPE TRADES HEALTH & WELFARE TRUST FUND	
TFO:	925/356-8921 Fax 925/356-8938
Email: **Website:**	*tfo@ncpttf.com* *www.ncpttf.com*
Address:	935 Detroit Ave, Suite 242A, Concord, CA 94518-2501

*KAISER PERMANENTE (Group No. 31342)	
Member Services:	800/464-4000
Website:	*www.kp.org*
Address:	PO Box 12923 Oakland, CA 94604-2923

*BLUE SHIELD OF CALIFORNIA (Group No. W0051500)	
Member Services	855/256-9404
Website:	*www.blueshieldca.com*
Address:	PO Box 272540 Chico, CA 95927-2540

*VISION SERVICE PLAN ("VSP") (Group No. 12005611)	
Member Services:	800/877-7195
Website:	*www.vsp.com*
Address:	PO Box 385018 Birmingham, AL 35238-5018

*DELTA DENTAL OF CALIFORNIA (Group No. 17422)	
Member Services:	800/765-6003
Website:	*www.deltadentalins.com*
Address:	PO Box 997330 Sacramento, CA 95899-7330

PRINCIPAL LIFE INSURANCE	
Life and Disability Claims	800/245-1522 Fax 800/255/6609
Website:	*www.principal.com*
Address:	711 High St Des Moines, IA 50392-0001

HEALTH REIMBURSEMENT ACCOUNT ("HRA")	
NWPS Benefits (HRA Administrator)	855/512-1170 Fax 408/298-1180
Website:	*www.mywexhealth.com*

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

NORTHERN CALIFORNIA PIPE TRADES HEALTH AND WELFARE PLAN

935 Detroit Ave., Suite 242A, Concord, CA 94518-2501
(925) 356-8921
www.ncpttf.com

Dear Participant or Dependent,

This updated booklet is both the actual Plan document and Summary Plan Description (known as the "Plan rules") for the Northern California Pipe Trades Health and Welfare Plan ("Plan"). The Plan's purpose is to provide medical, mental health/substance abuse, hospital, prescription drug, hearing aids, dental, vision, and other 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 eligible Dependents (as defined by the Plan). The Plan consists of benefits that may be available to both Active Participants and Retired Participants. This booklet also contains an explanation of the eligibility and benefit rule 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***.

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, it is recommended that you contact the Trust Fund Office ("TFO") to determine if there have been Plan amendments or other developments that may affect your Retirement Plan options. Should there be any changes to the Plan rules, you will receive written notification in the form known as "Summary of Material Modification" ("SMM"). It is important that you keep all mailings received with this booklet. However, all Plan Documents are available on the TFO website; www.ncpttf.com.

Only the full Board of Trustees is authorized to interpret the Plan. The Board of Trustees 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 of Trustees or to act as an agent of the Board of Trustees. The Board of Trustees also has the discretion to make any factual determinations concerning your claim or eligibility for benefits.

The TFO may respond in writing to your written questions. If you have an important question about your benefits, you should write to the TFO at the above address. As a courtesy to you, the TFO may respond informally to verbal or written questions by telephone, email, or in-person at the TFO. As such **verbal or written 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.** If you would like an interpretation of the Plan, you should address your request in writing to the Board of Trustees at the TFO. 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 that 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 inadvertent error in payment or on other matters which may require correction upon audit or review. The Board of Trustees reserves the right to make corrections whenever an any error or overpayment is discovered.

You must notify the TFO 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 ("RHW") Coverage.**

We urge you to carefully review the sections in this booklet and throughout about certain notices and responsibilities you may have. This includes but is not limited to notifying the TFO of any life-changing event (e.g., marriage, divorce, separation from Spouse in any form, adoption, birth, or updating an address).

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.

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 greater copayments at any time. The Board of Trustees may change the eligibility requirements and any other Plan rules at any time.

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 make it medically necessary to guarantee that it is a covered service.

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

Please direct any questions you have concerning your benefits to the TFO at the above address or at (925) 356-8921 ext. 246.

Fraternally,

Board of Trustees

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 (which is also the SPD) (collectively sometimes referred to as the "Plan rules") as of **July 1, 2023**. The Plan is a fully insured multiemployer Group Health Plan and the Plan's medical, mental health/substance abuse, hospital, prescription drug, and hearing aid benefits are currently offered through contract with: (1) Blue Shield of California HMO and PPO ("Blue Shield") or (2) Kaiser Permanente HMO ("Kaiser"). Refer to limitations on enrollment outlined in the applicable sections of this booklet. You should refer to the Evidence of Coverage ("EOC") booklets for each Plan option for information on insured coverage and benefits. The Plan offers certain other benefits as listed below in subsection 5.

   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 their eligible Dependents in one or more 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 service. You may be responsible for a copayment (e.g., $30) for some services and products. Benefits provided pursuant to the group insurance or HMO contract are paid by the applicable Insurer or HMO. The Plan has no financial responsibility to pay any Participant or Dependent any insured benefits. Instead, the Insurer or HMO is solely responsible for paying such benefits.

   To be eligible to enroll in an HMO, you must live within the HMO's service area agreed upon by the Board of Trustees and the Carriers. You are required to include a residence address when you complete your Enrollment/Change Form. If you move out of the HMO Service Area, 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). Generally, your Primary Care Physician ("PCP") must preauthorize services for them to be covered and you must follow the HMO procedures and use an HMO network provider.

3. **Participating Provider Organization ("PPO") Benefit Option:** Currently, the Plan also offers nationwide PPO benefits insured through contract under Blue Shield. 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, copayment, and/or coinsurance) and the ability to visit any specialist without obtaining a referral from your primary physician. The PPO network providers contracted by Blue Shield have agreed to accept negotiated rates for payment and you should not be billed for amounts beyond your applicable deducible (if any) and copayment. If you choose to receive your care from a Non-PPO provider, then you will be responsible not only for, if any, deductible and your

portion of the coinsurance, but you may also be billed for the difference between what the plan pays, and the actual charge made by the Non-PPO Provider.

To illustrate how the PPO option works, you pay a copayment (e.g., $30) at the time of your office visit. You may also have a yearly deductible (e.g., $200 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., 30%) 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):

Eligible Active Participants and their Dependents(s) are eligible for these additional benefits (unless otherwise listed as an exclusion under a specific Classification and/or Contract):

Death, Accidental Death, and Dismemberment Benefits (insured by Principal Life Insurance Company);
Dental Benefits (insured by Delta Dental);
Orthodontic Benefits (insured by Delta Dental);
Vision Care Benefits (insured by VSP); and

Eligible Retired Participants and their Dependent(s) are eligible for these additional benefits:

Dental Benefits (insured by Delta Dental);
Vision Care Benefits (insured by VSP); and

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

2. **Board of Trustees Responsibilities:** The Plan is self-administered and governed 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 as of this publication 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 the authority to make changes as it pertains to 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 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 of Trustees shall make such rules, interpretations, and computations, and take such other actions to administer the Plan as the Board of Trustees, in its sole discretion, may deem appropriate. The rules, interpretations, computations, and actions of the Board of Trustees are binding and conclusive on all persons.

3. **Standards of Interpretation:** The Board of Trustees, and/or persons appointed by the Board of Trustees, 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 of Trustees. 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.

4. **Delegation of Duties and Responsibilities:** The Board of Trustees may engage Advisors and Consultants, such as an Auditor, Legal Counsel, Administrators, and Investment Managers, 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.

5. **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.

> **IMPORTANT:**
> **Notify the Union and the TFO 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.

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 **20th 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 Contributions Report ("ECR") 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. Employer Contributions to the Plan are **not** subject to withholding for FICA, FUTA, or state, or federal taxes.

The TFO reviews the ECRs for mathematical accuracy and notifies the Employer if there is any error in the Employer's computations which requires correction.

The amount of Employer Contributions made to the Plan for non-bargaining unit Employees (such as applicable Employees of the Union, the JATC, the TFO 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.

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

7. **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.

8. **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.

9. **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 is responsible for signing a written repayment agreement with the Plan providing for payments of at least $250 per month until the Overpayment is fully paid, including reasonable interest. If payment in full or an Agreement to Repay is not received, the Plan has the authority to:

   - For an Active Participant, the Plan may apply the Participant's Active Health and Welfare Premiums until the Overpayment is paid in full.
   - For a Retired Participant, the Plan may deduct $250 from the Participant's monthly Retirement Benefit until the Overpayment is paid in full.

   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 has the authority to potentially offset any amounts owed against any benefits that may be payable for a Participant and/or their 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 distribution from the NCPT Pension Plan and/or the NCPT Supplemental 401(k) Retirement Plan payable to you or your Beneficiaries.

D. YOUR RESPONSIBILITIES

1. **Your Mailing Address:** It is your responsibility to notify the TFO 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/Change Form for your Health Plan selection or a Change Request Form, both of which are available on the TFO's website at ***www.ncpttf.com***. While UA Local 342 may advise the TFO of an address change, you are required to fill out the applicable form to update your address with the TFO.

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

3. **Beneficiary Designation Form:** Complete a Beneficiary Designation Form ("Form") at the time of Initial Enrollment. If you decide to change your Beneficiary, you must complete a new Form. Note that the TFO cannot provide copies of previously submitted Forms or confirm the name of your Designated Beneficiary(ies). For additional information, please refer to Article VI, Section D. The Form is available at ***www.ncpttf.com***.

4. **Authorization for Release of Information Form:** 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 to access information from the TFO on your behalf, complete an Authorization for Release of Information Form and return it to the TFO. The Form and

the Plan's Notice of Privacy Practices are available at *www.ncpttf.com*.

5. **Identification ("ID") Cards:** Depending on the Health Plan you have selected on your Enrollment/Change Form, Kaiser, and/or Blue Shield, and Delta Dental will send you ID cards to access your medical and prescription drug or dental benefits. Note, VSP does not issue ID cards. ID cards provide information but are not a guarantee of eligibility or benefits, which are verified on a month-to-month basis.

6. **Payment Obligations under the Plan:** As a courtesy, the TFO may send monthly Billing Statements for extended coverage options and/or Domestic Partner Imputed Income Tax payments. It is the responsibility of the Participant and/or Dependent to submit payments when due, or termination of coverage may occur.
   - **a.** All payments must be made by check, cashier's check, money order, or online card payment. Cash cannot be accepted as a method of payment. Checks, cashier's checks, and/or money orders must be made payable to: NCPTTF. Online payment may be made at ***www.ncpttf.com***.
   - **b.** Full Payment must be received by no later than the 20th of the month. Failure to submit the required payment(s) timely may cause a delay and/or termination of coverage. Eligibility and/or benefits will not be verified until the payment has been received and processed. Eligibility may be posted retroactively to the 1st of the coverage month.
   - **c.** If mailing your payment to the bank, send with the top portion of your Billing Statement to:

     NCPTTF
     PO Box 55606
     Hayward, CA 94545-0606

     Processing of payments received at the TFO will be delayed.

   - **d.** The Plan can accept three (3) months of pre-paid self-payments for all types of payments, with the exception of Domestic Partner Imputed Tax Payments. Payments received for more than three (3) months, or any Domestic Partner payments in excess of one (1) month may be refunded to the payee.
   - **e.** All payments must be made timely and consecutively.

II. SUMMARY OF AGREEMENTS AND BENEFITS

Review the table below according to your classification. 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**.

Classification	Initial Eligibility Requirement	Hours Required for Monthly Eligibility	Reserve Hour Bank ("RHB")	Active Subsidized Self-Payment
ACTIVE (MLA + Others) **SHORTLINE** *(Helpers - KAISER ONLY)*	300 hours in consecutive 6-mos.	130	6-mos. Max (780 hours)	12-mos. Max & overall 18-mos. Max in rolling 36-month period
HELPER (MLA+ Others) (*KAISER ONLY)* **SAFETY ATTENDANT** (Levels 2 through 4, Foreman through Senior General Foreman) (*KAISER ONLY*)	130 hours in consecutive 6-mos.	130	2-mos. Max (260 hours)	4-mos. Max & overall 6-mos. Max in rolling 36-month period
NON-BARGAINING	1 HW Flat Rate Contribution	1 HW Flat Rate	NONE	NO
RESIDENTIAL *(KAISER ONLY)* **RESIDENTIAL LIGHT COMMERCIAL (RLC)** *(KAISER ONLY)*	120 hours in consecutive 6-mos.	120	1 mo. Max (120 hours) **-OR-** 3-mos. Max (360 hours) if worked 1200 hours in each of the preceding 2 calendar years	4-mos. Max & overall 6-mos. Max in rolling 36-month period
SERVICEMAN (Other Applicable Agreements) *(KAISER ONLY)*	300 hours in consecutive 6-mos.	130	6-mos. Max (780 hours)	4-mos. Max & overall 6-mos. Max in rolling 36-month period
TRADESMAN *(KAISER ONLY)*	300 hours in consecutive 6-mos.	130	2-mos. Max (260 hours)	4-mos. Max & overall 6-mos. Max in rolling 36-month period
UA NATIONAL DISTRIBUTION AGREEMENT (*KAISER ONLY)*	300 hours in consecutive 6-mos.	130	6-mos. Max (780 hours)	12-mos. Max & overall 18-mos. Max in rolling 36-month period

III. ELIGIBILITY RULES

An Employee is defined as an individual who has not yet met Initial Eligibility Requirements as stated within this SPD. Once an Employee has met the requirements, they are considered a Participant.

A. 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 RHB). The number of hours required to maintain eligibility each month could increase in the future, at the discretion of the Board of Trustees.

Remember that the hours you work in any given month determine your eligibility in the second calendar month following your hours worked (known as "skip 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.

EXAMPLE:

Hours Worked:	**Hours Reported:**	**May Provide Eligibility / Coverage for:**
January	By February 20th	March

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

View Eligibility

This information is based on data from the previous business day and is subject to change. Documentation may be received at the TFO 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.

Eligibility	Month	Status	Plan	Standard Hour Bank	Residential Hour Bank
10/01/2022	10/31/2022	ELIGIBLE	KAISER	263.50	0.00
09/01/2022	09/30/2022	ELIGIBLE	KAISER	388.50	0.00
08/01/2022	08/31/2022	ELIGIBLE	KAISER	513.50	0.00

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, may be 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 TFO. 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 TFO 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.

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

1	2	3	4 SKIP MONTH	5	6	7

If you work 300 or more hours in these 3 months

You are eligible as of the first day of this month

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 certain Other Applicable Agreements are entitled to RHW coverage. Employees under the Master Labor Agreement ("MLA") may be entitled to Active Subsidized Self-Payments for up to 12 consecutive months with an overall maximum of 18 months in each month's previous consecutive thirty-six (36) month period (e.g., rolling 36 months).

MLA Helpers, Shortline Helpers and Safety Attendant Levels 2 through 4 Classification. All Helpers working under the MLA, Shortline, and Safety Attendant Agreements (and their eligible Dependents) must enroll in the Kaiser Plan option.

UA National Distribution Agreement Employees. All Employees (including, but not limited to, Journeymen, Welders, Fitters, Fusers, and Helpers) working under the UA National Distribution Agreement (and their eligible Dependents) must enroll in the Kaiser Plan option.

b. **Employees Working Under Residential Agreement/Residential and Light Commercial ("RLC") Agreement for New Construction.** A new Employee who is a member in good standing of UA Local 342 and working in Covered Employment under the Residential/RLC 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:
You work 120 hours in January. February is a skip month. Your coverage would begin March 1st.

1	2 SKIP MONTH	3	4
If you work 120 or more hours		You are eligible first day of this month	

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.

Provisions that apply to the Residential/ RLC Agreements for New Construction:

(i) Employees (including their eligible Dependents) may only enroll in Kaiser and are entitled to life insurance, dental, orthodontics, and vision benefits. However, the bargaining parties and/or the Board of Trustees have the discretion to waive the Kaiser enrollment requirement for Employees under limited special circumstances.

(ii) Employees are NOT entitled to RHW coverage because of their lower contribution rate.

(iii) Employees may be entitled to Active Subsidized Self-Payment for up to four (4) consecutive months with an overall maximum of six (6) months in each month's previous consecutive 36-month period (e.g., rolling 36 months).

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.

c. **Employees working under the Helper ("MLA") Classification and Safety Attendant Levels 2 through 4 Classification, Foreman through Senior General Foreman.** A New Employee who is a member in good standing of UA Local 342 and working in Covered Employment under the Helper (MLA) classification or Safety Attendant Levels 2 through 4, or Foreman through Senior General Foreman classifications will become covered under the Plan on the first day of the second calendar month following the month in which the Employee works 130 hours. *Safety Attendant Level 1 classification does not have Plan benefits.*

EXAMPLE:
You work 130 hours in January. February is a skip month. Your coverage would begin March 1st.

1	2 SKIP MONTH	3	4
If you work 130 or more hours		You are eligible first day of this month	

Provisions that apply to the Helper and Safety Attendant Levels 2 through 4 Classifications:

(i) There is a maximum of two (2) month RHB for Employees working under the Helper and Safety Attendant classification.

(ii) Employees are NOT entitled to RHW coverage because of their lower contribution rate.

(iii) Employees may be entitled to Active Subsidized Self-Payments for up to four (4) consecutive months with an overall maximum of six (6) months in each month's previous consecutive 36-month period (e.g., rolling 36 months).

d. Tradesmen and 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.

The following provision(s) apply to all Tradesmen working under the Refrigeration and Air Conditioning Agreement and Food Store Addendum:

(i) All Tradesmen and Applicable Employees (including their eligible Dependents) must enroll in Kaiser and are entitled to life insurance, dental, orthodontic, and vision benefits. However, the bargaining parties and/or the Board of Trustees have the discretion to waive the Kaiser enrollment requirement for Participants under limited special circumstances.

(ii) Employees are NOT entitled to RHW coverage because of their lower contribution rate.

(iii) A Participant may accumulate excess hours up to a maximum of 260 hours or two (2) months in their RHB.

(iv) Employees may be entitled to Active Subsidized Self-Payment for up to four (4) consecutive months with an overall maximum of six (6) months in each month's previous consecutive 36-month period (e.g., rolling 36 months).

The following provision(s) apply to all Serviceman working under the Refrigeration and Air Conditioning Agreement and Food Store Addendum:

(i) All Serviceman and Applicable Employees (including their eligible Dependents) must enroll in Kaiser and are entitled to life insurance, dental, orthodontic, and vision benefits. However, the bargaining parties and/or the Board of Trustees have the discretion to waive the Kaiser enrollment requirement for Participants under limited special circumstances.

(ii) Employees are NOT entitled to RHW coverage because of their lower contribution rate.

(iii) A Participant may accumulate excess hours up to a maximum of 780 hours or six (6) months in their RHB.

(iv) Employees may be entitled to Active Subsidized Self-Payment for up to four (4) consecutive months with an overall maximum of six (6) months in each month's previous consecutive 36-month period (e.g., rolling 36 months).

Contact the TFO 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 only to Refrigeration Service and Refrigeration Supermarket Construction:

(i) 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 TFO. 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 TFO 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 130 hours per month to continue their eligibility under the Master Labor Agreement and other applicable agreements, or 120 hours per month under the Residential/RLC Agreements. 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 ("RHB") Rules:** Coverage for Participants is based on the accrual of hours at the current contribution rate, determined by the Board of Trustees. Hours are accumulated in a Participant's RHB and are credited for actual work hours in a particular month subject to the maximum cap in hours allowed based on your job classification. Thus, hours reported late because of untimely contributions, reciprocity, or because of insufficient payments discovered through a payroll audit, may not increase your RHB. Any hours remaining in your RHB are cancelled after 12 consecutive months of failing to maintain eligibility. You do not have a vested right to your RHB. The Board of Trustees has the discretion to reduce and/or cancel these hours at any time.

   a. **Master Labor Agreement-6 Month RHB.** When a Participant working under this Agreement accumulates at least 130 hours during a month, any hours in excess of 130 are banked in their RHB to provide coverage for a later month when the Participant is not working sufficient hours. Up to 130 hours may be deducted from the RHB to provide each month's coverage. A Participant may accumulate excess hours up to a maximum of 780 hours or six (6) months.

   b. **Residential Agreement (including Residential and Light Commercial Agreement for New Construction)-3 Month RHB.** When a Participant working under this Agreement accumulates at least 120 hours during a month, any hours in excess of 120 may be banked in

their RHB to provide coverage for a later month when the Participant is not working sufficient hours. Up to 120 hours will be deducted from the RHB to provide each month's coverage.

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

c. **Shortline Agreement-6 Month RHB.** When a Participant working under the Shortline Agreement accumulates at least 130 hours during a month, any hours in excess of 130 are banked in their RHB to provide coverage for a later month when the Participant is not working sufficient hours. Up to 130 hours will be deducted from the RHB to provide each month's coverage. A Participant may accumulate excess hours to a maximum of 780 hours or six (6) months.

d. **Helpers and Safety Attendant Levels 2 through 4, Foreman through Senior General Foreman Classifications - 2 Month RHB.** When a Participant working under these classifications accumulates at least 130 hours during a month, any hours in excess of 130 are banked in their RHB to provide coverage for a later month when the Participant is not working sufficient hours. Up to 130 hours will be deducted from the RHB to provide each month's coverage. A Participant may accumulate excess hours up to a maximum of 260 hours or two (2) months).

e. **Refrigeration and Air Conditioning Agreement**

(i) **Tradesman Classification – 2 Month RHB.** When a Participant working under this Agreement accumulates at least 130 hours during a month, any hours in excess of 130 are banked in their RHB to provide coverage for a later month when the Participant is not working sufficient hours. Up to 130 hours will be deducted from the RHB to provide each month's coverage. A Participant may accumulate excess hours to a maximum of 260 hours or two (2) months.

(ii) **Servicemen Classification – 6 Month RHB.** When a Participant working under this classification accumulates at least 130 hours during a month, any hours in excess of 130 are banked in their RHB 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 780 hours or six (6) months.

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

(i) **Retirement:** When you Retire, Active coverage may continue until you have exhausted the hours in your RHB.

(ii) **Death:** Upon death (Active Participant), Active coverage for your Eligible Dependent(s) may continue as long as there are sufficient hours in your RHB. After your RHB exhausts, your Surviving Spouse and/or Dependent(s) may qualify for COBRA Continuation of Coverage or Plan Continuation Coverage under the RHW Plan (if you qualify). Please refer to Article XI and Article XIII to see if you qualify.

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

5. **Cancellation of RHB:** Once the TFO has been advised that you have lost your UA Local 342

"Union" Membership and/or are no longer considered a member in good standing, you will lose your RHB.

a. **Expelled** from the Union means a member goes more than six (6) consecutive months without paying their Union dues. The first day of the 7th consecutive month is when the person is expelled and 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 Union. They are 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 Union. Upon receipt of the notice by the Union, the person is no longer a member.

Loss of Union membership and/or if no longer considered a member in good standing resulting in the cancellation of your RHB 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 Participant loses their RHB, they will have to meet the requirements for Initial Eligibility again. Reinstatement requirements vary depending on your classification. Refer to Article III for information on Initial Eligibility.

6. **Loss of Eligibility - Depletion of RHB:** This applies to all Active Participants with an RHB. A Participant's eligibility shall terminate at the end of any month in which the Participant's RHB falls below the minimum monthly hour requirement. If a Participant's eligibility terminates, the Participant may qualify for COBRA Continuation of Coverage and/or Active Subsidized Self-Payments.

7. **Reinstatement of Eligibility:** This applies to all Active Participants. A Participant who has lost eligibility will need to regain eligibility as described under the Initial Eligibility requirements in Article III.

B. NON-BARGAINING UNIT/SUBSCRIPTION AGREEMENT EMPLOYEES

Non-Bargaining Unit/Subscription Agreement Employees of Contributing Employers are eligible to participate in the Health and Welfare Plan, pursuant to the eligibility rules, and conditions as approved by the Board of Trustees.

IV. RECIPROCITY (TRAVELERS) – 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 United Association Reciprocity Agreement with certain other UA Health and Welfare Plans, which provides for "Money Follows the Person" reciprocity.

UA Local 342 Member working under another UA Local's Jurisdiction: If you are working under another UA Local Union's jurisdiction (Incoming Reciprocity), your Employer Contributions will be reciprocated to the TFO.

At the time of this publication, the Board of Trustees has amended the Plan to allow, for a limited time period, all Incoming Reciprocal Health and Welfare hours/contributions for ALL UA Local Unions to be credited based on actual hours worked, regardless of the Health and Welfare contribution rate. This provision is currently provided through December 31, 2024 (February 2025 eligibility). This provision only applies to Health and Welfare contributions and does not affect other fringe benefit contributions, such as Pension contributions. The Board of Trustees has the authority to extend or terminate this provision at any time.

IMPORTANT: All incoming reciprocal Health and Welfare contribution are applied to Active Eligibility ONLY and DO NOT APPLY toward any Retiree Health and Welfare benefits or eligibility for Retiree Health and Welfare Benefits. This is because generally other UA Local Union plans have lower contribution rates, all Health and Welfare contributions, including supplemental contributions, such as Retiree Health and Welfare and HRA, are applied toward Active Health and Welfare benefits, in order to help you maintain eligibility. **Therefore, if you are working on a Travel Card immediately prior to your Date of Retirement, please contact the TFO for more information regarding whether or not you are eligible for Retiree Health and Welfare Benefits.**
If the provision to receive Hour for Hour credit is NOT extended, the hours reciprocated would be pro-rated at the standard rate.

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 their Reserve Hour Bank ("RHB") cancelled for up to a maximum of three eligibility months if a sufficient amount of hours are in their RHB.

If your transfer date falls between the 1st and the 19th of the month, the first of that month will be used as your transfer effective date to determine the cancellation of your RHB.

Example:

Transfer Date	**Transfer Effective Date:**	**RHB Cancelled:**
January 6th	January 1st	May 31st

If your transfer date falls between the 20th and the last day of the month, the first of the following month will be used as your transfer effective date to determine the cancellation of your RHB.

Example:

Transfer Date:	**Transfer Effective Date**:	**RHB Cancelled:**
January 27th	February 1st	June 30th

If additional time is needed to obtain Health and Welfare Coverage through the new UA Local Union, the Participant can provide the TFO with a letter requesting the option to continue coverage up to the amount of hours in your RHB, and a copy of new UA Local Union's Trust Fund eligibility requirements. The Participant may be eligible to make COBRA Continuation of Coverage payments and, if approved, make Active Subsidized Self-Payments until they are eligible for Health and Welfare coverage through their new UA Local Union's Trust Fund.

VI. ENROLLMENT/BENEFICIARY DESIGNATION

A. ENROLLMENT PROCEDURES

You must complete and submit an Enrollment/Change Form to the TFO 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 TFO. 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.

You are also required to complete a new Enrollment/Change Form when you have any changes in life circumstances (e.g., marriage, termination of Domestic Partnership, separation in any form,

divorce, Spouse no longer residing with you, new Dependents, Dependent status changes, address changes, etc.).

Failure to notify the TFO 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 reasonable 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 first qualify for benefits based on eligibility requirements under your job classification. 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 eligible. If you fail to submit an Enrollment/Change Form, you will remain unenrolled and will have no coverage. Retroactive coverage may be limited due to the Carriers retroactive limitations/rules.

B. CHANGING HEALTH PLAN SELECTION

Depending on your job classification, the Plan rules allow an eligible Participant to change their Health Plan Selection once in any rolling 12-month period, as there is no open enrollment. 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.

C. NEW DEPENDENT(S)

If you wish to enroll a new eligible Dependent, including a new Spouse, newborn, adopted child, or stepchild, etc., 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 eligible Dependent becomes eligible as of the date of marriage, birth, or adoption, etc., provided that within 30 days of the date of the qualifying event, you have submitted an updated Enrollment/Change Form adding your eligible Dependent along with all Plan required documents. 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 an original Beneficiary Designation Form to assign your preferred Beneficiaries of any applicable death benefits. 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. To change your Beneficiary at any time, you must complete and return a new Beneficiary Form. 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 TFO is unable to provide any information 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.

Please further note the Plan does not get involved in any probate disputes between you and your family or estates and others. As such, it is important that you have a most up to date Beneficiary Designation Form on file with the TFO to avoid any uncertainty.

VII. ELIGIBLE DEPENDENTS

A. DEPENDENT ELIGIBILITY

Upon enrollment, a Dependent will be eligible when a Participant's eligibility is effective and/or when they qualify as an eligible Dependent and they must be enrolled in accordance with the Plan's enrollment procedure.

You must immediately notify the TFO when an eligible Dependent ceases to meet the definition of an eligible Dependent. When completing an Enrollment/Change Form, you indicate that the Dependents listed meet all of the Plan's Dependent enrollment requirements. Failure to notify the TFO 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 ineligible Dependent and such amounts are discharged in United States Bankruptcy Court or another Court, will not be permitted to enroll and/or maintain enrollment of a Lawful Spouse or Domestic Partner.

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 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 required documentation are 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 they are legally required to maintain coverage. 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.

IMPORTANT:
It is the obligation of the Participant and Separated Spouse to notify the TFO within 30 days of the date of any form of separation. If the TFO subsequently finds out that you maintained an ineligible Dependent under the Plan, you will be responsible for reimbursing the Plan for any overpayments made due to failing to notify the TFO of a Separated or Former Spouse.

The Plan considers the date of separation to be the earlier of:

1. The date that a Participant and their Spouse separate by joint decision regardless of whether they still reside at the same physical residence; **or**
2. The date that a Participant and their Spouse no longer reside on a full-time basis at the same physical address; **or**
3. 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 TFO was notified within four (4) months of the date of separation, as defined by the Plan, after a Separated Spouse's coverage terminates, they 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 NATURAL CHILD(REN) (ACTIVE PARTICIPANTS ONLY)

1. **Domestic Partner Eligibility Requirements.** The term "Dependent" includes the Registered or Non-Registered Domestic Partner who resides with an eligible Active Participant. A Registered or Non-Registered Domestic Partner would need to meet all of the conditions described in the Northern California Pipe Trades Trust Fund "Affidavit of Domestic Partnership." The Plan complies with the amended section of California Family Code Section 297 as follows for any Domestic Partnerships

registered with the Secretary of State:

a. Both persons are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring;

b. Neither person is married to someone else or is a member of another Domestic Partnership with someone else that has not been terminated, dissolved, or adjudged a nullity;

c. Both persons are not related by blood in a way that would prevent them from being married to each other in this state; and

d. Both persons are at least 18 years of age and capable of consenting to the Domestic Partnership.

2. A Domestic Partner under the Laws of a foreign country 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 Natural 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 VII, 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:

a. The Child(ren) must be the Natural Child(ren) of an Active Participant's eligible and enrolled Domestic Partner; **and**

b. 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 Natural 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 Natural 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 Natural Child(ren) under the Plan.

5. **Imputed Income Taxes.** The Participant is responsible for monthly payment in full of Imputed Income Taxes for coverage of a Domestic Partner and a Domestic Partner's Natural 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 will result in the immediate termination of the Domestic Partner's and Domestic Partner's Natural Child(ren)'s 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 may not be accepted and may be refunded to the payee. Partial payments and/or credits under $10.00 and/or erroneous payments will not be refunded. If the Participant and Domestic Partner marry, the Imputed Income Tax payment made for the month in which the marriage occurred will not be eligible for a refund.

The value of Domestic Partner Plan benefits is considered imputed income and it must be reported to the Internal Revenue Service ("IRS"). 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 TFO once a Domestic Partner no longer meets the Plan's Domestic Partner eligibility requirements. Eligibility of a Domestic Partner will terminate on the last day of the month in which 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 TFO within 30 days of the date that a Domestic Partner has a change in eligibility status will be legally responsible to repay any premiums made by the Plan from the date the Domestic Partner became ineligible for coverage.

7. **Domestic Partner's Natural Child(ren) No Longer Qualifies.** It is the Participant's responsibility to notify the TFO once a Domestic Partner's Natural Child(ren) no longer meets the Plan's Domestic Partner's Child(ren)'s eligibility requirements. Eligibility of a Domestic Partner's Natural Child(ren) shall terminate on the last day of the month in which the Domestic Partner no longer meets the Plan's eligibility requirements or on the last day of the month in which 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 a lack of timely payment of the Imputed Income Taxes. A Participant who fails to notify the TFO within 30 days of the date that a Domestic Partner's Natural Child(ren) has a change in eligibility status will be legally responsible to repay any premiums made by the Plan from the date the Domestic Partner's Natural 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 premium. It shall be the responsibility of the Participant to immediately notify the TFO of the dissolution of any Domestic Partnership recognized by the Plan.

9. **Termination of Domestic Partner & Reinstatement of Coverage.** A Domestic Partner and/or Domestic Partner's Natural Child(ren) who was previously enrolled in the Plan and loses coverage either by: (a) termination of the Domestic Partnership or (b) failure to pay the Imputed Income Tax may be permitted back into the Plan as a Domestic Partner or Domestic Partner's Natural Child(ren) in the future upon written request by the Participant and subject to the rules in this section. For coverage to be reinstated:
   - **a.** The Participant and Domestic Partner and/or Domestic Partner's Natural Child(ren) will be subject to enrollment and eligibility requirements; **and**
   - **b.** The applicable Healthcare Carrier's retroactive guidelines must be met; **and**
   - **c.** Payment(s) for any missed month(s) must be received by the TFO for reinstatement.

10. **Domestic Partner Opt-Out of Coverage.** An enrolled Domestic Partner and/or Domestic Partner's Natural Child(ren) may opt out (disenroll) from the Plan and be permitted to opt back

into the Plan.

11. **No Continuation of Coverage.** A Domestic Partner and/or Domestic Partner's Natural Child(ren) is not entitled to Continuation of 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 their own employment or through their Spouse's employment. Benefits for Dependent Child(ren) are subject to timely remittance of any required monthly premium payment or Imputed Income 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 will result in termination 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 TFO. 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 Participant.

3. **Legally Adopted and/or Foster Child(ren) by the 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 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.

   * Refer to Article VII, B under Lawful Spouse for the definition of a separation.

In order to enroll and maintain enrollment of a Dependent Child(ren), the Participant is required to provide the TFO 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 National Medical Support Notice 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 TFO.

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 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 prior to age 26 while covered under the Plan; **and**
3. The Dependent Child(ren) also meets ALL of the following requirements:
   - **a.** The Dependent Child(ren) is the Participant's Natural or Legally Adopted Child(ren); **and**
   - **b.** The Dependent Child(ren) is unmarried; **and**
   - **c.** 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:
     - **(i)** Submits a copy of the Social Security Administration Disability Award Letter;

     or
     - **(ii)** 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**
   - **d.** The Dependent Child(ren) remains totally, permanently, and continuously disabled as determined by the Plan; **and**
   - **e.** The Participant submits certification of total and permanent disability from a licensed physician to the TFO within 30 days of the Dependent Child's 26th birthday and thereafter as determined by the Board of Trustees; **and**
   - **f.** 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 of Trustees 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 TFO 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 an 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 TFO must be in receipt of an NMSN or QMCSO that establishes the Participant's legal obligation to maintain coverage on a Dependent Child(ren) and the TFO will respond within 30 days of receipt. 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 state such.

The Plan requires that the Participant and all of their eligible Dependents be enrolled under only one Health Plan option. Therefore, if a Participant's classification allows a choice in Health Plan options, they 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 Dependents into a different Plan option that would cover the Child(ren) named in the QMCSO and/or NMSN. If a Participant is under a Kaiser Only classification and fails to complete an Enrollment/Change Form listing the Dependent Child(ren), the Plan will be unable to enforce 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 Natural 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, their Surviving Dependent's coverage may continue until the RHB is exhausted. After exhausting the deceased Active Participant's RHB, 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 RHB, Surviving Spouse/Child(ren) Continuation of Coverage is available to eligible Surviving Dependents under the RHW 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.

VIII. BLUE SHIELD COVERAGE OPTIONS

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

A. ENROLLING IN BLUE SHIELD PPO OR HMO OPTION

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 their eligible enrolled Dependents. If the Participant elects Blue Shield HMO and their place of residence is within a Blue Shield HMO California 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. The Blue Shield PPO is a nation-wide Plan.

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, 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 EOC for information about your Blue Shield Plan. However, please be aware that some services listed in your EOC may not be available under all of the Blue Shield HMO Physician Group Plans. In order to determine whether services listed in the EOC are available, contact the Blue Shield Member Services at 855/256-9404 to obtain specific information and/or for questions on coverage for health care services. Participants can also access the Blue Shield website at ***www.blueshieldca.com.***

IX. KAISER COVERAGE OPTION

For information regarding Kaiser Senior Advantage, refer to Article XIII

A. ENROLLING IN KAISER HMO OPTION

If you reside in the California Kaiser Service Area, you have the option to enroll yourself and your eligible Dependents in the Kaiser HMO Plan. Kaiser does not provide benefits for Participants residing outside of the California Kaiser Service area. Kaiser members must receive all covered care from Providers at California Kaiser Plan Facilities, except in emergency situations. You should refer to your Kaiser EOC for information about your Kaiser HMO Plan. However, be aware that some services listed in your EOC may not be available under the Kaiser HMO Plan. To obtain specific information and/or for questions on coverage for health care services, contact Kaiser's Member Services at 800/464-4000 or visit their website at ***www.kp.org***.

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 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 will not be refunded.

IMPORTANT:
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 billing statement on or around the 1st of the month in which Plan coverage/eligibility terminated. You should also expect to receive a COBRA Notice upon your initial loss of coverage. Payment for coverage is due by no later than the 20th day of the coverage month. After your first full payment is received, eligibility will be retroactively reinstated to the first of the coverage month (listed on your billing statement).

Timely payments are required to maintain coverage under Active Subsidized Self-Pay. Your eligibility and/or benefits cannot be verified until after full payment has been received and processed. 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.

A Participant is responsible for monitoring their hours. When you know and/or determine that your RHB is low, you should contact the TFO to determine if you are eligible to make Active Subsidized Self-Payments.

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

a. Must be a member in good standing with UA Local 342; **and**

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

c. Must be either: (a) disabled for at least 14 consecutive days in the calendar month prior to their loss of coverage and receiving either Workers' Compensation Benefits, State Disability Insurance Benefits, or Social Security Disability Benefits; or (b) unemployed and on UA Local 342's out of work/will notify list; or (c) have returned to work and are working short hours; **and**

d. Must have been covered under the Plan for at least 12 consecutive months immediately preceding the loss of coverage based on: (a) hours worked in a classification/contract that provides this benefit; and/or (b) RHB; and/or (c) Active Subsidized Self-Payment (excluding COBRA Continuation of Coverage) or the Participant worked a minimum of

1500 hours in a classification/contract that provides this benefit during the 24 months immediately preceding the coverage termination date; **and**

e. A Participant and/or their current or former Spouse and/or other Dependent(s) does not owe any money any of the Northern California Pipe Trades Plans, unless on an approved payment plan; **and**

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

Participants may be eligible for up to a maximum of 12 consecutive months of Active Subsidized Self-Payments. Participants may receive an overall maximum of 18 months of Active Subsidized Self-Payments in any consecutive 36-month period (e.g., rolling 36 months)**.** After exhausting Active Subsidized Self-Payments, the 18-month COBRA continuation period will be reduced by the number of Active Subsidized Self-Payments made.

EXAMPLES:

If a Participant loses coverage in December 2023, the Plan will look at the number of Active Subsidized Self-Payments made by the Participant in the 36-month period through December 2023 (January 2021 through December 2023).

If you are eligible to make 12 months of Active Subsidized Self-Payments, you may continue to make COBRA payments for an additional 6 months.

After exhausting Active Subsidized Self-Payments, if you choose to continue coverage through COBRA, you will only be eligible to elect the COBRA Core option (medical and prescription drug coverage) for the remaining 6 months.

2. Special Plan rules for Residential, Tradesman/Serviceman, MLA Helpers, Safety Attendant Levels 2 through 4 and Other Special Contract Participants to be eligible to make Active Subsidized Self-Payments:

a. Must be a member in good standing with UA Local 342; **and**

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

c. Must be either: (a) disabled for at least 14 consecutive days in the calendar month prior to their loss of coverage and receiving either Workers' Compensation Benefits, State Disability Insurance Benefits, or Social Security Disability Benefits; or (b) unemployed and on UA Local 342's out of work/will notify list; or (c) have returned to work and are working short hours; **and**

d. Must have been covered under the Plan for at least 12 consecutive months immediately preceding the loss of coverage based on: (a) hours worked in a classification/contract that provides this benefit; and/or (b) RHB; and/or (c) Active Subsidized Self-Payment (excluding COBRA Continuation of Coverage) or the Participant worked a minimum of 1500 hours in a classification/contract that provides this benefit during the 24 months immediately preceding the coverage termination date; **and**

e. A Participant and/or their current or former Spouse and/or other Dependent(s) does not owe any money any of the Northern California Pipe Trades Plans, unless on an approved payment plan; **and**

f. Must have their monthly payment(s) received by 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 each month's previous consecutive thirty-six (36) month period (e.g., rolling 36 months). After exhausting Active Subsidized Self-Payments, the 18-month COBRA continuation period will be reduced by the number of Active Subsidized Self-Payments made.

EXAMPLES:

If a Participant loses coverage in December 2023, the Plan will look at the number of Active Subsidized Self-Payments made by the Participant in the 36-month period through December 2023 (January 2021 through December 2023).

If you are eligible to make 4 months of Active Subsidized Self-Payments, you may continue to make COBRA payments for an additional 14 months.

After exhausting Active Subsidized Self-Payments, if you choose to continue coverage through COBRA, you will only be eligible to elect the COBRA Core option (medical and prescription drug coverage) for the remaining 14 months.

3. **Non-Bargaining and Subscription Agreement Participants:** Non-Bargaining and Subscription Agreement Participants 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.

XI. COBRA CONTINUATION OF COVERAGE

A. ELIGIBILITY FOR COBRA CONTINUATION OF COVERAGE

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

When you no longer have sufficient hours in your RHB, your COBRA coverage will run concurrently with any Continuation of Coverage as described in Article X, Section A.

If you do not elect COBRA Continuation of Coverage, your Spouse and each of your eligible Dependents have a separate right to elect it and should review the COBRA Notice in full.

A Qualifying Event is any of the following:

1. The death of the Participant; or
2. The Participant's termination of employment (except for gross misconduct); or
3. A reduction in the Participant's hours; or
4. The divorce or legal separation (e.g., obtained final divorce decree or no longer residing

together) of the Participant and their Spouse; or

5. A child no longer meets the definition of a Dependent; or

6. Participant becomes entitled to Medicare.

If you or your Dependent's Qualifying Event does not meet any of the scenarios above, you are not eligible for COBRA Continuation of Coverage pursuant to Federal law. Furthermore, to receive this COBRA coverage, a Participant and/or their eligible Dependents must: (1) timely notify the TFO of their Qualifying Event, (2) file a timely Election Form following the Qualifying Event and, (3) make monthly self-payments in an amount determined by the Board of Trustees.

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 of Coverage as follows:

(a) Termination of Employment or Reduction in Hours. A Participant or Dependent may elect COBRA Core for medical benefits and prescription drug coverage only, or COBRA Full for medical, prescription drug, dental and vision coverage 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 RHB), 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, you may be electing to maintain benefits on behalf of you and/or your eligible Dependents. If you do not elect COBRA, your Spouse may independently elect such coverage on behalf of themselves 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, a Participant or other eligible Dependent may elect Continuation of Coverage for up to an additional 11 months if the Participant or eligible Dependent is determined by the Social Security Administration to be totally and permanently disabled within 60 days of the date of the Participant'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 TFO 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 of Coverage for up to 36 months as a result of one the following qualifying events:

a. The death of the Participant; **or**

b. Divorce or legal separation of the Participant and Spouse; **or**

c. A child ceases to meet the Plan's definition of an eligible Dependent.

3. **Multiple Qualifying Events**: An 18-month period of COBRA Continuation of 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 due to the Participant's termination of employment. The Participant passes away after 12 months of coverage during the 18-month period. The Participant's death is a second "qualifying event", which entitles the Spouse to the remaining balance of 24 months (36 months maximum, minus the 12 months that have already been covered).

The period of coverage under this section is reduced by any period in which the Participant or Dependent was provided coverage through the Plan's Active Subsidized Self-Pay provisions.

C. ELECTION OF COBRA CONTINUATION OF COVERAGE

The TFO will provide you with COBRA Continuation of Coverage and enrollment information within 45 days of receiving notification of a qualifying event entitling you and/or your Dependent(s) to COBRA Continuation of Coverage. You and/or your Dependent(s) must elect COBRA within 60 days after your Plan coverage ends or the date you receive the election form, whichever is later. Anyone electing COBRA must pay for it retroactive to the date they lost coverage under the Plan. Payment for this retroactive coverage is due within 45 days after the date COBRA is first elected. After this first premium, there is a 30-day grace period for making future COBRA Continuation of Coverage payments. No benefit claim will be honored unless the TFO 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 Participants and Dependents in the Plan. Therefore, if there are any changes to the Plan for Active Participants, your benefits will also change.

The premiums for COBRA are subject to change. You have the option of changing Medical Plans while covered under COBRA, subject to residing within the Health Carrier's HMO service areas, and remittance of the applicable COBRA payment for the Medical Plan you have selected.

D. YOUR OBLIGATION TO NOTIFY THE TFO

You or your eligible Dependents are required to notify the TFO if (1) you become divorced or legally separated (including an unofficial separation where you no longer live with your covered Spouse) or (2) you or your Dependent enrolls in Medicare Part A or B, after electing COBRA Continuation of Coverage, or (3) if there are any other changes in life circumstances that may affect your or a Dependent's eligibility for Plan benefits.

A Spouse who is separated in any form (such as divorce or legal separation, or unofficial separation where you no longer live with your covered Spouse) will be allowed the opportunity to purchase coverage at an unsubsidized rate determined by the Board of Trustees, provided that notice to the TFO was provided timely, through the Plan's Separated Spouse Coverage. For more information on what is considered a timely notification of a Separated Spouse, refer to Article VII.

E. TERMINATION OF COBRA CONTINUATION OF COVERAGE

COBRA Continuation of 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 make the required payment 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. **No Active Plan:** The TFO and your Employer cease to maintain any health plan for Active Participants 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 Participants 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 of 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. Contact the Plan's Carriers (Kaiser and Blue Shield) for Cal-COBRA eligibility questions.

XII. PATIENT PROTECTION AND AFFORDABLE CARE ACT

A. GRANDFATHERED HEALTH PLAN (FOR RETIREE MEDICAL PLAN OPTION ONLY)

The Board of Trustees believes the Retiree Medical Plan (through Kaiser and Blue Shield) 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)***. The Active Health & Welfare Plan (also through Kaiser and Blue Shield) is a Non-Grandfathered Plan.

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 866/444–3272 or ***www.dol.gov/ebsa/healthreform***. This website has a table summarizing which protections do and do not apply to Grandfathered Health Plans. 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 their own employer-sponsored group health plan (or the Participant's Spouse's plan) and regardless of the Child(ren)'s marital status, student status, financial dependency, residency, or employment status.

D. INDIVIDUAL MANDATE (STATE REQUIREMENT) AND MINIMUM ESSENTIAL COVERAGE

Minimum Essential Coverage Requirement (FEDERAL). The ACA establishes a minimum value standard of benefits for health plans and requires employers to provide Minimum Essential coverage to their Employees. Minimum Essential Coverage includes jointly sponsored multiemployer group health plans such as this Plan. 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.

Individual Mandate Requirement (STATE). California has its own Minimum Essential Coverage reporting and individual mandate obligations that began on or after Jan. 1, 2020. This means California requires its residents unless an exception is met to have health coverage that qualifies as Minimum Essential Coverage or pay a penalty for noncompliance. As indicated above, the Board of Trustees believe this Plan provides Minimum Essential Coverage to you and your eligible Dependents. For your California Individual Tax reporting purposes, the insured carriers will send the applicable Form 1095-B statements to satisfy your California tax reporting obligations for maintaining Minimum Essential Coverage. Contact the Insured Carrier (Kaiser or Blue Shield) for that you are enrolled in for a copy of the Form 1095-B statement if you haven't received one.

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

The ACA requires health insurers to provide an SBC to Participants and their Dependents. The SBC is a standard format, written in easy-to-understand language, summary of what each Plan option 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 (seven) 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 HMO and/or PPO Plan SBC, contact Blue Shield at 855/256-9404. If you want a copy of the Kaiser HMO Plan SBC, contact Kaiser Permanente at 800/464-4000.

F. ELIMINATION OF LIFETIME AND ANNUAL DOLLAR 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.

G. ACA NONDISCRIMINATION

It is the intention of the Board of Trustees and the contracted insurers (Kaiser and Blue Shield) that the Plan's benefits be provided in compliance with the requirements of the Affordable Care Act Section 1557 Non-Discrimination rules. The Plan complies with the ACA Non-Discrimination rules (including applicable Federal civil rights laws) and does not discriminate on the basis of race, color, national origin, age, disability, or sex, nor does the Plan exclude people or treat them differently because of their race, color, national origin, age, disability, or sex. This Plan covers maternity benefits for eligible Dependent Children up to age 26 and also covers Transgender services determined to be medically necessary by a licensed physician through its insured HMO and PPO benefits. Refer to the EOC booklets provided to you by Kaiser or Blue Shield for a complete description of the benefits available to you.

H. CHOICE OF PROVIDER (NON-GRANDFATHERED PLANS)

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

You do not need prior authorization from this Plan or from any other person (including a PCP) in order to obtain access to Obstetrical or Gynecological care from a Health Care Professional in the Plan's PPO or HMO network who specializes in Obstetrics or Gynecology. The Health Care Professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating Health Care Professionals who specialize in Obstetrics or Gynecology in the Plan's Kaiser or Blue Shield Plans, contact Kaiser or Blue Shield.

I. IN-NETWORK OUT-OF-POCKET MAXIMUM LIMITSD (NON-GRANDFATHERED PLANS)

Under the ACA, Non-Grandfathered Group Health Plans cannot have an out-of-pocket maximum that exceeds $9,100 self-only coverage and $18,200 family coverage for In-Network essential health benefits in 2023. However, this limit does not apply to spending for Non-Essential Health Benefits or Out-of-Network cost-sharing. This amount is subject to change every year and released by the IRS. This Plan's insured HMO and PPO out-of-pocket maximums do not exceed the federally mandated limits.

J. APPROVED CLINICAL TRIAL PARTICIPATION

Under the ACA, Non-Grandfathered Plans cannot deny participation in an approved clinical trial for cancer and other life-threatening diseases, cannot limit or impose additional conditions on coverage of routine patient's costs for items and services furnished in connection with the approved clinical trial, and cannot drop or limit coverage because an individual participates in the trial.

K. PROHIBITION ON RECISSIONS OF COVERAGE

As required by the ACA, this Plan does not cancel or discontinue coverage retroactively except for fraud or an intentional misrepresentation of material fact. For instance, your coverage cannot be rescinded because you make a mistake on your Enrollment/Change Form. However, a retroactive cancellation or discontinuation of coverage is not prohibited by the ACA, if voluntarily initiated by the Participant, is due to a delay in administrative recordkeeping, Participant's failure to timely pay required premiums or

contributions toward the cost of coverage, termination of coverage is retroactive to the divorce/legal separation if the Plan does not cover former Spouses, or a cancellation/discontinuance of coverage that has only a prospective effect.

L. FOR MORE HEALTH CARE REFORM INFORMATION

Under the ACA, the Plan (through its Insured Carriers) is required, among other things, to include certain consumer protections, for example, requiring the provision of preventive health services without any cost sharing, elimination of annual and lifetime dollar limits on Essential Health Benefits, and extension of Dependent coverage. Please visit the Department of Labor website at ***www.dol.gov/ebsa/healthreform*** for more information about the ACA's provisions.

XIII. RETIREE HEALTH AND WELFARE PLAN

The Board of Trustees has established the RHW 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 RHW coverage. It is recognized that the benefits provided by this Plan can be paid only to the extent that the Plan has adequate resources available. Benefits under this Plan are not vested and can be changed or eliminated at any time. Monthly premium payments/deducts for Retirees are subject to change.

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

All Retirees eligible for RHW coverage entitled to a gross monthly Retirement Benefit 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 Retirement Benefit as a result of the benefit option elected; including, but not limited to, Early Reduced 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. Monthly premiums are subject to change at the discretion of the Board of Trustees without a 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 RHW coverage.

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

To maintain coverage under the RHW Plan, once a Retiree or Retiree's Dependent(s) becomes eligible for Medicare coverage, enrollment in both Medicare Parts A and B is mandatory. Medicare Part D (Prescription Drug benefits) is part of your Medical Plan and requires completion of applicable Carrier forms sent by the TFO. If you earn a higher income, Federal Law also requires that you pay an additional premium to the Social Security Administration ("SSA"), which is known as the Income-Related Monthly Adjustment Amount ("IRMAA") for your Medicare Part D Prescription Drug. 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, but directly to Medicare. For more information on the additional premium or Medicare, please call Medicare at 800/MEDICARE (800/633-4227) or visit ***www.medicare.gov***. TTY users should call 877/486-2048.

If an individual does not enroll in Medicare Part B when they become entitled to Medicare coverage, they may lose coverage under their Medical Plan option (Kaiser or Blue Shield) and additional premium amounts would be applicable to continue participation in the RHW Plan. **FAILURE TO NOTIFY THE TFO REGARDING YOUR AND/OR YOUR DEPENDENT(S) MEDICARE ELIGIBILITY MAY IMPACT YOUR COVERAGE AND RESULT IN A PREMIUM PENALTY**.

It is your obligation to notify the TFO in writing when your Dependent(s) no longer meet the definition of an eligible Dependent. You will be required to complete a new Retiree Enrollment/Change Form.

A. ELIGIBILITY RULES

A Participant must meet all of the following requirements:

1. To be eligible for RHW coverage, a Participant must have been eligible through hours worked, including maintaining the minimum amount of hours in the RHB or Active Subsidized Self-Payment, under a contract/classification that provides RHW Employer Contributions through the Northern California Pipe Trades Health and Welfare Active Plan ("NCPT Active Plan") and one of the following:
    - **a.** Have been eligible under the NCPT Active Plan for at least 12 months of the last 18 consecutive months immediately preceding their Date of Retirement **(excluding COBRA payments and Incoming Reciprocity)** under a contract/classification that provides for and contributes the required amount of Employer Contributions to the RHW Plan. 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 they left Covered Employment (unless on the UA Local 342's "out of work" list between such work and their Covered Employment) to their 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 their Employer as requested by the TFO and otherwise must cooperate with the TFO for any request for documentation of such work; **or**
    - **b.** Have worked at least 1500 hours in Covered Employment under a contract/classification that provides for and contributes the required amount of Employer Contributions to the RHW Plan in the 24-month period immediately preceding their Date of Retirement **(excluding Incoming Reciprocity)**; **or**
    - **c.** Have been eligible for at least one (1) month in the 18-month period immediately preceding their Date of Retirement**,** providing the Participant has earned at least 25 Benefit Credits and 25 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 their Date of Retirement; **and**

IMPORTANT:
Contact the TFO if you have a question or concern as to whether your Employer is contributing the required contribution to the RHW Plan. This issue will arise more if you are having funds reciprocated from another UA Local Health and Welfare Plan and/or you are working under an agreement, such as Residential (and others), that does not provide the required contributions to the RHW Plan.

2. Have at least 15 Benefit Credits and 15 Vesting Credits at any age **or** at least 13 years of Benefit Credits and 13 years of Vesting Credits for Participants Age 55 or over, exclusive of:
    a. Pro Rata Reciprocal Vesting Credits and/or (b) Contiguous Service Vesting Credits as defined in the Northern California Pipe Trade Pension Plan.

3. Have at least 15 years of RHW Contributions (excluding Incoming Reciprocity) under a contract/classification that provides for and contributes the required amount of contributions under the RHW Plan at any age, or at least 13 years of RHW contributions (excluding Incoming Reciprocity) under a contract/classification that provides for and contributes the required amount of contributions under the RHW Plan for Participant's Age 55 or over. The maximum a Participant can earn is one year of RHW contributions during any one Plan Year; **and**

4. Be a Member in Good Standing with UA Local 342; **and**

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

B. ADDITIONAL REQUIREMENTS

1. Submit timely monthly premiums for coverage (if applicable).

2. 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 owed to the Plan, and such amount was discharged in U.S. Bankruptcy Court or any other Court, in addition to the regular premium amount, the Retired Participant would be required to pay an additional $500/per month. The Retired Participant will not be permitted to enroll and/or maintain enrollment of a Lawful Spouse.

3. A Retiree may return to Covered Employment once, and not forfeit their RHW coverage. Thus, upon reinstatement of the Retiree's Retirement Benefits, the Plan will allow a one-time only reinstatement of RHW coverage.

   Any subsequent termination of RHW coverage due to return to Covered Employment will result in a permanent termination of RHW coverage. Also see Work after Retirement for additional information (Subsection 10 below).

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

4. **Timely Receipt of RHW Application:** In addition to meeting the "General Requirements" above,

an eligible Participant must timely submit a RHW Application and a Retiree Enrollment/Change Form (including required documentation) to the TFO. 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 their Application for Retirement Benefits has been approved and subject to receipt of the RHW Application and premium payment.

5. **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 RHW coverage effective the 1st of the following month after the TFO receives notification from UA Local 342.

> EXAMPLE:
> If the TFO 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.

6. **Reinstatement of Coverage after Reinstating Union Membership:** If you once again become a member in good standing with UA Local 342 and previously lost RHW coverage, you may have coverage reinstated effective the 1st day of the following month after the TFO receives notification from UA Local 342. Reinstatement of coverage is contingent upon your timely submission of any RHW premiums due, if applicable.

7. **Retiree Coverage for Individual Employers / Associations / Related Groups:** Retiree coverage may be maintained for Non-Bargaining Unit Participants and Owner/Manager Participants 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 RHW Plan, who satisfy at least three (3) of the following five (5) conditions as of their Date of Retirement:

   a. Is a UA Local 342 Member in good standing;
   b. Has a minimum of five (5) Vesting Credits with contributions from UA Local 342 Employers (excluding Pro-Rata Reciprocal Vesting Credits);
   c. Is 58 years of age or older;
   d. Has a minimum of 15 years (180 months) in which contributions (excluding COBRA) have been made to the Northern California Pipe Trades Active Health and Welfare Plan;
   e. 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 the Date of Retirement.

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 RHW coverage assuming the Participant met the Eligibility Requirements for Military Service Vesting Credits and Benefits Credits.

Only service in the Armed Forces of the Unites 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 RHW coverage when Military Service is voluntary or for enlistment in the Reserves.

8. **Surviving Dependent Coverage:** When a Retiree (who meets all RHW eligibility requirements) passes away and the Surviving Spouse/Dependent is eligible for and elects Surviving Dependent Health and Welfare Benefits (which are the same as RHW coverage), the Plan provides for continued coverage for eligible Dependents at the Surviving Dependent Coverage monthly premium rate effective the month following the Participants death.

   In addition to other eligibility requirements, a Surviving Dependent Spouse must be married to the Participant for at least one (1) year prior to the Retiree's death in order to continue Surviving Dependent Coverage under the Plan.

   If the Retired Participant's Surviving Dependent Spouse and/or Surviving Dependent Child(ren) were eligible and enrolled as Dependents under the Participant's RHW 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 of Trustees. Surviving Spouses who remarry lose coverage immediately (effective the last day of the month of marriage). 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. Refer to Article VII, Sections D, E, F and G. For Surviving Dependent Child(ren), when reviewing the Eligibility Requirements Section, the term "Participant" should be substituted with Surviving Dependent.

   If the Surviving Dependent has alternate coverage at the time, they are eligible for the Continuation of Coverage, they may choose to delay the RHW coverage until termination of the alternate coverage, provided that they notify the TFO 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 Dependent 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 and 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 Dependent Health and Welfare coverage.

   A Surviving Spouse Dependent of a deceased Active Participant may be offered Surviving Dependent coverage under the RHW Plan providing ALL of the following requirements are met:

a. If the Surviving Dependent is a Dependent Spouse, the Spouse was married to the Participant for at least one (1) year prior to the Active Participant's death; **and**

b. 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, excluding Domestic Partners; **and**

c. At the time of the Participant's death, they accrued a minimum of ten (10) Benefit Credits and ten (10) Vesting Credits, excluding Pro-Rata Reciprocal Vesting Credits, without a Permanent Break in Service under the Northern California Pipe Trades Pension Plan; **and**

d. The Participant had Active eligibility through hours worked, RHB, or Active Subsidized Self-Payments (excluding COBRA payments) under the Northern California Pipe Trades Health and Welfare Active Plan for at least 12 months of the last 18 consecutive months immediately preceding the month of death in a classification which provides contributions to the RHW Plan; **and**

e. The Participant worked at least 1000 hours in Covered Employment during the 36 months immediately preceding the Participant's month of death; and

f. The Participant was a member in good standing with UA Local 342 at the time of death.

9. <u>Termination of Coverage</u>: Eligibility for Retiree/Surviving Dependent Health and Welfare benefit coverage will terminate if:

a. The required premium payments (if applicable) are not made in a timely manner in accordance with the rules adopted by the Board of Trustees; and/or

b. The Retiree fails to maintain membership in good standing with UA Local 342 (this is not applicable to Surviving Dependents); and/or

c. The date Retirement Benefits from the Northern California Pipe Trades Pension Plan terminate, including the return to Covered or Prohibited Employment.

d. 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, even if such amount was discharged in U.S. Bankruptcy Court or any other Court, the Participant and/or the Participant's current Spouse or other Surviving Dependents no longer qualify for RHW coverage.

10. <u>Work after Retirement</u>:

a. A Retiree may return to Active Covered Employment one time with written approval from UA Local 342 without becoming ineligible for RHW coverage. Thereafter, if a Retiree returns to Active Employment within the Pipe Trades Industry ("Industry Service") without written approval from UA Local 342, the Retiree shall immediately upon such reemployment become ineligible for Retirement Benefits and shall thereafter be ineligible for RHW coverage, even if they terminate such Industry Service. As a result, before engaging in any Work after Retirement that might in any way be considered "Industry Service", a Retiree should submit a written request to the TFO for guidance as to whether such employment might adversely affect their RHW coverage.

b. If a Retiree returns to Active Covered Employment within the Pipe Trades Industry, with written approval from UA Local 342, such employment will not adversely affect their RHW coverage. For Retirees who have obtained written approval from UA Local 342 to return to Active Covered Employment within the Industry Service, Health and Welfare Benefits would be handled as follows:

Retirees with Retiree Health and Welfare Benefits

- You will be allowed to maintain coverage under RHW until you gain Active Health Plan coverage.
- Initial Eligibility requirements for Active Health Plan coverage are waived. After your first dispatch and your Employer reports 130 hours, you may be eligible for Active coverage. You are required to complete a new Active Enrollment/Change Form under your current Health Plan option (Blue Shield or Kaiser).
- If you or any enrolled Dependent has Medicare, once you gain Active Health Plan coverage, Medicare will be secondary payer.
- As a result, Medicare eligible individual(s) enrolled in the Kaiser Plan will need to immediately complete and timely submit a KPSA Disenrollment Form.
- You will be eligible for all Active benefits in accordance with the Health and Welfare Plan rules.
- *As a reminder, eligibility is skip-month, so 130 hours worked in July will provide September eligibility; therefore, your RHW premium deduction would not be due for September.*
- You can accumulate excess hours up to a maximum of 780 hours in your RHB.
- If you do not have Active Health and Welfare eligibility through hours worked, you may qualify to make Active Subsidized Self-Payments subject to Plan maximums.
- You must notify the TFO once you have ceased working. When you have exhausted Active Health and Welfare eligibility, you must re-enroll in the Retiree Health Plan and will be responsible for payment of RHW premiums, if applicable. You will be required to complete a new Retiree Enrollment/Change Form.

In addition, if you or any enrolled Dependent has Medicare, once you re-enroll in the Retiree Health Plan, Medicare will be primary. Medicare eligible individual(s) will need to immediately complete a Blue Shield Medicare Rx Plan Enrollment Form or KPSA Plan Enrollment Form.

Retirees without Retiree Health and Welfare Benefits

- Initial Eligibility requirements for Active Health Plan coverage are waived. After your first dispatch and your Employer reports 130 hours, you may be eligible for Active coverage. You are required to complete an Active Enrollment/Change Form.
- You will be eligible for all Active benefits in accordance with the Health and Welfare Plan rules.
- *As a reminder, eligibility is skip-month, so 130 hours worked in July will provide September eligibility.*
- You can accumulate excess hours up to a maximum of 780 hours in your RHB.
- If you do not have Active Health and Welfare eligibility through hours worked, you may qualify to make Active Subsidized Self-Payments subject to Plan maximums.

You must notify the TFO once you have ceased working. When you have exhausted Active Health and Welfare eligibility, you may be eligible for COBRA Continuation of Coverage.

The Retiree must immediately notify the TFO in writing that they will terminate or have terminated employment along with their termination date. After all Employer contributions are received and processed by the TFO, if applicable, the Retiree's Retirement Benefits will be recalculated and increased accordingly. In accordance with Plan rules, if a Retiree's monthly Retirement Benefit is under $1,000, and is eligible for RHW coverage, they do not currently pay a monthly RHW Premium. However, if a Retiree's monthly Retirement Benefit increases to $1,000 or more when recalculated, they will be required to pay a monthly RHW Premium.

C. 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 receive a Social Security Disability Notice of Award, you generally become eligible for Medicare coverage 24 months after the date in which Social Security has deemed you disabled.

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.

Medicare Parts A and B. 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. 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. Medicare Part B has a separate premium that is required, as determined by the Social Security Administration.

IMPORTANT: The RHW Plan coordinates benefits with Medicare as if you are covered under both Medicare Parts A and B. This means you must enroll in both Medicare Parts A and B as soon as you are eligible for Medicare. If you do not enroll in Medicare Parts A and B, the Plan will assess additional monthly penalties until proof of enrollment has been received. Medicare Part D is also required to participate in the RHW Plan, and may have a separate premium that is required, as determined by the Social Security Administration.

When a Participant and eligible Dependents are covered under an Active Plan (based on either you or your Spouse working), enrollment in Medicare at age 65 is not required by the Plan. However, rules and regulations for opting in or out of Medicare while working are subject to the rules enacted by the Social Security Administration.

IMPORTANT NOTICE: ENROLL IN MEDICARE

To be eligible for RHW coverage under this Plan you and/or your eligible Dependent(s) are required to timely enroll in both Medicare Parts A and B and pay all the required applicable premiums for Parts B and D as soon as you and/or your eligible Dependent(s) are entitled to coverage. *You and/or your eligible Dependents can only enroll in one Medicare Plan. If you are enrolled in another Medical Plan, you will not be eligible to enroll in the Plan's Kaiser or Blue Shield Medical Plans.*

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 enroll. If a person declines Part B when first eligible, the cost of enrolling in Part B at a later date may be increased for the period that they should have had Part B.

For enrollment and eligibility information, you should call the Social Security Administration at 800/772-1213. You can also find Medicare information at ***www.medicare.gov***. You and/or your Dependents must enroll in Parts A and B of the Federal program during the three months before the month in which you and/or your Dependents become eligible for Medicare. 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. The rate of this additional premium is determined by the Board of Trustees, who have the discretion to change the rate at any time.

Notice of Medicare Part D Creditable Coverage. The Federal Medicare Prescription Drug, Improvement and Modernization Act created a prescription drug benefit referred to as Medicare Part D Prescription Drug Coverage (Medicare Part D coverage "coverage"). The coverage is available to all Medicare eligible Participants and/or Dependents that are age 65 or older or are disabled and are receiving Social Security disability benefits, and those with End Stage Renal Disease. Contact the Social Security

Administration for Open Enrollment or Special Enrollment dates or information.

Prescription drug benefits offered by Kaiser and Blue Shield are, on average, expected to pay out as much as standard Medicare Prescription drug coverage pays and is therefore considered "Creditable Coverage". Creditable Coverage means that the Prescription Drug Plan offered by the Plan Sponsor is as generous or more generous than the standard coverage under the Medicare Part D Prescription Drug Benefit. 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/or your Dependents may not be able to reenroll with the Plan.

D. KAISER PERMANENTE SENIOR ADVANTAGE ("KPSA") AND BLUE SHIELD MEDICARE OPTIONS

The KPSA and Blue Shield PPO Plans are available to Retirees and their eligible Dependents who are enrolled in Medicare Parts A and B and who reside in Kaiser's Northern California Service Area or Blue Shield's PPO Service Area. Retirees with Medicare must enroll in Kaiser or the Blue Shield PPO Plan. The Blue Shield HMO Plan is not available to Retirees and/or their Dependents with Medicare. The TFO 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***.

IMPORTANT INFORMATION

1. You MUST enroll in Medicare Parts A and 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 assignment of your Medicare Benefits to KPSA.
4. Retirees and/or their eligible Dependents enrolled in KPSA MUST receive all 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 enrolled in KPSA and you and/or your Dependents move outside of Kaiser's Northern California Service Area, you cannot continue to have KPSA. You must disenroll from KPSA and change your health plan to the Blue Shield PPO Plan.
6. If you are enrolled in the Retiree Blue Shield HMO Plan and you and/or your Dependents become Medicare eligible, you will not be able to maintain enrollment in the HMO Plan. You must change your Plan to the Blue Shield PPO Plan or to Kaiser (if residing in Kaiser's Northern California Service Area).

If you have any questions regarding KPSA, or require any additional information, contact Kaiser Member Services at 800/464-4000. If you have any questions regarding the Blue Shield Plan or require any additional information, contact Blue Shield at 855/256-9404.

E. DELAYING OR OPTING OUT OF/INTO THE RHW PLAN

1. **Delaying or Opting Out.** If you are eligible for RHW coverage at the time of Retirement, you may choose to opt out or delay enrollment in the Plan one time only. If you elect to opt out of or delay enrollment, you may be required to submit a written request to the TFO. **If you opt out or delay enrollment in the RHW Plan, this will terminate all RHW coverage which includes medical, prescription drug, dental, and vision**.

If you are enrolled in the Plan, not currently eligible for Medicare Benefits, and are electing to opt out, you will be disenrolled effective the first of the following month after your request has been received and processed by the TFO. If you are enrolled in the Plan and currently eligible for Medicare Benefits and are electing to opt out, you will be disenrolled as described below:

a. **KPSA.** In addition to your request, you must sign a Kaiser Disenrollment Form. Provided that your request is submitted in a timely manner, you will generally be disenrolled on the first of the following month after your fully completed Disenrollment Form has been received and processed.

b. **Blue Shield.** Provided your request is submitted in a timely manner, you will generally be disenrolled effective the first of the following month after your request is received and processed.

Because Medicare requires time to process your disenrollment request, failure to disenroll on a timely basis may result in a lapse in utilizing your Medicare Benefits. Contact the TFO if you need assistance.

2. **Limited Exceptions.** If you opt out of or delay enrollment for RHW coverage, 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:**

   a. In accordance with Plan rules, you may delay enrollment or opt out of the RHW Plan for yourself and/or your Dependents until you and/or your Dependents become Medicare eligible. If you delay enrollment or opt out of the RHW Plan, 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 Parts A and B. In order for a Dependent to be eligible to opt back into the Plan based on Medicare enrollment, at the time of the Dependent's Medicare eligibility, the Retiree would have to already be eligible for and enrolled in the RHW Plan.

   b. Plan rules also provide that if you and/or your Dependents are eligible for coverage under another plan, you may also delay enrollment or opt of out of the RHW Plan for yourself and/or eligible Dependents until coverage under the other Group Health Plan terminates, provided that you notify the TFO in writing and enroll in the RHW Plan within 30 days of the date the other coverage terminates.

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

If you are planning to move, contact the TFO in advance to obtain information regarding how your new address may affect the RHW Plan. 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 disenrolled effective the first of the following month after your request has been received and processed by the TFO.

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:

   a. **KPSA.** In addition to your request, you must sign a Kaiser Disenrollment Form. Provided that your request is submitted in a timely manner, you will generally be disenrolled on the first of the following month after your fully completed Disenrollment Form has been received and processed.

b. Blue Shield. Provided your request is submitted in a timely manner, you will generally be disenrolled effective the first of the following month after your request is received and processed.

Because Medicare requires time to process your disenrollment request, failure to disenroll on a timely basis may result in a lapse in utilizing your Medicare Benefits. Contact the TFO if you need assistance.

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

If you are eligible for RHW 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, money order, or online card payment. Cash cannot be accepted as a method of payment. Checks, cashier's checks, and/or money orders must be made payable to NCPTTF. Online payments may be made at ***www.ncpttf.com.***

2. Payments must be received by the due date, 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. Eligibility and/or benefits will not be verified until the payment has been received and processed.

3. If mailing your payment to the bank, your payment and the top portion of your billing statement must be addressed as follows:

NCPTTF
PO Box 55606
Hayward, CA 94545-0606

4. You may only pre-pay up to three (3) months. Payments received for more than three (3) months will be refunded to the payee.

5. Payments must be made timely and consecutively.

As a courtesy, the TFO may send monthly billing statements. It is the responsibility of the Participant and/or Dependent to submit payments when due. Once coverage has been terminated due to non-payment, the Retiree, Surviving Dependent, and/or their Dependents may not be allowed to reinstate coverage.

XIV. PRESCRIPTION DRUGS BENEFITS

Prescription Drug Benefits are provided through your selected Health Plan. You should review your selected Health Plan's Summary of Benefits or contact your selected Health Plan directly if you have questions.

XV. DENTAL & ORTHODONTIC BENEFITS

Dental and Orthodontic Benefits are through Delta Dental. Refer to Delta Dental's EOC for more detailed information.

A. 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 eligible Dependents are not eligible for Orthodontic Benefits. Active Participants whose coverage is based on Active Subsidized Self-Payments or COBRA CORE Coverage are not eligible for Dental or Orthodontic Benefits.

B. DENTAL PLAN BENEFITS FOR ACTIVE AND RETIRED PARTICIPANTS

Under the Dental Plan, a Participant and their eligible Dependents can go to any licensed dentist for necessary dental care that accepts Delta Dental. Delta Dental will cover up to the Maximum Contract Allowances ("MCA") for eligible dental expenses, not to exceed the amount you are charged.

1. **Dental Maximums.** The following Calendar Year Maximums are provided as follows:

   Actives. The dental maximum is **$4,000** per calendar year for each eligible individual. There is no deductible.

   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**.

2. **Covered Fees.** Delta Dental will cover up to the MCA amount for eligible Dental expenses, not to exceed the amount you are charged. MCA is the reimbursement under the Enrollee's Benefit Plan against which Delta Dental calculates payment and the Enrollee's financial obligation. Subject to adjustment for extreme difficulty or unusual circumstances, the Maximum Contract Allowance for services provided: By a PPO Provider is the lesser of the Provider's Submitted Fee or the Delta Dental PPO Contracted Fee, by a Premier Provider is the lesser of the Provider's Submitted Fee or the Delta Dental Premier Contracted Fee, by a Non-Delta Dental Provider is the lesser of the Provider's Submitted Fee or the Program Allowance.

3. **Diagnostic and Preventive Services.** The Plan provides payment of 100% of MCA for Active Participants (and their eligible Dependents) and 50% of MCA for Retirees (and their eligible Dependents) on diagnostic and preventive services. The Plan defines diagnostic and preventive services to be:
   - **a.** Diagnostic Services: Procedures to aid the Provider in determining the required dental treatment.
   - **b.** Preventative Services: Cleaning (including scaling in the presence of generalized moderate or severe gingival inflammation – full mouth, which is considered to be a Diagnostic and Preventative Benefit, and periodontal maintenance, which is considered to be a Basic Benefit for payment.

4. **Basic and Major Services.** The Plan provides payment of 80% of MCA for Active Participants (and

their eligible Dependents) and 50% of MCA for Retirees (and their eligible Dependents) for Basic Services. The Plan defines basic services to be:

Basic Services:

a. Oral Surgery: Extractions and other surgical procedures (including pre- and post-operative care).

b. General Anesthesia or IV Sedation: When administered by a Provider for covered Oral Surgery or selected endodontic and periodontal surgical procedures.

c. Endodontics: Treatment of diseases and injuries of the tooth pulp.

d. Periodontics: Treatment of gums and bones supporting teeth.

e. Sealants: Topically applied acrylic, plastic, or composite materials used to seal developmental grooves and pits in permanent molars for the purpose of preventing decay.

f. Restorative: Amalgam and resin-based composite restorations (fillings) and prefabricated crowns for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of decay).

g. Professional Visits: Visits to a Provider for observation or after regularly scheduled hours.

h. Other Basic Services: Space Maintainers.

i. Palliative: Emergency treatment to relieve pain.

j. Night Guard/Occlusal Guard: Intraoral removable appliances provided for treatment of harmful oral habits associated with periodontal disease.

k. Specialist Consultations: Opinion or advice requested by a general dentist.

Major Services:

a. Crowns and Inlays/Onlays: Treatment of carious lesions (visible decay of the hard tooth structure) when teeth cannot be restored with amalgam or resin-based composites.

b. Dental Repairs: Repair to partial or complete dentures, including rebase procedures and relining.

5. **Prosthodontic Services.** The Plan provides payment at 80% of MCA for Active Participants (and their eligible Dependents) and 50% of MCA for Retirees (and their eligible Dependents) on prosthodontic services. The Plan defines prosthodontic services to be those procedures for construction of fixed bridges, partial or complete dentures, and the repair of fixed bridges; implant surgical placement and removal; and for implant supported prosthetics, including implant repair and recementation.

6. **Service and Limitations.** Dental Benefits are subject to the following limitations:

a. Supplementary bitewing (individual) x-rays are limited to two (2) times in a Calendar Year when provided to Enrollees under age 18 and one (1) time each Calendar Year for Enrollees 18 and over. Bitewings of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances.

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

c. 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.

d. 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.

e. 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.

f. Coverage on occlusal guards/night guards is subject to review. On covered occlusal guards/night guards, the Plan pays 80% of MCA for Active Participants (and their eligible Dependents) and 50% of MCA 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.

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

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

i. 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.

j. 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.

7. **Treatment Plan/Preauthorization.** Before treatment is started, be sure to discuss with the dentist the total amount of their fees and the portion that will be your responsibility. Have your dentist submit the Preauthorization or Dental Claim Form to Delta Dental. Preauthorization of benefits is not a requirement under the Plan, however, to learn about your benefits in advance, have your dentist submit a Preauthorization of benefits. Delta Dental will notify your dentist of the Plan's MCA for the procedures and whether or not there are any alternative treatments available. Even though your benefits are "preauthorized", you must also remain eligible for coverage.

   a. Delta Dental may deny payment for services submitted more than one year after the date the services were provided.

   b. Dentally Necessary. Only dentally necessary services will be covered. Dentally necessary expenses are defined as those expenses which are:

      i. Necessary for your dental care; **and**

      ii. Prescribed by a licensed dentist or licensed dental surgeon; **and**

      iii. The appropriate type, level, amount and frequency of care necessary to treat a dental condition; **and**

      iv. Consistent with generally accepted United States dental standards of practice; **and**

      v. Within the scheduled limits; **and**

      vi. Covered by Delta Dental.

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

C. ORTHODONTIC SERVICES (ACTIVE PARTICIPANTS AND THEIR ELIGIBLE DEPENDENTS ONLY)

The Orthodontic Lifetime Maximum is $3,500 for each eligible individual. The orthodontic lifetime maximum is independent of the dental maximum.

Retirees and their Dependents are not eligible for Orthodontic Benefits.

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 MCA fees up to the lifetime maximum. Delta Dental may, at any time, request supporting proof of clinical reports, charts, x-rays, and other documentation.

On approved active phase orthodontia treatment plans less than $500, providing the individual is eligible under the Plan on the date of banding, Delta Dental will pay the treatment plan in one lump sum. 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 and/or Dependent has Dental Benefit eligibility.

D. EXCLUSIONS

Exclusions below with age limitations will be subject to exception based on medical necessity. Delta Dental does not pay benefits for:

1. Treatment of injuries or illness covered by Worker's Compensation or Employer's Liability Laws; Services received without cost from any federal, state, or local agency, unless this exclusion is prohibited by law, expect as provided in Section 1373(a) of the California Health and Safety Code.
2. Cosmetic Surgery or procedures for purely cosmetic reasons.
3. Maxillofacial prosthetics.
4. Provisional and/or temporary restorations (except as an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed services.
5. Services for congenital (hereditary) or developmental (following birth) malformations, including by not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth), except those services provided to newborn children for medically diagnosed congenital defects or birth abnormalities.
6. Treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion, or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include, but are not limited to equilibration, periodontal splinting.
7. Any single procedure provided prior to the date the Enrollee became eligible for services under the Plan.
8. Prescribed Drugs, Medication, Pain Killers, Antimicrobial Agents, or experimental/investigational procedures.
9. Charges for anesthesia, other than General Anesthesia and IV Sedation administered by a Provider in connection with covered Oral Surgery or selected Endodontic and Periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.
10. Extraoral grafts (grafting of tissue from outside the mouth to oral tissues).
11. Laboratory processed crowns for Enrollees under age 12.
12. Fixed bridges and removable partials for Enrollees under age 16.
13. Interim implants and endodontic endosseous implants.
14. Indirectly fabricated resin-based Inlays/Onlays.
15. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
16. Treatment by someone other than a Provider or a person who by law may work under a Provider's direct supervision.
17. Charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, or tobacco counseling.
18. Dental practice administrative services including, but not limited to, preparation of claims, any

non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks, or relaxation techniques such as music.

19. Procedures having a questionable prognosis based on a dental consultant professional review of the submitted documentation.

20. Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.

21. Deductibles, amounts over plan maximums and/or any service not covered under the dental plan.

22. Services covered under the Dental Plan, but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.

23. Services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except as provided under the Orthodontic Services section, if applicable.

24. Services for any disturbance of the Temporomandibular (jaw) Joints (TMJ) or associated musculature, nerves, and other tissues.

25. Missed and/or cancelled appointments.

26. Actions taken to schedule and assure compliance with patient appointments are inclusive with office operation and are not a separately payable service.

27. The fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.

28. Dental case management motivation interviewing and patient education to improve oral health literacy.

29. Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in structure of enamel, dentin, and cementum.

30. Extral-oral-2D projection radiographic image and extra-oral posterior dental radiographic image.

31. Diabetes testing.

32. Corticotomy (specialized oral surgery procedure associated with Orthodontics).

XVI. VISION CARE BENEFITS

The Vision Service Plan ("VSP") covers eligible Participants and their eligible Dependents for a regular examination, lenses, and frames when necessary for proper visual function or correction. Refer to your VSP EOC for more details.

A. TO OBTAIN SERVICES

To obtain services, 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 and provide the last four (4) digits of the Participant's 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 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 part of the

VSP network, you will be responsible for the fees or charges associated. You may later be reimbursed by VSP in accordance with the VSP guidelines. Call VSP for vision care request forms at 800/877-7195 prior to visiting your provider or at ***www.vsp.com***.

B. SERVICES AND MATERIALS (IN-NETWORK PROVIDER)

1. **One Exam 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.

2. **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:

   a. **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

   b. **Frames** - available once every 12 months for eligible Active Participants and their Dependents and once every 24 months for eligible Retired Participants and their Dependents. Frames are covered up to Plan Allowance of $150.00 plus 20% off any out-of-pocket expenses.

3. **Lens Options.** Tints/Photochromic and adaptive transitions lens enhancements are Covered in Full.

4. **Low Vision Benefits.** The Plan provides the following professional services obtained for severe visual problems that are not corrected with regular lenses:

   a. **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.

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

5. **Safety Glasses.** Prescription safety glasses obtained within the VSP network are available for Active Participants at $25 material copayment and $65 retail frame allowance, every twelve (12) months.

6. **Light Care Coverage.** Light Care coverage for non-prescription sunglasses and blue light filtering glasses in lieu of frames and prescription lenses, is available to all Eligible Active and Retired Participants and their eligible Dependents.

C. CONTACT LENSES CARE (IN-NETWORK PROVIDER)

Contact Lenses. When an eligible Participant or Dependent chooses contacts instead of glasses, the 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 and is available once every

12 months. Eligible Participants or Dependents are also covered up to a $130.00 allowance on contact lenses and this is available once every 12 months.

D. YOUR COPAYMENT (SUBJECT TO CHANGE)

Exam and Prescription Glasses $25.00
Contacts Lens Exam .....$60.00 (capped)
Contacts ..... No copay applies

XVII. HEALTH REIMBURSEMENT ACCOUNT

This Health Reimbursement Account "HRA" is intended to qualify as a Health Reimbursement Arrangement under the IRC Section 105 and shall be interpreted in a manner consistent with such IRC Section and the IRS regulations issued thereunder.

A. ESTABLISHMENT AND ELIGIBILITY OF SUPPLEMENTAL ACCOUNTS

1. Each Active Participant for whom contributions are made under a UA Local 342 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 ("RHB"). Notwithstanding the above:

a. A Participant of UA Local 342 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 their RHB to give Eligibility. The Board of Trustees has determined that this is more beneficial to Participants since other UA Local Union Plans have lower contribution rates and these Supplemental Benefits can help maintain their Eligibility.

b. Contributions to this Plan shall be in amounts provided in the Collective Bargaining Agreement.

2. Supplemental Accounts may be used for any purpose allowed under the HRA Plan rules and only for such purposes pursuant to IRS rules. 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. The Plan has contracted with NWPS as the Plan's HRA Plan Administrator to help jointly administer the Supplemental Accounts under the Plan. As such, HRA Statements are to be mailed on a semi-annual basis (through NWPS), unless special circumstances prevent such distribution.

4. 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, Active Participants must have established Initial Eligibility in the Health and Welfare Plan. Active and Retired Participants, and their eligible Dependent(s) must be enrolled in the Northern California Pipe Trades Health and Welfare Plan or other group health coverage that provides minimum value pursuant to the IRC 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 IRC Section 213(d) that does not constitute essential health benefits.

5. Nondiscrimination Requirement.

a. It is the intent of this HRA to not discriminate in violation of the IRC and the IRS regulations thereunder.

b. If the Administrator deems it necessary to avoid discrimination under this HRA, it may, but shall not be required to reduce benefits provided to "highly compensated individuals" (as defined in IRC Section 105(h)) in order to assure compliance with that Section. Any action taken by the Administrator under this Section shall be carried out in a uniform and non-discriminatory manner.

B. USE OF SUPPLEMENTAL ACCOUNTS

1. Retiree Health and Welfare ("RHW") Payments. Once a Participant is receiving a Retirement Benefit from the Northern California Pipe Trades ("NCPT") Pension Plan and is enrolled for RHW coverage under this Plan, the credits accrued in their Supplemental Account may be used to reimburse the monthly charge set by the Board of Trustees for RHW coverage.

2. Qualified Expenses. Any Active and Retired Participants who are eligible for benefits under this Plan may be reimbursed from their Supplement Account for any Qualified Expenses that are not otherwise covered under the Plan for themselves and/or their eligible, enrolled Dependent(s) (excluding Domestic Partner's and their Natural Children). 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 Healthcare as defined in IRC § 213(d), as follows:

(i) The Participant is using their Supplemental Account to reimburse themselves for Active Subsidized Self-Payments, COBRA Payments, or for the premium paid for RHW coverage for Retirees. The Supplemental Account can be used to reimburse the premium for coverage of a Dependent under insurance or a Group Health Plan other than this Plan; or

(ii) 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 Supplement 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

(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. Effective for expenses incurred on or after January 1, 2020, Qualified Expenses extend to:

(i) Over-the-Counter ("OTC") medicines and drugs without a prescription; and

(ii) Menstrual care products.

Refer to IRC Section 213d for more information on Qualified Expenses.

c. The expense must have been incurred after Initial Eligibility was established for HRA Benefits.

d. The expense must have been incurred by the Participant or an eligible Dependent within the meaning of IRC § 152. No cash Death Benefit distribution may be made unless permitted by the IRC or lawful regulations issued thereunder.

e. Domestic Partners and their Natural Children, or Dependents covered through legal guardianship are not considered Dependents pursuant to the IRC.

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

g. A claim for reimbursement from the Supplemental Account may be made at any time after the expense is incurred.

h. The Participant or eligible Dependent(s) must provide proof to the HRA Plan Administrator that the claim satisfies the requirements under Section 3.

i. 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 & Claims 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 are 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. Claim for Benefits. 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 eligible Dependent is aggrieved by the action on a claim, they may appeal that action to the Board of Trustees under Health and Welfare Claims and Appeals Procedure. The HRA Plan Administrator has the 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.

e. If the maximum amount available for reimbursement is not used in its entirety, such remainder shall be carried forward to the next coverage period or forfeited pursuant to the HRA rules in this section.

4. **Claims and Appeals Procedure.** The same Claims and Appeals Procedure 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.

6. **Death of Participant & Forfeiture Rules.**

a. Upon the Participant's death, if the Participant **has no** eligible Surviving Dependent(s), any unused balance in the Supplemental Account can be used for claims on behalf of the deceased Participant up to six (6) months from the Participant's Date of Death. The claims can be submitted by the Participant's Estate or Personal Representative. After six (6) months, the balance will be immediately and permanently forfeited and will revert to the Plan to be used for administrative expenses.

b. Upon the Participant's death, if the Participant **has** eligible Surviving Dependent(s) (defined as a covered eligible Dependent Spouse or Child under the Plan or a Dependent within the meaning of IRC § 152) the Participant's eligible Surviving Dependent(s) will continue to have access to the HRA Account and receive reimbursements for related Qualified Expenses incurred under this Plan or another Group Health Plan by the Surviving Dependent(s) until the HRA account reaches a zero balance or falls below the amount outlined in Section 6.d Small Account Balance Forfeiture. Claims for reimbursement by any Surviving Dependent(s) of allowable Qualified Expenses must be submitted to the Plan Administrator as soon as reasonably possible from the date of Participant's death.

c. Except as permitted by the IRC, in no event will the remaining assets be paid in cash to any person without regard to Qualified Expenses.

d. Small Account ($10 or less) Balance Forfeiture. Any Account with a balance of ten dollars ($10) or less, if no contributions are received for a twelve (12) consecutive month period, the Account will be permanently forfeited, and the balance will revert to the Plan.

7. **HRA Prepaid VISA Debit Cards.** The Plan allows eligible Participants and/or Dependents to electronically access their pre-tax amounts in their HRA accounts to pay for qualified medical care or benefit expenses through a prepaid VISA Benefits Card ("Benny Card"). Participants and their eligible Dependents are required to save itemized receipts on HRA purchases made with the Benny Card since they may be asked to submit receipts to substantiate that their expenses comply with IRS guidelines. Each receipt must show the patient's name, merchant or provider name, the service received, or the item purchased, the date, and the amount of the purchase. The IRS requires that every card transaction must be substantiated unless an IRS permitted exception applies. All charges shall be conditional pending confirmation and substantiation unless an IRS permitted exception is met. One exception is through **automated matching co-payment** processing as outlined by the IRS (e.g., *if the amount of transaction at the provider level equals the dollar amount of the applicable copay for that service under the Plan the charge is substantiated without the need for submission of a receipt or further review*). If the automated processing is unable to substantiate a transaction, the IRS requires that itemized receipts must be submitted in order to validate expense eligibility. Another exception is through what is called **recurring expenses** that match expenses previously approved as to the amount, provider and time period (e.g., *participant refills prescribed RX drugs on regular basis at the same provider for the same amount*).

If such purchase is later determined by the Administrator to not to qualify as a Qualifying Medical Expense, the Administrator, in its discretion, shall use the one of the following IRS required correction methods to make the Plan whole.

a. Continue sending request to participants (and dependents if applicable) to repay the improper amount or to submit proof of substantiation of claims (ex., EOB, Receipts),

b. Offset of future claims until the amount is repaid (if applicable),

c. Denial of access to cards (aka suspension) but card will be reactivated only upon repayment of amount owing or required proof to substantiate claims is provided or after the Form 1099 is re-issued), and

d. If the above steps fail and supporting documentation is not provided, you and or your eligible Dependent(s) could be required to repay the improper amount. The unsubstantiated amount will be reported to the IRS as taxable income if the amount exceeds $600. You will receive an IRS Form 1099-Misc by January 31st of the following year end. To avoid receiving a 1099-Misc,

appropriate documentation needs to be received by December 31st of each calendar year.

Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

Individuals should check their balance and find out which merchants are participating by visiting my.wexhealthcard.com. If receipts are not submitted as requested to verify a charge made with the Benny Card, your Card may be suspended until receipts are received. In addition, there will be a deactivation of your Benny Card if there has been 12-consecutive months of ineligibility.

It is your responsibility to check your account balance and to ensure you use your card only during times where you have coverage and eligibility.

Contact the HRA Plan Administrator, NWPS, for more information. Their contact information is listed on page v.

XVIII. DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (Active Participants Only)

A. LIFE INSURANCE BENEFIT FOR ACTIVE PARTICIPANTS

1. **Basic Death Benefit.** A $25,000 death benefit is payable to the designated beneficiary of a Covered Participant in the event of the Participant's death from any cause, on the job or off, while the Participant 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. Benefits are only payable if the Participant has Active eligibility at the time of death through hours worked, RHB, or Active-Subsidized Self-Payment (excluding COBRA). (**This benefit is not applicable for Retirees.)**

2. **Facility of Payment.** If, in the opinion of the Insurance Company, 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 Insurance Company 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 Insurance Company under the Plan.

3. **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 Participant or Participant'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.

4. **Beneficiary Designation.**

   (i) Any person(s) may be named by the eligible Participant as the Designated Beneficiary and the designation may be changed at any time by completing the proper form. If a Beneficiary Designation Form has not been filed with the TFO,

or if the Participant wishes to change their Beneficiary, they must obtain a Beneficiary Designation Form and submit it to the TFO.

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

- The Participant's Spouse;
- The Participant's Surviving Child(ren);
- The Participant's Surviving Parent(s);
- The Participant's Surviving Brothers and Sisters; or
- The Participant's Estate.

B. LIFE INSURANCE FOR DEPENDENTS OF AN ACTIVE PARTICIPANT ONLY

1. **Coverage.** For a Participant'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. For the definition of an Eligible Dependent, refer to Article VII. Eligible Dependents.

   If an eligible enrolled Dependent dies, the following amount of insurance on the life of that Dependent will be paid to the Participant as Beneficiary:

   Lawful Spouse/State Registered Domestic Partner $2,000
   Child(ren) (from live birth through Plan's maximum age).....$1,000

   If the Participant loses eligibility for Active benefits from the Plan, this benefit will terminate. Benefits are only payable if the Participant has Active eligibility at the time of death through hours worked, RHB or Active-Subsidized Self-Payment (excluding COBRA).

2. **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 their coverage terminates.

C. ACCIDENTAL DEATH AND DISMEMBERMENT FOR ACTIVE PARTICIPANTS ONLY

1. **Basic Coverage.** An eligible Participant is insured for up to $25,000 against Accidental Death or Dismemberment in an accident, on the job or off while the Participant 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. Benefits are only payable if the participant has Active eligibility at the time Accidental Death or Dismemberment in an accident, through hours worked, RHB, or Active-Subsidized Self-Payment (excluding COBRA). (**This benefit is not applicable to Retirees).**
   a. **Loss of Life.** If a Participant is killed in an accident or dies within 365 days as a result of an accident, their beneficiary will be paid $25,000 in addition to the $25,000 to be paid under the Basic Death Benefit, or

b. Loss of Hands/Feet/Sight. If a Participant 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 Participant, or

c. Loss of One Hand/Foot/Sight. If a Participant 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 Participant; or

d. Loss of Thumb and Index Finger on the Same Hand. If a Participant 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 Participant.

2. 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:

a. Willful self-injury or self-destruction, while sane or insane; or
b. Disease or the treatment of disease; or
c. War, or an act of war; or
d. Voluntary participation in an assault, felony, criminal activity, insurrection, or riot; or
e. 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
f. Duty as a member of a military organization; or
g. The use of alcohol if, at the time of injury, the Participant's blood alcohol concentration exceeds the legal limit allowed by the jurisdiction where the injury occurs; or
h. The operation by the Participant of a motor vehicle or motorboat if, at the time of the injury, the Participant's blood alcohol concentration exceeds the legal limit allowed by the jurisdiction where the injury occurs; or
i. The use of any drug, narcotic, or hallucinogen not prescribed for the Participant 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.

XIX. MILITARY SERVICE

A. 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:

1. To have their RHB frozen effective the first day of the month following the commencement of Active Service, which will terminate eligibility for the Participants and/or any Dependents; or
2. To continue eligibility for the Participants and/or any Dependents using the Participant's RHB until it is exhausted.

If a Participant elects option 1 (above), the Participant and/or their Dependents will immediately be eligible for COBRA Continuation of 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 2 (above).

B. 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 Participant must meet the following requirements:

1. **Purpose of Leave:** The Participant had to leave civilian employment for the purpose of entering a "Uniformed Service." Uniformed services include 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.
2. **Participant Provided Prior Notice of Service:** A Participant leaving for uniformed service has to provide prior notice that their absence will be due to uniformed service. Written notice is not required. You are required to notify the Union, TFO, and your Employer.
3. **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 TFO to determine if your situation may meet an exception to the five-year rule
4. **Participant must be honorably discharged from Service:** The Participant must have been honorably discharged from the military service.
5. **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:
   a. **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.
   b. **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.
   c. **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.

C. RIGHT TO CERTAIN HEALTHCARE BENEFITS UNDER THE PLAN

1. **Absent for 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.

2. **Absent for 31 or greater Days of Service:** If you are absent from Covered Employment as a result of military service for 31 or greater 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.

3. **Twenty-Four (24) Month COBRA Continuation of Coverage**: The Participant and/or Dependent(s) may be eligible to pay for Continuation of Coverage for up to 24 consecutive months. Coverage under the Participant's RHB may recommence after discharge from active military service if the Participant 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 Participant returns to work or registers within the period set forth in Section B.5 above.

XX. GENERAL PROVISIONS

A. CLAIM FORMS

All claims for benefits shall be filed on forms provided by the Carriers and/or the Plan, which are available from the applicable Carriers and/or TFO.

B. PROOF OF LOSS – within 180 days

Written proof of loss (for claims not covered under the insured carriers) 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. Proof of loss shall be considered to have been furnished as soon as a claim is received at the TFO, 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 Participants, Retired or terminated Participants, Dependents or any other person a vested right to continued coverage under this Plan. The Board of

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(s) 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 they can be located for payment, the Plan may, during the lifetime of the Covered Person, pay any amount otherwise payable to the Covered Person, 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. COORDINATION OF BENEFITS

The Plan's Coordination of Benefits rules in this section apply only to the extent that Kaiser, Blue Shield, VSP, 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 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:** Listed below are special rules for determining the order of benefit payment by the Plans:
   - **a.** The benefits of a plan that covers an individual as a Participant shall be determined before the benefits of a plan that covers an individual as a Dependent.

   - **b.** The benefits of a plan which covers a person as an Active Participant (or as that Participant's Dependent) are determined before those of a plan which covers that person as a laid-off or Retired Participant (or as that Participant'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.

   - **c.** 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.

   - **d.** 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.

(iii) 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.

(iv) 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;

e. 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.

f. If a covered Participant 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:

   a. The normal charge billed for the expense by the provider.
   b. The contractual rate for such expense under a preferred provider contract between the provider and this Plan.
   c. The contractual rate for such expense under a preferred provider contract between the provider and the plan with which this Plan is coordinating benefits.
   d. The maximum usual, reasonable, and customary allowance permitted under this Plan.
   e. 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:

a. Group Insurance Plans,
b. Group Hospital or Medical Service Plans and other Group Pre-Payment Plans,
c. Labor-Management Trusteed Plans, Union Welfare Plans, Employer Organization Plans,
d. Governmental programs or programs required or provided by any statute, and
e. General Coordination of Benefits Rule.

4. **Coordination with Medicare:** The Coordination of Benefits provision in the applicable Plan document for Kaiser will apply to claims covered by such HMOs. This provision applies to any other benefits provided under this Plan.

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

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

   a. An Active Participant performing Covered Employment and over age 65;
   b. A Dependent, who is either over age 65, or who is receiving a Social Security Disability Award and is receiving Medicare while covered under an Active 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 eligible Dependent(s) have the option of electing Medicare as primary. If Medicare is elected as primary, coverage under this Plan will cease as required by Federal Law.

5. **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 Active member or their 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 their Dependent who is entitled to Medicare benefits due to End Stage Renal Disease.

6. **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 TFO may 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.

J. SUBROGATION RIGHTS/THIRD PARTY LIABILITY

The subrogation third party liability provision in the applicable EOC 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 TFO 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 motorist's 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 they are making a present assignment of their 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.

The Plan is entitled to a first priority recovery for the full amount of Covered Charge it has paid or may pay for the injury or illness of a Covered Person that are related to the Third-Party Claim. As a condition of receiving benefits under the Plan, the Covered Person grants specific and first rights of subrogation, reimbursement and restitution to the Plan. Such rights shall come first and are not adversely impacted in any way by: (a) the extent to which the Covered Person recovers their full damages and/or attorneys' fees; or (b) how such recovery may be itemized, structured, allocated, denominated, or characterized; e.g., without regard to any characterization as a recovery for such matters as lost wages, damages, attorneys' fees, etc. rather than for medical expenses, the type of property or the source of the recovery, including any recovery from the payment or compromise of a claim (including an insurance claim), a judgment or settlement of a lawsuit, resolution through any alternative dispute resolution process (including

arbitration), or any insurance (including insurance on the Covered Person, no-fault insurance, or uninsured and/or underinsured motorist coverage).

Such reimbursement, restitution, and subrogation rights shall extend to any property (including money) that is directly or indirectly in any way related to the Plan benefits. Without in any way limiting the preceding, the Covered Person agrees to subrogate the Plan to any and all claims, causes of action, or rights that the Covered Person has or that may arise against any person, corporation, and/or other entity who has or who may have caused, contributed to and/or aggravated the injury or condition for which the Covered Person claims an entitlement to benefits under the Plan, and to any claims, causes of action, or rights the Covered Person may have against any other no-fault coverage, uninsured and/or underinsured motorist coverage, or any other insurance coverage or fund.

The Plan's right to subrogation, reimbursement, restitution, to a lien, and as a beneficiary of a constructive trust shall in no way be affected, reduced, compromised, or eliminated by any doctrines limiting its right (equitable or otherwise, whether established at common law or statute) such as the make-whole doctrine, collateral source, contributory or comparative negligence, the common fund doctrine, or any other defense.

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. The Plan's claim shall be a lien on said recovery and attach to the recovery or any tangible property that the recovery may be transmuted to. The Covered Person also agrees that until such lien is completely satisfied, the holder of any such property (whether the Covered Person, their attorney, an account, or trust set up for the Covered Person's benefit, an insurer, or any other holder) shall hold such property as the Plan's constructive trustee. As such, the constructive trustee agrees to immediately pay over such property to or on behalf of the Plan pursuant to its direction to the extent necessary to satisfy the equitable lien.

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.

K. WORK RELATED CONDITIONS

The work-related claims provisions in the applicable Kaiser or Blue Shield EOC 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 they are making a present assignment of their 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.

L. 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) all stages of reconstruction of the breast on which the mastectomy was performed, including coverage for nipple and areola reconstruction, and repigmentation to restore the physical appearance of the breast (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.

M. NEWBORN'S 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. However, you may be required to obtain pre-certification for any days of confinement that exceeds 48 hours (or 96 hours). In addition, plans and insurers may not set levels of benefit or out-of-pocket costs so that any portion of the 48-hour (or 96 hour as applicable) stay is treated in a manner that is less favorable to the mother or newborn than any earlier portion of the stay.

N. OUT OF COUNTRY/TEMPORARY STAY

Please refer to your EOC**.** Covered services under both the Kaiser and Blue Shield HMO Plans are 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 (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.

O. HEALTH REIMBURSEMENT ACCOUNT ("HRA")

This Plan includes an HRA. The HRA under the Plan uses pre-tax dollars in the account to pay for qualified out-of-pocket medical, dental, vision, 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 and Domestic Partner's Natural Children). 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.*** 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. The Plan has engaged the services of NWPS to administer its HRA benefits. Contact NWPS at 855/512-1170 for questions about your HRA. For more details on the Plan's HRA, please refer to Section XVII of this booklet.

P. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT ("MHPAEA").

The MHPAEA is a federal law that prevents large Group Health Plans (such as this Plan), Health Insurers, and HMOs (Kaiser and Blue Shield) that provide mental health or substance abuse benefits from imposing less favorable benefit limitations, including financial requirements (e.g., deductibles, copayments, coinsurance, and out of pocket limitations), treatment limitations (e.g., number of visits or days of coverage), and non-quantitative treatment limitations (e.g., preauthorization requirement, exclusion based on medical necessity) on those benefits than on medical and surgical benefits offered. As such, the limitations applicable to Mental Health or Substance Abuse Benefits can be no more restrictive than the predominant limitations applied to substantially all medical and surgical benefits. Pursuant to the final MHPAEA rules, the Plan or Health Insurer will provide any current Participants or potential Participants, or contracting providers, upon request, the criteria for medical necessity determinations with respect to mental health/substance abuse benefits and the reason for any denial of reimbursement or payment for services with respect to Mental Health/Substance Abuse Benefits will also be provided upon request.

It is the intention of the Board of Trustees and the contracted insurers (Kaiser and Blue Shield) that the Plan's benefits be provided in compliance with the requirements of MHPAEA and lawful regulations issued thereunder. For more information on MHPAEA, please visit the Department of Labor website at ***www.dol.gov/ebsa/mentalhealthparity/***. Refer to the EOC booklets provided to you by Kaiser or Blue Shield for a complete description of the mental health/substance use benefits available to you.

Q. COVID-19 TESTING, SERVICES, TREATMENT AND VACCINE COVERAGE

1. **Testing & Diagnostic Services or Items Coverage.** Effective for services received on or after March 18, 2020, and only until November 11, 2023 (unless further extended), the Plan will cover through its HMO coverage with Kaiser or Blue Shield and insured PPO coverage with Blue Shield

charges (both in-network and out-of-network) for the following tests only to detect the SARS-COV-2 or COVID-19 (also known as the Coronavirus) or the diagnosis of the virus that causes COVID-19 (including serological tests [antibody tests] for COVID-19 used to detect antibodies against the SARS-CoV-2 virus and are intended for use in the diagnosis of the disease or condition of having current or past infection with SARS-COV-2, the virus which causes COVID-19) at no cost sharing (meaning no copayment, deductible, or coinsurance):

- **a.** tests approved, cleared or authorized by the FDA;
- **b.** a test that a test developer intends or has requested FDA authorization for emergency use;
- **c.** a state authorized test and the state has notified the Department of Health and Human Services; and
- **d.** other tests that the Secretary of Health and Human Services determines appropriate in guidance developed during the COVID-19 public health emergency period.

This COVID-19 coverage extends to any diagnostic services or items provided during a medical visit including an in-person or telehealth visit to a doctor's office, urgent care center, or an emergency room that results in an order for an administration of the SARS-COV-2 or COVID-19 testing or screening but only to the extent such items and services relate to the furnishing or administration of the test or to the evaluation of the need for a test. Prior authorization or other medical management requirements is not required for diagnostic services related to COVID-19 testing.

2. <u>Coverage of Over-the-Counter ("OTC") COVID-19 Tests</u>.

Effective for purchases on or after January 15, 2022, and only until November 11, 2023 (unless further extended), the Plan (through its Insured Carriers, currently Kaiser and Blue Shield) will provide coverage for, including reimbursement of, all OTC tests (also known as at-home tests or self-tests): (a) approved, cleared or authorized by the FDA, (b) test that received FDA authorization for emergency use, (c) state authorized test and state has notified the Dept. of HHS, and (d) other tests that the Secretary of HHS determined appropriate in guidance during the public health emergency period, to detect the SARS-COV-2 (the virus that causes Coronavirus Disease 2019) or the diagnosis of COVID-19, purchased through pharmacies, retail stores and online retailers, without any cost-sharing, prior authorization or medical management requirements and without a prescription or involvement of a health care provider or individualized clinical assessment.

Pursuant to federal guidance, the Plan or Insurers are permitted (but not mandated) to make quantity and cost limitations under the following Safe Harbors pursuant to FAQ Part 51. If the Safe Harbor requirements are met the Plan or Insurers are permitted to implement the following limitations:

- **a. Cost Limits (Through Pharmacy Network or Direct Coverage).** The Plan or Insurer is permitted to limit reimbursement from a non-preferred pharmacy or other retailers to the lesser of: (i) the actual price of the test or (ii) $12 per test, provided that the:
  - **(i)** Plan or Insurer provides access to direct coverage, without cost-sharing (meaning the Participant does not pay an upfront cost and instead the plan or its contracted entity pays the preferred pharmacy or retailer directly) of OTC COVID-19 tests through a preferred pharmacy network or other retailers, including direct-to-consumer shipping programs; and
  - **(ii)** Plan or Insurer takes reasonable steps to provide adequate access to OTC COVID-19 tests through an adequate number of retail locations (both in-person and on-line locations).
- **b. Quantity Test limit.** The Plan or Insurer is permitted to limit OTC COVID-19 tests without a prescription or provider involvement, to no less than 8 tests per covered individual (e.g., Participant, Dependent Spouse, Dependent Child) per 30-day period or calendar month. In applying the quantity limit of 8, the Plan or Insurer may count each test separately, even if multiple tests are sold in one package. The Plan or Insurer is permitted to set more generous limits although not mandated.

If the above Safe Harbors (a) is not met (for example, if there are delays that are significantly longer than the amount of time it takes to receive other items under, if applicable, the Insurer's direct-to-consumer shipping program), the Insurer must provide coverage of the OTC COVID-19 test without cost-sharing and cannot deny coverage and cannot set limits relating to reimbursement on the amount of OTC COVID-19 tests.

If the above Safe Harbor (b) is not met (for example, OTC COVID-19 test with doctor's note), the Insurer must provide coverage of the OTC COVID-19 test without cost-sharing and cannot deny coverage and cannot set quantity limits.

To address suspected fraud or abuse the Insurer is permitted to require reasonable documentation of proof of purchase with a claim for reimbursement for the cost of the OTC COVID-19 test or require a self-attestation.

For Kaiser HMO Participants and Kaiser Permanente Senior Advantage ("KPSA") Retirees, you can submit a claim for reimbursement of FDA-approved rapid antigen home tests by signing onto https://healthy.kaiserpermanente.org.

For Active Blue Shield Participants ONLY, you can submit a claim for reimbursement for OTC COVID-19 tests by visiting the following website: https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/coronavirus/how-to-file-claim-covid-test-reimbursement**. This reimbursement program is not applicable to Blue Shield Retirees.**

3. **COVID-19 Qualifying Preventive Service & Vaccination Coverage.**
   Effective the earlier of January 1, 2021, or 15 business days after the date on which the United States Preventive Services Task Force ("USPSTF") or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") makes an applicable recommendation relating to qualifying COVID-19 immunizations, the Plan will cover approved COVID-19 vaccinations, including any qualifying coronavirus preventive service defined as an item, service or immunization that is intended to prevent or mitigate coronavirus disease 2019 that has received either an "A" or "B" in the recommendation of the USPSTF or the CDC through both the Kaiser and Blue Shield Plans during the duration of the COVID-19 Public Health Emergency Period.

   - **Temporary Extension (through November 11, 2023).** COVID-19 vaccinations are available to all eligible Participants and Dependents (through Kaiser and Blue Shield) at **no cost (meaning no copayment, coinsurance or deductible) whether received in-network or out-of-network** and **without prior authorization** at doctors' offices and medical facilities, including applicable participating pharmacies with Kaiser and Blue Shield until November 11, 2023.
   - **After November 11, 2023.** Effective November 12, 2023 (unless subject to change by law or subsequent government guidance), as a Non-Grandfathered plan for the Active Plan options, COVID-19 vaccinations will be covered at no-cost only received in-network (through Kaiser and Blue Shield) but COVID-19 vaccinations received out-of-network will either not be covered or will be subject to an applicable cost-sharing pursuant to the medical option policy (Kaiser or Blue Shield) you are enrolled in.

Providers are prohibited from seeking reimbursement from Participants and Dependents for the vaccine itself including the vaccine administration costs whether as a cost sharing or balance billing until November 11, 2023.

4. **COVID-19 Treatment Coverage**

Blue Shield of California HMO and PPO Plans. Effective March 1, 2020, and **further extended through November 11, 2023**, if a Blue Shield Participant or Dependent is diagnosed with COVID-19, charges for treatment of the COVID-19 (including anti-viral treatments while supplies last from the government, hospital admission, transportation and pharmacy services) will be covered in accordance with the terms and conditions set forth in the EOC pursuant to the terms and conditions of the Plan. Cost sharing (e.g., copayments, coinsurance deductibles) related to a positive COVID-19 diagnosis and treatment will be waived. After this six-month extension expires, in-network coverage for these services will continue at no member cost-share. Out-of-network coverage for these services will continue to be mandated, but cost-sharing may be applied based on a member's out-of-network plan benefits.

Kaiser Permanente HMO Plan. Effective April 1, 2020, and **further extended through November 11, 2023,** unless superseded by government action or extended by Kaiser, if a Kaiser Participant or Dependent is diagnosed with COVID-19 charges, such as out-of-pocket costs for treatment of COVID-19, will be covered for inpatient medical, inpatient pharmacy, outpatient medical, office visits, telemedicine, hospitalization, emergency room, urgent care, and transportation costs. This means any out-of-pocket costs, co-payments or other cost share related to a positive COVID-19 diagnosis and treatment will be waived by Kaiser. Kaiser should notify its enrollees if anything changes relating to COVID-19 coverage, after the six-month extension expires.

R. CONSOLIDATED APPROPRIATIONS ACT OF 2021 ("CAA")

The Plan's Insured Carriers (Kaiser and Blue Shield) are responsible for complying with certain provisions of Division BB of the Consolidated Appropriations Act under the No Surprise Act (Title I) and Transparency (Title II) provisions, including any subsequent implementing regulations as it relates to the CAA. More information on these federal requirements is also available directly with Kaiser and Blue Shield.

1. **Identification Cards (CAA Section 107).** The Plan's Insurers' (Kaiser and Blue Shield) Identification Cards (physical or electronic) issued to a Participant, or their eligible Dependents should include: (a) the amount of the in-network and out-of-network (if any) deductible and out-of-pocket maximums, (b) telephone number and website address to seek further consumer assistance. Contact Kaiser or Blue Shield for more information depending on which Plan option you are enrolled in.

2. **Ensuring Continuity of Care (CAA Section 113).**
When a provider or contracted facility is removed from the self-funded Plan (if applicable) or Insurer's (Kaiser or Blue Shield) coverage, following termination of the provider/facility contract between the Plan or Insurer and the Provider/Facility, the Plan (for self-funded plans) or Insurer (Kaiser and Blue Shield) should timely notify Participants or their eligible Dependents who are receiving continuing care for a serious and complex condition (serious and complex condition means an acute illness that is a condition that is serious enough to require specialized medical treatment to avoid reasonable possibility of death or permanent harm or in the case of chronic illness a condition that is life-threatening, degenerative, potentially disabling or congenital and requires specialized medical care over a prolonged period of time) from that provider or facility that:
    - **a.** the Provider/Facility is no longer part of the Insurer's network and
    - **b.** the Participant or eligible Dependent has the right to continue receiving transitional care for up to ninety (90) days at the in-network cost sharing and at the same terms that would have applied had termination not occurred.

Kaiser and Blue Shield are responsible for sending the appropriate notice to their enrollees. Contact Blue Shield or Kaiser for questions about continuity of care.

3. Accuracy of Provider Directory Information (CAA Section 116).

a. Verification Process. Not less frequently than once every ninety (90) days the Plan (for self-funded plans) or Insurer (Kaiser and Blue Shield) should verify and update its provider directory information included on the self-funded Plan or Insurer's database (as applicable). Providers are required to submit regular updates to the Plan or Insurer to assist with the verification and update process, including notice of material changes to their provider directory information. The database of provider directories must then be updated within two (2) business days of the plan receiving such data from the providers.

b. Response Protocol. The Plan (for self-funded plans) or Insurer (Kaiser and Blue Shield) will respond to a Participant or Dependent's request (whether by telephone, electronic, web-based or internet-based), within one (1) business day of the request, about a provider's network status. The Plan or Insurer must also retain communication records for two (2) years.

c. Database. The Plan (for self-funded plans) or Insurer (Kaiser and Blue Shield) (as applicable) should maintain a public website directory that contains a list of each of its contracted and facility providers, relevant information (name, address, specialty, number, digital contact information) and post information on balance billing protections and appropriate federal and state agency contacts to report violations.

d. Cost-Sharing for Services provided Based on Reliance on Incorrect Provider Network Information. If Participant or Dependent provides documentation (received through database, provider directory or response protocol) that they received and relied on incorrect information from the Plan (for self-funded plan) or Insurer (Kaiser and Blue Shield) about a provider's network status prior to the visit and the item or services would otherwise be covered under the insured coverage, if furnished by a participating provider/facility, the Plan or Insurer cannot impose cost-sharing amount greater than in-network rates and it must count towards the participant or dependent's in-network out-of-pocket maximum and in-network deductible. If a provider submits a bill to an enrollee in excess of the in-network cost-sharing amount and the enrollee pays, the provider must refund that excess amount with interest.

4. Surprise Billing Protections (CAA Sections 102 and 105).

a. Balance Billing Prohibition. Pursuant to the No Surprises Act, Participants and Dependents are prohibited from being balance billed for the following types of claims:

(1) out-of-network emergency services,
(2) non-emergency services performed by an out-of-network provider received at in-network facility, and
(3) out-of-network air ambulance services.

Providers are prohibited from holding patients liable for excess amounts not covered by the Plan or Insured coverage. "Surprise Billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care, such as when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

If you believe you received an impermissible balance bill, please contact Kaiser or Blue Shield directly. You may also contact 888/466-2219 for enforcement issues related to state regulated plans (such as the Kaiser or Blue Shield options) to submit a complaint regarding potential violations of the No Surprises Act against the Insurers.

b. Cost-Sharing Limits. In addition, for the three above-mentioned Surprise Act items and services (#1, #2 and #3) any cost-sharing (such as copayment, coinsurance, or deductible) must not be greater than the in-network cost sharing amount and must count towards the Insured Coverage's in-network deductible and out-of-pocket maximums, as of the items and

services were provided by a participating provider. The Participant or Dependent's cost-sharing is based on the recognized amount. By statute, the recognized amount is (in order of priority) for only out-of-network emergency services and non-emergency services provided by an out-of-network provider at participating facilities:

(i) Amount determined by All-Payer Model Agreement, if applicable;
(ii) Amount under specified state law (as applied to plans regulated by state law);
(iii) The lesser of the billed charge or Qualifying payment amount (is the median of the contracted rates for similar services in a particular geographic area-based on the metropolitan statistical area adjusted by the consumer price index for inflation for items or services furnished during 2023 or subsequent years).

For out-of-network air ambulance bills, the cost-sharing limit must be calculated by using the lesser of the: (1) billed charge or (2) qualifying payment amount.

c. Determination of Out of Network Rates. By statute, the total amount to be paid to a provider/facility must be based on (less any cost-sharing from participant or dependent) the following out-of-network rate, in order of priority:

(i) Amount determined by All-Payer Model agreement, if applicable,
(ii) Amount under specified state law (as applied to plans regulated by state law);
(iii) Amount agreed upon by Plan/Insurer and Provider/Facility; and
(iv) Amount determined by Independent Dispute Resolution Entity.

d. Patient Protections Disclosure Requirements Against Balance Billing.

Self-funded Plans and Insurers (Kaiser and Blue Shield) are required to make publicly available, by posting on the website of the Plan or Insurer and including on each Explanation of Benefits for an item or service as it relates to: (1) emergency services or (2) non-emergency services provided by non-participating provider at in-network facility, balance billing, and patient protections in certain circumstances and appropriate government agency contact information if the Participant or Dependent believes the provider/facility has violated the No Surprise Act provisions.

Contact Kaiser and Blue Shield directly for more information.

XXI. GENERAL EXCLUSIONS

For a full list of exclusions, refer to the Carrier's Evidence of Coverage ("EOC's"). Refer to page vi for a list of Carrier contact information.

XXII. POTENTIAL LOSS OF BENEFITS

You and/or your eligible Dependent(s) may lose your benefits and/or have payments delayed in at least the following circumstances, but not limited to:

A. PLAN EXCLUSIONS/COPAYMENTS/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, copayments, and other facets of the Plan in which you may not receive full payment on a claim, 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 TFO 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 RHW coverage.

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 XX, Section J 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 XX, Section I 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 may not pay 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, 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 SUBMIT COMPLETE APPLICATION

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

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 TFO, 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 submit hours timely on your behalf, you may not be eligible for RHW coverage.

XXIII. CLAIMS AND APPEALS PROCEDURE AND EXTERNAL REVIEW

A. GENERAL RULES

1. **Comply with Department of Labor Regulations:** The Board of Trustees has established the Claims and Appeals Procedures with the intent of complying with regulations issued by the U.S. Department of Labor ("DOL"). The Plan abides by the Claims and Appeals procedure. It is imperative that you timely file your Claims and Appeals according to these provisions.

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 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 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. The application will state something similar to the following:

   > **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 EOC.

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:

- **(i)** A payment of less than 100% of a Claim for benefits (including coinsurance or copayment amounts of less than 100% and amounts applied to the deductible);
- **(ii)** 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 (if applicable through the carriers);
- **(iii)** A failure to cover an item or service because the Plan considers it to be Experimental, Investigational, not Medically Necessary;
- **(iv)** A restriction on reimbursement for particular services because they are classified as related to a mental or nervous, rather than a physical, condition; and
- **(v)** A decision that denies a benefit based on a determination that a claimant is not eligible to participate in the Plan;
- **(vi)** Any rescission of coverage (meaning retroactive cancellation or discontinuance as described in Labor Reg. Section 2590.715-2712(a)(2)) of your benefits including disability benefits will be considered an adverse benefit determination that would trigger the Plan's appeals procedures. However, if the retroactive rescission was due to a failure to timely pay required premiums or contributions towards the cost of coverage that would not be considered an adverse benefit determination.

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:

(i) 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.

(ii) 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.

(iii) 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.

(iv) 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.

(v) 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 & Time Limits for Claims Procedures:

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

Claim Type	Plan Must Make Decision Within:
Urgent Claims	72 hours
Pre-Service Claims	15 days
Post-Service Claims	30 days
Disability Claims	45 days
Please see below for extensions and details.	

a. Urgent Claims. An "Urgent Claim" is a request by a Participant or a provider for authorization before medical care or treatment is obtained and delay in a decision of up to 15 days 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.

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 TFO, the TFO 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.** A "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. 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" 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. A Post-Service claim must be submitted to the TFO in writing, using an appropriate claim form, as soon as possible after expenses are incurred. A claim form may be obtained by contacting the TFO. 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 TFO.

Ordinarily, Participants will be notified of decisions on Post-Service Claims within 30 days from the receipt of the Claim by the TFO. 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 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 TFO within 90 days after the date of the onset of the disability. If the benefits are conditioned on someone other than the Plan making a disability determination (e.g., the Social Security Administration) then it would not be considered a disability benefit claim. 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 TFO. If the Plan requires an extension of time due to matters beyond the control of the Plan, the TFO will notify the 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.

Effective January 1, 2018, a retroactive rescission (meaning cancellation or discontinuance) of your disability benefit coverage will be considered an adverse benefit determination that would trigger the Plan's appeals procedures. However, if the retroactive rescission was due to a failure to timely pay required premiums or contributions toward the cost of coverage that would not be considered an adverse benefit determination.

If the Plan has failed to comply with the claims and appeals procedure requirements for disability claims, you will not be prohibited from filing suit or seeking court review of a claim denial based on a failure to exhaust the administrative remedies under the Plan unless the violation was the result of a minor error or considered "de minimis." This would mean: (a) non-prejudicial, (b) attributable to good cause or matters beyond the Plan's control, (c) in the context of an ongoing good-faith exchange of information, (d) and not reflective of a pattern or practice of non-compliance by the Plan.

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 their behalf. An Authorization to Release PHI/Appointment of Authorized Representative form, which may be obtained from the TFO, must be used to designate an authorized representative. The TFO 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 (meaning if all or a part of your claim is denied), the notice will include:

(i) The specific reason(s) for the determination;
(ii) Reference to the specific Plan provision(s) on which the determination is based;
(iii) A description of any additional material or information necessary to perfect the Claim and an explanation of why the material or information is necessary;
(iv) Information sufficient to identify the claim involved, including the date of service (if applicable), the health care provider (if applicable) and the claim amount (if applicable);
(v) 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 and any Plan imposed limitation to sue;

(vi) If an internal rule, guideline or protocol or other similar criterion, was relied upon in deciding the Claim, a statement that a copy is available upon request at no charge (if applicable);

(vii) If the determination was based on the absence of Medical Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances is available upon request at no charge (if applicable);

(viii) 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);

(ix) If applicable, a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, as soon as practicable (the Plan will not consider a request for such diagnosis or treatment information, in itself, to be a request for an internal appeal or an external review); and

(x) A description of the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act section 2793.

Effective January 1, 2018, for **Denial of Disability related claims**, in addition to the information set forth above, the denial notice will also include the following:

(i) Explanation for: (a) disagreeing with the views of any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable), (b) disagreeing with the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable), and (c) disagreeing with the view of any disability determination made by the Social Security Administration (if applicable);Statement that you have the right to receive, upon request and free of charge, reasonable access to and copies of all relevant documents, records and other information to your claim for benefits;

(ii) Statement of your right to present evidence and testimony in support of your claim during the appeal/review process;

(iii) Statement that either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the denial or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria does not exist;

(iv) Statement that on appeal, you will have the right to respond to the denial if the Plan receives new or additional evidence and you will also be provided, free of charge, with any new or additional evidence considered, as soon as it becomes available to the Plan and sufficiently in advance of the date on which the appeal determination notice is required to be provided to you under the Plan's rules. (This will usually be before the next regularly scheduled meeting of the Board of Trustees unless special circumstances require a further extension of time); and

(v) If applicable, notice will be provided in a culturally and linguistically appropriate manner in the predominant non-English language spoken where you live.

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 TFO **within 180 days** after the Participant receives the notice of Adverse Benefit Determination.

(i) **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:

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

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

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

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

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

- The patient's name and address;
- The Participant's name and address, if different;
- A statement that this is an appeal of an Adverse Benefit Determination to the Board of Trustees;
- 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.

b. **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 their 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.

The decision of the Board of Trustees or its designee as to any claim is final and binding, subject to such judicial review as provided by ERISA and the terms of this Plan.

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

(i) **Urgent Claims.** Notice of the appeal determination for Urgent Claims will be sent within 72 hours of receipt of the appeal by the TFO.

(ii) **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 TFO.

(iii) **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 TFO 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 their Claim in accordance with Section 4 below.

d. **Content of Appeal Determination Notices.** The determination of an appeal (Final Adverse Benefit Determination) will be provided to the claimant in writing. A Final Adverse Benefit Determination is an Adverse Benefit Determination that has been upheld by the Plan at the completion of the Plan's internal appeals procedures have been exhausted under the "deemed exhaustion rules" (explained below in Item No. 5). The Notice of a Denial of an appeal (also known as a Final Adverse Benefit Determination) will include:

(i) The specific reason(s) for the determination;
(ii) Reference to the specific Plan provision(s) on which the determination is based;
(iii) A statement that the Participant is entitled to receive reasonable access to and copies of all documents relevant to the Claim (other than legally or medically privileged documents), upon request and free of charge;
(iv) A statement of the Participant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal and any Plan imposed limitation to sue;
(v) If an internal rule, guideline or protocol or similar criterion was relied upon, a statement that a copy is available upon request at no charge;
(vi) Information about your right to Independent External Review for certain types of claims (if applicable); and
(vii) 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.

Effective January 1, 2018, for Appeals of Disability-related claims, in addition to the information

set forth above, the Appeal Denial Notice will also include:

(i) Explanation for: (a) disagreeing with the views of any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable), (b) disagreeing with the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable), and (c) disagreeing with the view of any disability determination made by the Social Security Administration (if applicable);Statement that either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the denial or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria does not exist;

(ii) Any Plan imposed timeline for filing a lawsuit pursuant to your right under ERISA section 502(a) and the expiration date for bringing suit; and

(iii) If applicable, notice will be provided in a culturally and linguistically appropriate manner in the predominant non-English language spoken where you live.

4. <u>When a Lawsuit may be Started/Lawsuit Filed In Northern District of California/No Participation in Class Action Lawsuits</u>:

<u>One Year Limitation to File Suit</u>. No Participant, Dependent, Beneficiary, or other person shall have any right or claim to benefits under these Rules and Regulations or any right or claim to payments from the Fund, other than as specified herein. A Participant may not file a lawsuit to obtain benefits until after either:

(i) 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

(ii) The appropriate time frame described above has elapsed since the 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.

Upon exhausting the Claims and Appeals Procedures for an eligible claim pursuant to the Plan rules, if a Participant or Beneficiary (or Authorized Representative) is still not satisfied, the next step is to file a lawsuit. No legal action may be filed (started) or commenced or maintained against the Plan, an individual Trustees, the Board of Trustees, or any other person or entity involved or associated with the denial or decision on the appeal more than one (1) 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 or after a denial after review by an Independent Review Organization (if applicable for Kaiser or Blue Shield benefits). 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 a 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.

<u>Choice of Venue Limit</u>. If there is a lawsuit, the Participant or Beneficiary (or Authorized Representative) agrees to submit to the jurisdiction of the United States District Court for the Northern District of California and any such lawsuit has to be filed in the United States District Court, Northern District of California which shall be the exclusive venue of any such action or proceeding. The Participant

or Beneficiary (or Authorized Representative) also irrevocably and unconditionally waives any objection that it might now or hereafter have to the venue of the aforementioned court and any claim that any action or proceeding brought in aforementioned court has been brought in an inconvenient forum.

Class Action Waiver. In addition, any person including Participants and Beneficiaries seeking benefits or otherwise challenging action or inaction of the Plan (such as questioning the Plan's investments), the Board of Trustees, a Trustee, or other person or entity involved with any Plan action or omission is not permitted to participate in or bring a class action lawsuit as a member in any class or representative action against the Plan, the Board of Trustees, a Trustee, or any other person or entity involved with any such Plan action or omission. Only individual lawsuits are permitted meaning any person including Participants and Beneficiaries may only bring claims in their individual capacity, and not as a plaintiff or class member in any purported class or representative proceeding.

5. **Exhaustion of Internal Appeal Process.** Generally, you are required to complete all internal Claims and Appeals Procedures of the Plan before being able to bring a civil action. However, subject to an exception (explained below) if the Plan does not strictly adhere to all Internal Claims and Appeals requirements under applicable federal law, you are considered to have exhausted the Plan's appeal requirements ("Deemed Exhaustion") on the grounds that the Plan has failed to provide a reasonable Internal Claims and Appeals process that would result in a decision on the merits of the claim, and you may pursue any available remedies under ERISA Section 502(a) or under State law, as applicable. You may also initiate an External Review (discussed in the External Review Section below in C.).

There is an Exception to the Deemed Exhaustion rule. The Internal Claims and Appeals process will not be deemed exhausted if:

- Violation was minor and is not likely to cause, prejudice or harm to you; and
- Violation was for good cause or due to matters beyond the Plan or its Designee's control; and
- Violation occurred in the context of an ongoing, good faith exchange between you and the Plan or its Designee.

This exception is not available if the violation is part of a pattern or practice of violations by the Plan or its Designee.

You may request a written explanation of the violation from the Plan or its Designee, and the Plan or its Designee must provide such explanation within ten (10) days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal Claims and Appeals process to be deemed exhausted.

If a court rejects your request for immediate review on the basis that the Plan met the standards for the exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the court rejects the claim for immediate review (not to exceed 10 days), you will receive notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon your receipt of such notice.

C. EXTERNAL REVIEW (For Non-Grandfathered Plan Options/Not Applicable to Retiree Options)

Generally, you must exhaust the internal claims and appeals procedure before you or your Authorized Representative can request an external review unless the Plan has failed to comply with the Claims and Appeals Procedures described above. The Plan's Insurance Carriers (Kaiser and Blue Shield) have established their own external review process to examine coverage and claims denials under certain circumstances. Because this Plan's benefits are insured through Kaiser and Blue Shield, any External Review Process needs to be filed with the Insurance Carrier's own Independent Medical Review Process. For complete details please refer to your respective EOC Booklet for more information on how to file an External Review.

Kaiser HMO (Independent Medical Review). Information regarding Kaiser's grievance and external review process should be available by contacting Kaiser's member services and on Kaiser's website (***www.kp.org***). If you qualify, you or your authorized representative may have your issue reviewed through the Independent Medical Review ("IMR") process managed by the California Department of Managed Health Care (DMHC). The DMHC determines which cases qualify for IMR. This review is at no cost to you. If you decide not to request an IMR, you may give up the right to pursue some legal actions against Kaiser. You may qualify for IMR if all of the following are true:

a. You have a recommendation from a provider requesting Medically Necessary Services.
b. You have received Emergency Services, emergency ambulance Services, or Urgent Care from a provider who determined the Services to be Medically Necessary.
c. You have been seen by a Plan Provider for the diagnosis or treatment of your medical condition.
d. Your request for payment or Services has been denied, modified, or delayed based in whole or in part on a decision that the Services are not Medically Necessary.
e. You have filed a grievance and we have denied it or we haven't made a decision about your grievance within 30 days (or three days for urgent grievances). The DMHC may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function. If we have denied your grievance, you must submit your request for an IMR within six months of the date of our written denial. However, the DMHC may accept your request after six months if they determine that circumstances prevented timely submission.

You may also qualify for IMR if the Service you requested has been denied on the basis that it is experimental or investigational as described under "Experimental or investigational denials." (Please refer to the Kaiser EOC booklet for a definition of what is considered "experimental or investigational.)

If the DMHC determines that your case is eligible for IMR, it will ask Kaiser to send your case to the DMHC's IMR organization. The DMHC will promptly notify you of its decision after it receives the IMR organization's determination. If the decision is in your favor, Kaiser will contact you to arrange for the Service or payment.

Blue Shield (External Review). Information regarding Blue Shield's grievance and external review process should be available by contacting Blue Shield's member services and on Blue Shield's website (***https://www.blueshieldca.com***).

XXIV. 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.

XXV. ADDITIONAL INFORMATION REQUIRED BY ERISA

The ERISA requires that certain information be provided to each Participant in an Employee Benefit Plan. These Plan rules reflect the contents of the Plan. As required, additional supplemental information will be supplied to Participants indicating material changes in Plan rules.

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 Taft-Hartley Group Health and Welfare Plan exempt from income tax under Section 501(c) 9 of the IRC. The Plan provides the following types of benefits: medical, hospital, mental health, substance abuse benefits, prescription drug, dental, vision, life and accidental death and dismemberment.

B. PLAN ADMINISTRATOR

The Board of Trustees is the designated Plan Administrator of the Plan under ERISA. The Board of Trustees 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 Participants and Beneficiaries in accordance with ERISA. The Board has designated Jeanette Null to be the Fund Manager for the Plan; you may contact her as follows:

Jeanette Null, Fund Manager
Northern California Pipe Trades Trust Funds 935 Detroit Ave., Suite 242A
Concord, CA 94518-2501
Phone: 925/356-8921
Fax: 925/356-8938
E-mail: *tfo@ncpttf.com* Website: *www.ncpttf.com*

C. AGENT FOR THE SERVICE OF LEGAL PROCESS

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

Lois H. Chang & 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 IRS 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 TFO 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. Contributions to provide benefits through the plan are paid by the sponsoring employers in accordance with their Collective Bargaining Agreement, Subscription Agreement, or Participation Agreement.

G. FUND MEDIUM/INVESTMENTS

The Board of Trustees has delegated Mammini Company as the Plan's Investment Manager, with the responsibility for investing the Plan's assets. The Board of Trustees may select other Investment Managers in the future.

H. SPONSORING ORGANIZATIONS

The Plan is maintained in accordance with Collective Bargaining Agreements between UA Local 342 and the Employer Associations. Participants and Beneficiaries may contact the Union to inquire on whether a particular Employer is a sponsor of the Plan.

XXVI. 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 Participants shall be entitled to:

1. Examine, without charge, at the TFO and at other specified locations such as work sites and the Union Office, documents governing the Plan, including insurance contracts, Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 series) filed with

the Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

2. Obtain copies of Plan documents and other information required to be furnished by law, upon written request to the TFO. Pursuant to ERISA, the TFO 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 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 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 a 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 a suit in a state or federal court. As summarized earlier in this booklet, any lawsuit must be filed within one (1) year 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 one (1) year 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 TFO. 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:

Division of Technical Assistance and Inquiries
U.S. Department of Labor

Employee Benefits Security Administration 200 Constitution Avenue NW
Washington, DC 20210

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.

Adoption Resolution

RESOLVED, that effective July 1, 2023, the **Board of Trustees of the Northern California Pipe Trades Health and Welfare Plan** ("PLAN") hereby adopts this Restated Summary Plan Description and Plan Document (known as the "Plan rules" or "Plan Booklet").

The benefits provided by the Plan can be paid only to the extent that the plan has available resources for such payments. No contributing employer has any liability, directly or indirectly to provide the benefits established hereunder, beyond the obligation of the contributing employer to make contributions required in the applicable Collective Bargaining Agreement(s). Likewise, there shall be no liability imposed upon the Board of Trustees, individually or collectively, or upon the Union, Signatory association or any other person or entity of any kind to provide the benefits established hereunder if the Plan does not have sufficient assets to make benefits payments.

APPROVED: September 6, 2023

Union Trustee

Che Timmons, Chairman

Date: 9/13/2023

Employer Trustee

Alex Hall, Co-Chairman

Date: 9/7/23

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