U. A. LOCAL UNION NO. 467

HEALTH AND WELFARE PLAN
AND VACATION PLAN

SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT

(Medical, Prescription Drug, Dental, Vision, Disability and Life Insurance)

Restated as of January 1, 2015

KEEP THIS BOOKLET FOR FUTURE REFERENCE

HIGHLIGHTS OF THIS BOOKLET

This booklet contains the Summary Plan Description ("SPD") and the Formal Rules of your Health and Welfare Plan and your Vacation Plan restated as of January 1, 2015 and previously effective as of July 1, 2007. The first part of the booklet is the SPD of the Health and Welfare Plan. It starts with a short summary of significant new provisions which were adopted since the last booklet was published. That is followed by a summary of how you and your family establish and maintain eligibility for benefits and a summary of the benefits provided by the Plan. The SPD is followed by the Formal Eligibility Rules and Formal Benefit Rules known as the Plan Document. The Vacation Plan section also has both a summary and the Formal Rules of that Plan. Additional information about both Plans is provided in various Appendixes.

You may go to the U.A. Local 467 benefits website (www.local 467benefits.com) for additional information. On the website you may access monthly Hours reported and contributions remitted by employers, Health Care information including eligibility, hour bank status, claims, history, and dependents on file, and for Health care Plan information: Click on the "Hour Status/Eligibility" button under the "Personal Information" button. First time users contact United Administrative Services at (408) 2880-4443 to request your Personal Login ID and Password.

Please note that the summaries and the tables of benefits are provided only for your convenience and are not intended to differ from, or supersede, the Formal Rules which follow. If there is any difference between a summary or table and the Formal Rules, the Formal Rules govern. Please also note that all of the rules of the Plans are subject to modification by the Board of Trustees. Any amendments to either Plan adopted by the Board of Trustees after the publication of this booklet supersedes the Formal Rules and summaries in this booklet.

DON'T BE CAUGHT UNAWARE:
Basic Information about the Health and Welfare Plan

1. Your claims must be **medically necessary** and properly prescribed to be covered by the Health and Welfare Plan.

2. You or your provider may call the Trust Fund Office, United Administrative Services, at (408) 288-4400, to confirm your eligibility status or for information about the benefits payable under the Plan. A list of other addresses and phone numbers of Plan providers appears on page 3 of the SPD.

3. It is your responsibility to inform the Trust Fund Office of a change in address, and to complete an enrollment form within 30 days of any of the following events occurring:

- Change of name
- Change of address
- Change in marital status
- Change in beneficiary
- Change or addition of eligible dependents
- Member or dependent becoming eligible for Medicare

IMPORTANT NOTICES

BENEFITS ARE NOT VESTED!

Plan rules and benefits may change from time to time. Your benefits under the Plan are not vested. The Board of Trustees may reduce or eliminate or change any benefits 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.

LIMITATION UPON RELIANCE ON BOOKLET AND STATEMENTS

This booklet provides a brief, general summary of the Plan. It is not intended to cover all of the details of the Plan. Nothing in this Summary Plan Description is meant to change the Plan's provisions. You should review the Plan to fully determine your rights. The Plan, and any amendment, is available for your review at the Trust Fund Office upon written request.

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

If you wish an interpretation of the Plan you should address your request in writing to the Board of Trustees at the Trust Fund Office. To make their decision, the Trustees must be furnished with full and accurate information concerning your situation.

You should further understand that, from time to time, there may be an error in a statement that you receive or a payment that has been made which may be corrected upon an audit or review. **The Board of Trustees reserves the right to make corrections whenever any error is discovered.**

C A U T I O N - FUTURE PLAN AMENDMENTS

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

AUTHORIZED SOURCE OF INFORMATION

United Administrative Services ("UAS"), the administrative office of the Health and Welfare Trust Fund, is the only authorized source of information concerning the administration of the Trust and the interpretation of the Plan provisions affecting the rights and duties of any Employee, retiree, or other person. All other sources, including without limitation, any Individual Trustee or officers and representatives of the Local Union, individual Employer or Employer Association (whether a Trustee or not) are completely unauthorized, and statements and opinions from them are not to be relied upon. Employees, retirees and other persons desiring information about the administration of the Trust, or a ruling as to their particular rights and duties under the Plans of the Trust, must request the same in writing from the Trust Fund Office.

Only the Board of Trustees has the authority to make final and binding interpretations of the Plan. Any person who believes he or she is adversely affected by a determination of the Trust Fund Office may appeal it to the Board of Trustees. An appeal must be submitted in writing to the Trust Fund Office within 180 days of the receipt of the notice of the adverse determination, or all objections to that determination are considered waived.

As a courtesy to you, the Plan representatives may respond informally to oral questions; however, oral information and answers are not binding upon the Board of Trustees or the Plan and cannot be relied on in any dispute concerning your benefits.

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U.A. LOCAL UNION NO. 467 HEALTH AND WELFARE PLAN AND VACATION PLAN
P.O. Box 5057
San Jose, CA 95150-5057

BOARD OF TRUSTEES

Employee Trustees

Michael Swanson, Chairman
U.A. Local Union No. 467
1519 Rollins
Burlingame, CA 94010

Gary Saunders
U.A. Local Union No. 467
1519 Rollins
Burlingame, CA 94010

Mark Burri
U.A. Local Union No. 467
1519 Rollins
Burlingame, CA 94010

Chris Collins
U.A. Local Union No. 467
1519 Rollins
Burlingame, CA 94010

Employer Trustees

Scott Strawbridge, Co-Chairman
No. Calif. Mechanical Contractors Assn.
P.O. Box 159
Benicia, CA 94510

Michael Vlaming
UMIC, Inc.-Industrial Contractors
447 Georgia Street
Vallejo, CA 94590

Ken Westphal
Acco Engineering Systems
1133 Aladdin Avenue
San Leandro, CA 94577

Daniel Laratt
DLI Mechanical
944 Terminal Way
San Carlos, CA 94070

PLAN PROVIDERS

Trust Fund Office
United Administrative Services
P.O. Box 5057
San Jose, CA 95150-5057
(408) 288-4400
(800)-748-6417
www.uastpa.com

Kaiser Permanente
Northern California Region
1800 Harrison, 9th Floor
Oakland, CA 94612
800-464-4000
www.kp.org

Prescription Drug Benefits
Script Care, Ltd.
866-807-0072
www.scriptcare.com

Vision Benefits
Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195
www.vsp.com

Dental Benefits
Delta Dental
100 First Street
(800) 765-6003
www.deltadentalca.com

Utilization Review
Health Care Evaluation
6702 N. Inglewood Ave., Suite G
Stockton, CA 95207
(800) 333-3018

Blue Cross of California
P.O. Box 60007
Anthem, CA 90060-0007
(866) 791-5538
www.bluecrossca.com
Customer Service: 800-688-3828

PLAN ADVISORS

In addition to the providers listed on page 2, the following organizations and individuals provide services to the Plan.

Investment Advisor
New Century Partners
Steven D. Callow
2838 Union Street
San Francisco, CA 94123
415-345-1430

Actuary / Consultant
Kaufmann & Goble
Sidney T. Kaufmann & Marci Vukson
160 W. Santa Clara Street
San Jose, CA 95113
408-298-1170

Auditor
Hemming Morse, Inc.
Alex Miller
160 Spear Street, Suite 1900
San Francisco, CA 94105
415-836-4041

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

U. A. LOCAL UNION NO. 467 HEALTH AND WELFARE PLAN

RECENT DEVELOPMENTS

The following are important changes to the Plan since the last booklet was published. You have already received notice of most of these changes.

1. No Lifetime Maximum Benefit. Pursuant to the Patient Protection and Affordable Care Act (the new health care law), the Plan no longer imposes any lifetime maximum benefit.

2. Dependent Child Eligibility. The rules for Dependent Child Eligibility have been changed to comply with the Patient Protection and Affordable Care Act. A Dependent Child will be eligible for coverage until the last day of the month in which the child attains age 26.

3. Limits on Coverage for Out-of-State Retirees and Reimbursement. A retired participant in the PPO Plan or Kaiser Plan who lives outside of California will not be eligible for coverage until the first day of the month following the date the participant enrolls in both Part A and Part B of Medicare and applies for coverage under the Medicare Supplemental Plan. An out-of-state retiree will be reimbursed for the cost of purchasing medical coverage up to a maximum of $600 a month depending upon the cost of such coverage and upon filing sufficient proof (the amount to be re-evaluated at least annually by the Board of Trustees). **Amendment Four**

4. Extended Benefits for Total Disability. If a Participant retires under the U.A. Local 467 Defined Benefit Plan while being entitled to health and welfare benefits because of a disability, such health and welfare benefits will terminate as of the effective date of the Participant's retirement. However, the Participant will then be entitled to retiree health and welfare coverage, if he/she is eligible, as of the effective date of his/her retirement.
Amendment Two

5. Grandfathered Plan. The Board of Trustees believes the Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (also known as Obamacare or the Affordable Care Act). As permitted by the Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of the Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing; however, grandfathered health plans must comply with certain other consumer protections in the Act, such as the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Office at 1-408-288-4400. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor ("DOL") at 1-866-444-3272 or *www.dol.gov/ebsa/healthreform*. The DOL website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

I. HOW YOU BECOME, AND STAY ELIGIBLE FOR BENEFITS

A. Active Employees and Dependents

1. Basic Eligibility Rules (including Hour Bank System)

When you perform an hour of Covered Employment under a Collective Bargaining Agreement of U. A. Local Union No. 467 for which your Employer makes a contribution to the Plan, you receive one hour of credit under the Plan's Hour Bank. To become eligible for benefits as a new Employee, you must perform at least 650 hours of Covered Employment in a consecutive twelve-month period. Once you have qualified for benefits, your Plan Hour Bank is charged 130 Hours for that month's coverage. Any excess Hour Bank credit is accumulated, up to **six months of coverage** (including the current month), to be used when you have had low hours of Covered Employment.

These amounts are set by the Board of Trustees, who has exclusive discretion to amend all aspects of the Plan. In particular, the Board of Trustees may change the Hour Bank rules from time to time, and may adjust the amount of hours in Participants' Hour Bank reserve accounts. If the monthly charge and/or maximum reserve amount are changed, or if your Hour Bank is adjusted, you will be informed by the Trust Fund Office. See the Formal Eligibility Rules, A. Employee Eligibility, for more details about accruing and using your Hour Bank. **You do not have a vested right to your Reserve Hour Bank. The Board could reduce and/or cancel these hours at any time**. *In addition, Employers do 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.*

Your eligibility for benefits depends on the continued and timely payment of Employer contributions on your behalf. In accordance with Plan rules, if your Employer fails to make a contribution when it is due, your eligibility may terminate (depending on the available hours in your Reserve Hour Bank). Eligibility for prior periods may be reinstated when your Employer makes the required contribution on your behalf.

Please note that your Employer reports each month's hours during the next month, and they are applied two months after that ("the double skip-month system"). For example, your hours of Covered Employment in January are reported in February, and are first available to provide coverage in April. This may cause a delay in your initial eligibility, or create a gap in coverage even after a month in which you worked the number of hours required to maintain coverage.

EXAMPLE 1: INITIAL ELIGIBILITY:

Let's say Pat is a new member of Local Union No. 467, and that he works the following amounts of covered employment:

January:	130 hours	May:	125 hours
February:	0 hours	June:	125 hours
March:	135 hours	July:	125 hours
April:	130 hours		

In August, Pat's Employer will report his July hours. These hours will take his Hour Bank up to 780 hours, which is more than the 650 hours required for initial coverage. Since a member becomes insured on the first day of the month following the month in which the required hours are worked, Pat becomes insured retroactive to August 1st. Coverage for August will "cost" 130 hours. Because of the double skip month eligibility system, Pat will also be charged for September and October coverage (another 260 hours), leaving him with an Hour Bank of 390 hours, the maximum amount of Hours a Participant may have after obtaining initial eligibility.

EXAMPLE 2: **CONTINUING ELIGIBILITY**: Let's say Mike is an established member in good standing of Local Union No. 467, and that he works the following amounts of covered employment and has a current Hour Bank balance of 370 hours:

Balance in Hour Bank:	370
Plus January hours	+130
Less April coverage	-130
Balance:	370
Plus February hours	+150
Less May coverage	-130
Balance	390
Plus March hours	+90
Less June coverage	-130
Balance	350
Plus April hours	+130
Less July coverage	-130
Balance	350

2. Extended Coverage Options for Active Members – Self Pay Option

If your Hour Bank runs out, you may be allowed to maintain your eligibility for benefits by making self-payments at the rate established by the Board of Trustees (which changes in most years). To be eligible to make self-payments, you must be on U.A. Local 467's out-of-work list and must not refuse more than two offers of dispatch in a twelve-month period. While you are making self-payments, you are eligible for the same benefits you were receiving under the Hour Bank. If you become disabled and are eligible for Plan benefits during the month in which the disability occurs, your medical benefits will be continued for up to twelve months without a self-payment.

You may continue coverage under the self-payment rules or under the short-term disability rules for a combined total of 12 months in any 24 month period. To reestablish eligibility for this extended coverage, a Participant must perform a minimum of 390 hours of employment covered under a Collective Bargaining Agreement of U. A. Local Union No. 467. After these forms of coverage run out, you may be eligible for COBRA coverage, which is summarized on pages 7-10 of this booklet.

3. Enrollment Procedures

You must complete and submit an Enrollment Form to U.A. Local 467 with sufficient documentation to establish the eligibility of any Dependent you list on the Form (such as a marriage certificate, birth certificate(s), and/or Court Adoption Order(s)). Full completion and return of the Enrollment Form is mandatory for enrollment in the Plan or to make any type of enrollment or informational change. In addition, an updated Enrollment Form is required when requested. Failure to complete and return the Enrollment Form within 30 days of the request may affect you and/or your Dependents eligibility and/or future benefits. You may obtain an Enrollment Form from the U.A. Local 467 website: ua467benefits.com.

You are also required to complete a new Enrollment Form when you have any changes in life circumstances (such as a marriage, divorce, new Dependents, Dependent status changes, Qualified Medical Child Support Order (QMCSO) and/or address changes), and include any required documentation regarding such change.

Eligibility begins on the first day of the month in which you initially qualify for benefits based on the initial eligibility requirements or if you regain eligibility for benefits, as long as the Trust Fund Office has received your completed Enrollment Form.

If you fail to submit an Enrollment Form, you will have no coverage. Retroactive coverage may be limited due to HMO and self-funded Medical Indemnity Plan retroactive limitations/rules.

4. Reinstatement Rules (Reestablishing Hour Bank Coverage)

There are three different rules for reestablishing Hour Bank coverage, depending on how much extended coverage you have used and how long you have been without coverage:

a. If you have not had twelve months of self-paid or short-term disability coverage (combined) in a twenty-four month period and you have run out of your Hour Bank, your Plan coverage will be reinstated if you work 130 hours of covered employment in that twenty-four month period.

b. If you have had twelve months of self-paid or disability coverage in a twenty-four month period, your Plan coverage will be reinstated if you work 390 hours of covered employment in that twenty-four month period.

c. If you have had twelve months of self-paid or disability coverage in a twenty-four month period, but have not performed 390 hours of covered employment in that twenty-four month period, you may only be reinstated as a new Employee after accumulating a new Hour Bank of 650 hours in a twelve-month period.

5. Loss of Benefits Due to Non-Covered Employment

Your eligibility for benefits under the Plan and your Hour Bank will be cancelled if you work in the type of employment for which Employers contribute to this Plan, for an Employer who does not contribute to a health and welfare trust fund affiliated with a local union of the United Association, or you go into business in the plumbing or pipefitting industry without being signatory to an agreement with a local union of the United Association, or in other words, if you work non-union.

6. Reciprocity

This Plan participates in the U.A. National Reciprocity Agreement with certain other U.A. Health and Welfare Plans. If you elect to have your Employer Contributions sent to another Trust Fund (your "Home Trust Fund") through reciprocity, you will not be eligible for coverage under this Plan. Contact your Home Trust Fund Office if you have a question regarding reciprocity/eligibility. A reciprocal authorization requesting to transfer your contribution to another Trust Fund will act as a release and waiver of any and/all claims against this Plan. If you are not a member of U.A. Local 467, you are required to complete a Reciprocal Authorization Form for the transfer of a contribution to your Home Trust Fund.

If you work outside the jurisdiction of U.A. Local 467 and wish to have your benefits sent back to this Trust Fund, you must sign a Reciprocal Authorization Form before beginning work on that job. A delay in signing the form will delay and/or prohibit transfer of benefits to this Plan. If you are working within Local 467's jurisdiction and you are not a Local 467 member, you must sign a Reciprocal Authorization form or other type of request in the manner that is satisfactory to the Trust Fund Office. Hours will be reciprocated to your Home Trust Fund within a reasonable period. **Hours cannot be reciprocated retroactively due to benefits already granted.**

7. Dependent Eligibility – Up to Age 26 (for children)

Your eligible dependents are generally covered whenever you are covered if they have been properly and timely enrolled. On the initial enrollment form that you complete for yourself, you should list the name and social security number of your lawful spouse and each child that you wish to enroll. There is no charge for enrolling dependents. Your eligible dependents are your spouse and children, up to age 26. For purposes of this rule, "children" means natural children, stepchildren, or a child who is legally adopted or for whom you have assumed legal responsibility in the course of adoption. Special extended coverage is also available, under certain conditions, for children who were dependents under the Plan immediately prior to reaching age 19 and who are incapable of self-sustaining employment by reason of developmental or physical disability, up to age 26. Spouse includes a same-sex spouse in a lawful marriage. (The Plan no longer has coverage for Domestic Partners.)

After initial enrollment, if a change occurs in the family as the result of marriage, divorce, remarriage, or additional children, you should **submit a new enrollment form within 31 days of the change**. Otherwise your new dependents may not be eligible for medical benefits until the next open enrollment period.

If you die while eligible for benefits under the Hour Bank, your spouse and dependent children will remain covered until your Hour Bank runs out, and then for an additional six months at no charge. Thereafter, your surviving spouse may continue coverage for herself or himself and for your eligible children by making monthly payments as required by the Trustees, until the spouse gets remarried, subject to enrollment in Medicare Parts A and B when eligible to do so.

The rules on dependent coverage may be changed at any time in the future which could impact your right to coverage under the Plan.

WARNING–FRAUD AGAINST PLAN

It is fraud if you enroll a dependent(s) that does not meet the Plan's criteria or you fail to notify the Trust Fund Office once a dependent no longer meets the Plan's criteria. It is your responsibility to timely notify the Trust Fund Office of any such change. You will be required to repay the Plan for any overpayments, including any attorney's fees and costs incurred by the Plan in recovering such amounts.

8. Qualified Medical Child Support Order

The Plan will comply with a court order which requires the Plan to provide coverage for a Participant's child(ren) if it meets the standards of a Qualified Medical Child Support Order ("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 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 who resides outside of the Plan's HMO service areas. The Participant must timely provide the Trust Fund Office with a copy of any court order that establishes the Participant's legal obligation to maintain coverage on a Dependent child including a QMCSO. A QMCSO recognizes an eligible child's right to receive Plan benefits as a beneficiary of an eligible Plan Participant. The child, to be covered for benefits by this Plan, must meet Plan requirements for an eligible Dependent child including age requirements.

The Plan requires that the Participant and all of his eligible Dependents be enrolled under only one Health Plan option. Therefore, a Participant must select and enroll in a Health Plan option that would be available to the Participant, the child(ren) covered under the QMCSO and to the Participant's other eligible Dependents. If a Participant enrolls in a Plan that would not be available to the child(ren) covered under the QMCSO because the child resides outside of the Plan's service area, the Participant will be required to enroll in another Health Plan option that would cover the child(ren). The Plan will follow the requirements of the QMCSO even if that requires that the Participant be forced to enroll in a different Plan option.

B. Individual Employers

An Individual Employer is eligible to enroll in the Plan if the company is signatory to a Collective Bargaining Agreement with U. A. Local Union No. 467, regularly employs Employees under that agreement, and has its main office in San Mateo County. A company may enroll up to two persons who are employed full-time in management of the company, and their dependents. Coverage under these rules is subject to payment of charges determined by the

Board of Trustees, as well as the payment of all contributions required under the Employer's Collective Bargaining Agreement. A person may remain covered as an Individual Employer after retirement if he or she had been covered as an Individual Employer for at least 120 months preceding retirement, and was age 60 or more at retirement, subject to payment of a monthly premium and enrollment in Medicare Parts A and B when eligible. **However, only one person may be eligible for retiree Individual Employer coverage per signatory company**.

C. COBRA Continuation Coverage

1. Eligibility for COBRA:

A federal law, known as the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), requires that group health Plans such as this Plan offer covered Employees and their dependents the opportunity to elect to pay a monthly premium for a temporary extension of health coverage (called "COBRA Continuation Coverage" or "COBRA") in certain instances (called "qualifying events") where coverage under the Plan would otherwise end. To receive this continuation coverage the Employee, spouse and/or dependent(s) must make timely monthly payments directly to the Plan. When you no longer have sufficient hours in your Reserve Hour Bank, your COBRA coverage will run concurrently with any continuation of coverage. **In other words, your COBRA eligibility is reduced by the number of months of free or subsidized coverage.**

Even if you do not elect COBRA continuation coverage, your spouse and each of your eligible dependents have a separate right to elect it. You, your spouse and all of your eligible dependents should read this section of your benefit booklet. A qualifying event is any of the following: a. Death of the Participant; Participant's termination of employment which includes resignation, layoff, firing (except for gross misconduct), retirement, strike or lockout; c. A reduction in the Participant's hours; d. Divorce or legal separation of the Participant and his spouse; e. A child no longer meets the definition of a dependent; or f. Participant becomes entitled to Medicare.

To receive this COBRA coverage, a Participant and/or his eligible dependents must file a timely application following the qualifying event and make monthly self-payments to the Trust Fund Office in an amount determined by the Board of Trustees.

2. COBRA Rules

a. Upon payment of the required monthly premium set by the Board of Trustees you and/or your dependent(s) may elect COBRA continuation coverage as follows:

(i) Termination of Employment or Reduction in Hours. A Participant or dependent may elect COBRA for medical benefits and prescription drug coverage only (core), or medical, dental and vision coverage (core and non-core benefits) for a period **of up to 18 months** if you lose your health coverage because of termination of your Covered Employment or a reduction in hours (including having used all hours in your Reserve Hour Bank), unless such termination is due to your Gross Misconduct, which does not require a criminal conviction. **This 18 month period is reduced by the number of months of subsidized self-payment described above.**

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

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

b. Thirty-Six Month COBRA Coverage for Dependents. Your dependent spouse or child who would otherwise lose health coverage is eligible for continuation coverage for up to 36 months because of the following qualifying events:

(i) the death of the Employee;
(ii) divorce or legal separation of the Employee and spouse; or
(iii) a child ceases to meet the Plan's definition of dependent.

c. Multiple Qualifying Events. An 18-month period of COBRA continuation coverage may be extended for up to 36 months for your spouse or dependent child if a second qualifying event occurs (such as if you die, divorce, or your child no longer qualifies for coverage) 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

An Employee's spouse is on COBRA continuation coverage due to the Employee's termination of employment. The Employee dies after 12 months of coverage during the 18-month period. His death is a second "qualifying event" and entitles the spouse to the remaining balance of 24 months (36 months maximum minus the 12 months that has already been covered).

The period of coverage under this section is reduced by any period in which the Employee or dependent was provided coverage by the Plan at lower cost than coverage under this section pursuant to the subsidized self-pay provisions of the Plan.

3. Election of COBRA Coverage

Within 60 days after the Trust Fund Office is informed in writing of an event entitling you and/or your spouse or dependent children to COBRA coverage, the Trust Fund Office will provide you

with information concerning the coverage available and its cost. You and/or your dependent must elect COBRA coverage within 60 days after your coverage under the Plan ends or the date you receive the election form, whichever is later. Anyone electing COBRA coverage must pay for it retroactive to the date he or she lost coverage under the Plan. Payment for this retroactive coverage is due within 45 days after the date COBRA coverage is first elected. After this first premium, there is a 30 day grace period for making future COBRA payments. No benefit claim will be honored unless the required payment has been received for the period in which the claim was incurred.

If you elect COBRA, you will be entitled to the same health coverage that is provided to active Employees or family members in the Plan. Therefore, if there are any changes to the Plan for active Employees, your benefits will also change.

You have the option of electing one of the following COBRA Plans and paying the designated premiums:

a. Core Coverage. Provides coverage for medical and prescription drugs only.

b. Full Coverage: Core and Non-core. Provides coverage for medical, prescription drugs, dental and vision.

The premiums for COBRA will increase each year

4. Your Obligation to Notify the Trust Fund Office:

You are required to notify the Trust Fund Office if you become divorced or legally separated and/or have other important changes that affect your benefits or those of a dependent.

5. Termination of COBRA Coverage:

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

a. Failure to Timely Pay Premium. You or your dependent fails to pay the required premium on time;

b. Coverage Under Other Plan. You or your dependent becomes covered by another group health Plan after your COBRA election;

c. Medicare Entitlement. You or your dependent becomes entitled to Medicare after having elected COBRA;

d. No Longer Disabled. You or your dependents qualified for 29-month maximum continuation period based on disability, but are no longer disabled;

e. Employer No Longer Contributes. Your Employer who contributed on your behalf ceases to be a contributing Employer; or

f. No Active Plan. The Trust Fund and your Employer cease to maintain any health Plan for active Employees or retirees.

D. Retiree Eligibility

The Board of Trustees provides retiree medical benefits on the basis that Employer contributions for Active Participants will, if continued, partially maintain benefits for retirees. Participants are required to pay a portion or all of the cost of coverage for retiree benefits. Retirees eligible for retiree coverage are required to pay a monthly premium to the Plan based on the Medicare status of the retiree and other eligible enrolled Dependents. The due date for your self-payment is the 20th of the month (received by U.A. Local 467 by that date).

It is recognized that the benefits provided by this Plan can be paid only to the extent that the Plan has available adequate resources for those payments. You should contact the Trust Fund Office for current rates. **The Board of Trustees may change the rates at any time. Benefits under this Plan are not vested and can be changed or eliminated at any time. Monthly premium payments for Retirees are likely to increase.**

When any active Employee retires, coverage will continue under the Hour Bank until it runs out. After that, you will be eligible to apply and pay for retiree health and welfare benefits if you satisfy the following qualifications:

1. You are receiving benefits from the U. A. Local No. 467 Defined Benefit Plan.

2. You have at least ten Years of Benefit Credit under the U.A. Local No. 467 Defined Benefit Plan.

3. You were continuously eligible for benefits under the Health and Welfare Plan for the 44 months out of the 48 months immediately preceding your retirement (i.e., not counting COBRA coverage or any other coverage such as coverage under Covered California (the exchange).

4. You are and remain a member in good standing of U. A. Local Union No. 467.

To remain eligible for retiree welfare benefits, you must timely pay the monthly payment determined by the Board of Trustees, and you must remain a member in good standing of U. A. Local Union No. 467. In addition, if you are eligible for Medicare, you must enroll in Medicare Parts A and B.

NOTE:
YOUR RETIREE BENEFITS MAY BE SUSPENDED IN CERTAIN SITUATIONS

If your pension benefits are suspended, your retiree welfare benefits will be suspended until your pension benefits start again. Your retiree welfare benefits will also be suspended if you become covered under another group health Plan as an Employee, and you fail to report the other coverage to the Trust Fund Office. In that situation, your benefits will commence again when your other coverage ends, but only if there has been no lapse in your retiree welfare payments to the Trust Fund Office since your initial date of retirement.

RETIREE ENROLLMENT IS NOT A VESTED RIGHT!

The Trustees reserve the right to terminate retiree coverage and to change the eligibility rules, the amount of the monthly premium, or other conditions of retire coverage for all Participants, including already-enrolled retirees.

LIMITATION ON RETIREE BENEFITS

(a) THE BOARD OF TRUSTEES RESERVES THE RIGHT TO CHARGE FOR, MODIFY OR TERMINATE THE RETIREE PLAN AT ANY TIME. THE RETIREE PLAN IS NOT A VESTED RIGHT.

(b) For retirees and their eligible dependents who are eligible for Medicare enrollment, the benefits of this Plan apply only to eligible out-of-pocket expenses. This is the difference between eligible covered charges and the amounts payable by Medicare.

(c) Remember, you must enroll in Medicare when eligible. Claims will be paid as if you are enrolled in Parts A and B of Medicare (see number 8 below).

E. Participant in Active Military Service

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

a. to have his Reserve Hour Bank frozen as of the first day of the month following the commencement of active service, which will terminate all eligibility for the Employee and any dependents; or

b. to continue the eligibility of the Employee's dependents using the Employee's Reserve Hour Bank, until it is depleted.

2. **Eligibility Rules for USERRA**

To qualify for re-employment rights under the Uniformed Service Employees Reemployment Rights Act ("USERRA"), including certain limited health care benefits (summarized below), a covered Employee must meet the following requirements:

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

b. **Employee Provide Prior Notice of Service.** An Employee leaving for uniformed service has to provide prior written notice that his absence will be due to uniformed service. You are strongly urged to notify the Union Dispatch Office so that the uniformed

service may be noted on the dispatch rolls, your Employer, and the Plan Office so the Plan is aware of your situation.

c. **Assert Military Rights for no More than Five Years (with certain exceptions).** Contact the Trust Fund Office to see if your situation may meet an exception to the five year rule.

d. **Honorably Discharged**. You must have been honorably discharged from the military service.

e. **Return to Covered Employment Within 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 of your military service. The rules for return to employment are:

(i) **Service of Less than 31 Days.** If your period of military service is less than 31 days, you must be available for Covered Employment 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. If this is impossible or unreasonable, then you must return as soon as possible.

(ii) **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. If this is impossible or unreasonable through no fault of yours, then you must return as soon as possible.

(iii) **Service of More than 180 days**. If the period of service is 181 days or more, you must return and continuation coverage will end no later than 90 days after completion of your military service.

3. **Rights to Certain Health Care Benefits Under the Plan**

a. **If Absent for Less than 31 Days, One Month of Coverage.** If you are absent from covered employment for less than 31 days, you may elect to continue your coverage with this Plan at no charge to you

b. **Absent for More than Thirty Days**. If you are absent from covered employment as a result of military service for more than 30 days, you may elect to purchase COBRA-like coverage for up to 24 months (the first month of which is free). After that first 30 days you will be required to pay a premium which is 102% of the Plan's cost of the coverage. Typical rights under COBRA are for 18 months, rather than the longer 24 month periods for veterans. USERRA's continuation requirements are similar but not identical to COBRA's 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.

c. **Hour Bank Frozen if so Requested**. Unless you request otherwise, your Hour Bank under the Plan will be frozen effective with the first of the month following the month that eligibility will be provided from your last hours of employment before entering the

service. For example, if you last worked January, you will have your Hour Bank frozen as of March, with coverage for April provided at the Plan's expense. If you wish to continue coverage for up to the additional 23 months after April, you may then do so by electing and paying COBRA-like payments to the Plan Office. After you return to Covered Employment (with proper notice and documentation), your Hour Bank will be reinstated in accordance with the Plan rules.

d. **Twenty Four Months of Continuation Coverage**. The Participant and/or any dependents will be eligible to pay for Continuation Coverage for up to 24 consecutive months. Coverage under the Participant's Hour Bank will recommence after discharge from active military duty if the Employee returns to work for a contributing Employer or becomes available to work for a contributing Employer as shown by registration on the Union's out-of-work list provided the Employee returns to work or registers within 90 days of discharge.

F. Family Medical Leave Act–Required for Employees of Larger Employers

If you work for an Employer with more than **50 Employees**, your Employer must continue to pay for your health coverage during any approved leave under the federal Family and Medical Leave Act (FMLA). In general, you may qualify for up to 12 weeks of unpaid FMLA leave if a 12 month period if:

1. You worked for the Employer for at least 12 months and for a total of at least 1,250 hours during the most recent 12 months before your leave; and

2. You require leave for one of the following reasons:

   a. Birth or placement of a child for adoption or foster care,

   b. To care for your child, spouse or parent with a serious medical condition,

   c. Your own serious health condition which prevents you from performing the essential functions of your work

   d. Military Caregiver Leave for up to twenty-six (26) weeks during a 12 month period to care for your spouse, son, daughter, parent, or next of kin who is a member of the Armed Forces (including the National Guard or Reserves), and undergoing medical treatment, recuperation or therapy for a serious injury or illness, or

   e. Military Qualifying Exigency Leave for up to 12 weeks of leave because of any qualifying exigency arising out of the fact that your spouse, son, daughter or parent who is a member of the National Guard and Reserves (excluding a member of the Regular Armed Forces) is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation. Qualifying exigencies for which an employee may take leave include: short-notice deployment, military events and related activities, child care and school activities (such as arranging for alternative child care), financial and legal arrangements, counseling, rest and recuperation, and post-deployment activities.

If you are taking FMLA leave that has been approved by your employer, your employer is responsible for making contributions to the Plan on your behalf, as if you are working, in order to maintain your eligibility. To find out more about Family or Medical Leave and the terms on which you may be entitled to it, contact your Employer.

Requests for FMLA leave must be directed to your Employer; the Trust Fund Office cannot determine whether or not you qualify. If a dispute arises between you and your Employer concerning your eligibility for FMLA leave, you may continue your health coverage by making COBRA self payments. If the dispute is resolved in your favor, and your Employer makes the required contributions, the Plan will refund the corresponding COBRA payments to you. It is not the role of the Board of Trustees or the Plan to determine whether or not you are entitled to leave with continuing medical care under the applicable laws. Disputes as to entitlement to leave with continuing medical benefits must be resolved by the employer and employee.

If your Employer continues your coverage during an FMLA leave and you fail to return to work, you may be required to repay the Employer for all contributions paid to the Plan for your coverage during the leave.

G. Health Reimbursement Account (UA Local 467 Extended Reserve Account)

This Plan includes a Health Reimbursement Account (HRA) also known as the UA Local 467 Extended Reserve Account. The HRA Account under the Plan uses pre-tax dollars in the account to pay for qualified out-of-pocket health care expenses allowed under the Internal Revenue Code, and as defined below. Any pertinent rule of the Internal Revenue Code and/or the IRS Regulations as applied to an HRA shall apply to this Plan. Pursuant to the collective bargaining agreement, different amounts are contributed to an HRA Account. Technically, these are considered "Employer" contributions under the Internal Revenue Code.

1. No Vested Right to HRA Account/No Cash Death Benefits. No provision in these HRA rules shall be construed as making such Accounts vested at any time or subject to use in any manner except as provided in these rules. There is no vested right to an HRA balance. Pursuant to Internal Revenue Code guidelines, no cash death benefits are permitted under the Plan.

2. Qualified Expenses. The HRA will reimburse qualified health care expenses that are not otherwise covered by the Plan to any active or retired participant who is eligible for benefits under the Plan. To qualify for payment through an HRA Account, an expense must satisfy all of the following requirements:

a. The expense must have been for health care expenses as defined in Internal Revenue Code Section 213(d). For example, below is a list of some examples of expenses which are reimbursable if not otherwise covered by the Plan (for a complete list, please view the IRS publication at http://www.irs.gov/pub/irs-pdf/p502.pdf):

- Medication (Insulin, Prescription Drugs, Prescribed Birth Control and Vitamins);
- Medical Equipment (Crutches, Syringes, Wheelchair, Hearing Devises and Batteries, Oxygen Equipment);

- Vision Services (Contact Lenses, Laser Eye Surgeries, Prescription Sunglasses, Artificial Eyes);
- Medical Treatments (Acupuncture, Sterilization, Vasectomy, In Vitro Fertilization, Speech Therapy);
- Dental Services (Dental X-Rays, Dentures, Oral Surgery, Orthodontia/Braces, Extractions);
- Dependent Care Expenses, where participant and spouse must be gainfully employed, seeking gainful employment, or in school (Nanny expenses, After-school care, Babysitter fees, Summary day camps);
- Over-the-counter Drugs, must be for the treatment of illness or injury as defined by the Internal Revenue Code and must be prescribed by a physician, including receipt of purchase with completed claim form (Acne medications, Allergy & Sinus medications, Decongestants, Diaper rash ointments, Sleeping aids, Toothache relievers).

b. The expense must have been incurred while the Participant was covered by the Plan, or while retired, regardless of when the claim is made.

c. The expense must have been incurred by the Participant or by a person who was then either a covered eligible dependent of the participant or by a person who was a dependent within the meaning of the Internal Revenue Code Section 152.

d. The Participant or dependent must provide proof, satisfactory to the Board of Trustees that the claim satisfies the requirement of this Section.

e. The claim for reimbursement must be made within one year of the time the expense was actually incurred. Extensions of this time limit will be granted only for good cause shown, at the sole discretion of the Board of Trustees.

3. Account Balance Statements. HRA 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 HRA Accounts, the Board of Trustees reserves the right to assess an administrative change against HRA Accounts. Currently, there is a $2.50 monthly administrative fee charged to each account. The Plan will provide Participants with a statement of their account balance on an annual basis. Such statements will be provided within a reasonable period after the end of the Plan year. The Board of Trustees has discretion to provide statements more often.

4. Other Plan Premiums. Any Participant may use his or her HRA Account to make self-payments for his or her coverage, when otherwise eligible to make self-payments and/or COBRA payments. A surviving spouse or surviving eligible dependent of a participant may use the Participant's HRA Account to make monthly requirement payments for Plan survivor benefits, or to pay premiums for COBRA coverage based on the death of the participant. If the eligible dependent(s)' Plan survivor coverage or COBRA continuation coverage period ends before the participant's HRA Account is

exhausted, that Account may be used to pay for the extended coverage for the Participant's dependent(s), at the COBRA continuation coverage rate, until the earlier of the following time (i) the HRA Account is exhausted, (ii) other coverage becomes available (including, but not limited to, coverage through Medicare or through another group health plan), or (iii) for a surviving child, the child attains the applicable limiting age under the Plan.

5. Procedures for Payment of Benefits. Benefits will be paid only to a Participant or surviving eligible dependent after incurring a qualified expense, and timely submitting a claim for reimbursement with supporting documents. To request a claim form, please contact the Plan Administrator at 1-408-288-4400. Benefits will be paid in the manner and time established by the Board of Trustees. If a Participant, retiree, or dependent is aggrieved by the action on a claim he or she may appeal that action to the Board of Trustees, under the Plan's appeal procedure.

6. Forfeiture. An HRA Account will be immediately and permanently forfeited if either of the following applies to the participant and any amount forfeited will be used to offset the administrative costs of the Plan's HRA:

a. Upon your death, if you have no eligible dependent(s) or if your eligible dependent(s) die without using all of the amounts in your HRA, any unused balances in your HRA will be forfeited.

b. You accept employment in any capacity and of any duration from a contractor in the Plumbing and Pipefitting Industry who is not signatory to the collective bargaining agreement.

c. The Participant is an owner of a company, business, or entity in the plumbing and pipefitting industry which is not signatory to a collective bargaining agreement of an U.A. Local Union having jurisdiction of the work.

II. PLAN BENEFITS

A. General

The Plan offers two medical benefit options. The options currently offered to active Employees and to retirees who are not eligible for Medicare are the self-funded Preferred Provider Organization Plan (or "PPO Plan") operated through Blue Cross and one health maintenance organization ("HMO"): Kaiser Foundation Health Plan. The options currently offered to retirees who are eligible for Medicare are the self-funded Medicare Supplemental Plan and the Kaiser Senior Advantage Plan. **The Board of Trustees has reserved the power to change the medical benefits options at any time; Participants will be notified if this occurs.**

The Plan currently uses Blue Cross of California ("Blue Cross") as the Preferred Provider Organization. The list of preferred providers can be found online at anthem.com. This list changes frequently, so when you seek covered care, you should determine in advance with your doctor and hospital whether they are still part of the Blue Cross network. You may also check with Blue Cross.

If you elect coverage from Kaiser (an HMO) you and your eligible family members will receive your medical, hospital, and surgical care from that HMO. (All eligible family members are covered in the same option that you choose for yourself, if they become timely enrolled.) Kaiser members will receive their prescription drug benefits from Kaiser, while self-funded Plan members receive their prescription drug benefits through Script Care Pharmaceutical Service, and their vision care benefits through Vision Service Plan (VSP). Kaiser members have the option of having VSP benefits.

Limits on Coverage for Out-of-State Retirees/Reimbursement of Certain Premiums Paid. A retired Participant in the Self-Funded PPO Plan or Kaiser who lives outside of California is not eligible for coverage under the Plan until the first day of the month following the date he enrolls in both Part A and Part B of Medicare and applies for coverage under the U.A. Local 467 Medicare Supplemental Plan when first eligible. The Plan will reimburse an out-of-state retiree who does not have coverage under the Plan up to a maximum of $860 a month in premiums (this amount covers the Participant and any dependent), depending upon the cost of such coverage and upon filing sufficient proof of the cost. The amount of as well as the continuation of the reimbursement shall be reevaluated annually by the Board of Trustees.

A Participant reaching the age of Medicare eligibility must timely apply for and obtain both Medicare Part A and Part B and must apply for coverage under the U. A. Local 467 Medicare Supplemental Plan when first eligible. Failure to apply when first eligible will result in you and your beneficiaries not being eligible for coverage under the U.A. Local 467 Health and Welfare Plan in the future.

B. Benefit Payment Rates Under the PPO Plan

If you are covered under the PPO Plan, your medical benefits will be paid as summarized below. Although the Plan uses the Blue Cross network of providers, the PPO is a self-funded Plan. There is no insurance company paying your benefits. When you or a dependent first receive care each year, you are responsible for an annual **deductible of $50 per person, up to $150 per family**. Then, unless a special rule applies to a particular type of care you receive, the Plan pays the following amount of benefits:

1. Preferred Providers: 90% of the contracted rate for covered PPO hospital, nursing home and medical charges from Preferred Providers, until Stop-Loss benefits take effect. The remaining 10% is your co-payment after the deductible.

2. Non-Preferred Providers: You may choose to go outside the PPO network to obtain your medical services and pay more for such services. The Plan's reimbursement rate drops from 90% to 60% of UCR.

A covered charge is considered to have been provided outside the service area of the Plan PPO if there is no preferred provider within 40 miles of the person's residence.

A separate schedule of benefits applies under the Medicare Supplemental Plan to persons who are eligible for Medicare, and for whom the Plan is secondary.

3. Authorized Exceptions to the Non-Preferred Provider rates: Benefits are paid at the rates applicable to PPO providers for services provided by Non-Preferred Providers under the following circumstances:

a. when you do not have reasonable access to a Preferred Provider **because of an emergency**; or

b. when you receive care from a Non-Preferred anesthesiologist, assistant surgeon, or radiologist, if you are receiving care in a PPO hospital and your primary surgeon is a Preferred Provider.

C. Stop-Loss Benefits

Stop-Loss Benefits are benefits paid by the Plan, in excess of its standard rates, when you have paid a certain amount of out-of-pocket expenses for "Stop-Loss Covered Care." Stop-Loss Covered Care is any care you receive from Preferred Providers, or from Non-Preferred Providers in a qualified emergency or under one of the other authorized exceptions, or outside of the PPO's service area. When you have paid $2,050 in a calendar year for covered charges for Stop-Loss Covered Care, the Plan's "Stop-Loss" benefit rates take effect. The Plan will then pay the following amounts:

1. Preferred Providers, or Non-PPO anesthesiologists, radiologists or assistant surgeons when you have used a PPO hospital and PPO surgeon: 100% of Covered Charges; Thus, your co-payments are eliminated; or

2. Non-Preferred Provider 60% of Covered Charges, up to 60% of UCR.

D. Examples of Benefit Payments under the PPO Plan

1. You become sick, and see your doctor, who is a Preferred Provider and uses a Preferred Provider laboratory for tests. If the total covered charges are $250, and these are your first covered charges for the year, your benefits would be paid as follows:

a. You are responsible for the first $50 in charges, as your annual deductible.

b. Of the remaining $200 in charges, the Plan pays 90%, or $180. You are responsible for the remaining $20, making your total payment $70.

2. You go back for a second visit, to make sure you have recovered from your illness, at a charge of $250. Since you have already paid your deductible, the Plan pays 90% of $250, or $225, and you pay $25. So far, all of your care is "Stop-Loss Covered Care," and your total out-of-pocket expenses have been $95.

3. You then are in an accident, and get hospitalized for two days. You have total covered charges of $30,000, all from Preferred Providers. You are required to sign an agreement to reimburse the Plan when there is an accident and/or any incident involving a third party in the event you receive a recovery from a third party such as an insurance company or the individual who caused the accident. Here is how benefits would be paid:

a. Of the remaining charges, the Plan first pays 90%, or $26,730, with $2,970 in remaining charges.

b. All of this care is Stop-Loss Covered Care. This means that you are only responsible for $2,050 in a calendar year of the remaining charges, minus any out-of-pocket expenses you have already incurred that year for Stop-Loss Covered Care. In this example, you have already had covered out-of-pocket expenses of $95, leaving your total share at $1,955.

c. The Plan will pay 100% of any remaining charge after you have paid $2,050 in a calendar year, and will also pay all additional covered charges you incur for Stop-Loss Covered Care for the rest of the year.

E. Reservation of Rights – Self Funded Plan

The PPO Plan and Medicare Supplemental Plan are self-funded. Self-funded benefits are payable only to the extent assets of the Trust Fund are available to pay them.

F. Hearing Aid Benefits

The Plan provides hearing aid benefits to covered persons under the PPO Plan. The Plan pays for an initial examination by a physician no more than once in a 24 month period, and a hearing aid examination also no more than once in a 24 month period, up to $85 each. If you need a hearing aid, the Plan pays 80% of the cost, with a maximum benefit of $2,500 per ear over any five year period.

HMO Participants are covered under the hearing provisions of the applicable HMO.

G. Benefits Provided Through Other Organizations

The following benefits are provided through other organizations. More detailed summaries of the benefits they provide appear later in this booklet.

1. Prescription Drugs. Prescription drugs are provided on a self-funded basis through Script Care Rx Options ("Script Care") to all covered individuals, except Kaiser members who receive their prescription drugs through Kaiser. You may obtain up to a thirty-day supply of prescribed drugs on a retail basis, and up to a ninety-day supply through the mail order program. See page 33-36 for a summary of the prescription drug program.

2. Death Benefits. The Trust Fund provides death benefits for Participants, spouses, and eligible dependent children age 14 days and up, and accidental death and dismemberment insurance for Participants only. The summary of these benefits is on pages 40-42..

3. Dental Benefits. The Trust Fund has contracted with Delta Dental Plan of California to provide dental benefits to all Participants and eligible dependents. A detailed summary of your dental benefits starts on page 36.

4. Vision Benefits. The Trust Fund has contracted with Vision Service Plan (VSP) to provide vision care benefits for covered Participants. For further information, see the Vision Care Benefits summary, on pages 40-42.

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

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

I. NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT

Group health Plans, health insurance issuers, and HMOs (such as Kaiser) 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).

J. POTENTIAL LOSS OF BENEFITS

You, your spouse, child or other dependent could lose your benefits or have payments delayed in at least the following circumstances:

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

2. Plan Exclusions/Co-payments. The Plan and any HMO or PPO contains exclusions and exceptions for coverage. You should be aware of the Plan’s limitations, exclusions, co-payments and other facets of the Plan in which you may not receive full payment on a claim or reimbursement or for which there is a co-payment.

3. Work in Non-Covered Employment (Misconduct). Your eligibility for benefits under the Plan and your Hour Bank will be cancelled if you work in the type of employment for which Employers contribute to this Plan, for an Employer who does not contribute to a health and welfare trust fund affiliated with a local union of the United Association, or you go into business in the plumbing or pipefitting industry without being signatory to an agreement with a local union of the United Association, or in other words, if you work non-union. If this occurs, the only coverage for which you may be eligible is COBRA (and COBRA is not available in certain situations), unless you requalify for coverage as a new Employee by working 650 hours of covered employment after your misconduct.

4. 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 pages 82-83 of the rules for third party liability.

5. Coordination of Benefits. If dependents are covered by more than one Plan, this Plan may not be responsible for many claims. See page 82 for a short summary.

6. Failure to Enroll in Medicare Parts A and B. If you are eligible for and fail to enroll in Medicare parts A and B, the Plan will not pay many of your claims. See pages 12 and 27 for the rules regarding Medicare.

7. Work-related Injuries or Conditions**.** The Plan is not responsible for paying any claims incurred as a result of a work-related injury or for conditions 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. This is so even though you fail to file a claim with workers compensation.

8. Right to Recover Claims Paid or Offset 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.

9. Failure to File Complete Application. Benefits may not be payable until a completed application and other forms required by the Trust Fund Office are received by the Trust Fund Office.

10. One Year Claim Rule. Claims have to be submitted and paid within 12 months.

11. Incomplete Information/False Statement/Fraud**.** 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 fees and costs incurred in effecting recovery or which were incurred as a result of the false statement or information. This includes but is not limited to costs incurred by the Trust Fund Office, reasonable attorney fees, and interest charges. The Plan may deduct any such fees and costs from any benefits otherwise payable to you, your estate or a beneficiary.

The Board of Trustees reserves the right to suspend or terminate coverage for you and your dependents or any other person claiming eligibility through your participation if you or that person received benefits knowing that he is not entitled to benefits or coverage. If participation is suspended, the Board will determine the length of suspension. The Board may cancel your Hour Bank. The Board reserves the rights of recovery and offset of benefits provided elsewhere in the Plan.

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

K. CHANGE OF ADDRESS

We have important pension benefit information to give you. This information could be delayed or not received at all if you don't have a current address on file. More importantly, without a current address on file, payment claims may be withheld. If we receive returned mail from your address on file, we will place a hold on any payments as a fraud prevention measure.

If you are planning to move or have moved, please send us a letter which includes:

- Your name
- Social Security number (last 4 digits)
- Complete new address
- Telephone number
- Your signature

Make sure to submit any changes to your mailing address to keep your records current. Avoid receiving your benefits late or not at all. If you have any questions, please contact the Plan office.

L. ENROLL IN MEDICARE PARTS A & B

Participants who are enrolled in Parts A & B of Medicare should not cancel their Part B insurance. Individuals who cancel their Part B insurance will no longer qualify for a health premium subsidy nor the Medicare reimbursement. Any health premium subsidies and/or Medicare reimbursements received after cancelling Part B will need to be repaid to the Plan.

M. FOR MORE INFORMATION

If you have any questions regarding the Plan, please contact United Administrative Services, P.O. Box 5057, San Jose, California 95150-5057, telephone (408) 288-4400.

III. BENEFIT TABLE FOR SELF FUNDED PLAN

GENERAL CHARGES

Office Visit Copayment Not Applicable
Deductible $50 person/$150 family per year
Annual out-of-pocket limit: $2,050 per person

Items that do not count toward the out-of-pocket limit, and which are not subject to that limit, include: amounts paid for deductibles and co-payments to non-PPO providers; prescription copayments; drug addiction, and alcohol or chemical dependency; and charges in excess of the applicable contracted PPO rates.

There Is No Lifetime Maximum

SPECIFIC CHARGES	PPO	NON-PPO
INPATIENT BENEFITS	**PARTICIPANT PAYS:**	
Alcohol and Substance Abuse	No charge (1st stay), 20% (2nd stay); residential drug treatment (approved in advance) permitted for up to 90 days	40% of UCR[2] plus any charges above UCR
Anesthesia	10% of PPO rate	40% of UCR plus any charges above UCR
Blood	10% of PPO rate	40% of UCR plus any charges above UCR
Inpatient Hospital Benefits	10% of PPO rate	40% of UCR plus any charges above UCR
Inpatient Rehabilitation Care	10% of PPO rate	40% of UCR plus any charges above UCR
Maternity Care (incl. delivery or C-section)	10% of PPO rate	40% of UCR plus any charges above UCR
Mental and Nervous Conditions	10% of PPO rate	40% of UCR plus any charges above UCR
Newborn Care	10% of PPO rate; limited to pre-discharge illness, accident or congenital condition	40% of UCR plus any charges above UCR
Physician Visit	10% of PPO rate	40% of UCR plus any charges above UCR
Surgeon/Assistant Surgeon	10% of PPO rate	40% of UCR plus any charges above UCR
Skilled Nursing Facility	10% of PPO rate, if commencing within 14 days of a hospital stay of at least 3 days	40% of UCR plus any charges above UCR
Emergency Room/Urgent Care:	10% of covered charges	40% of UCR plus any charges above UCR
OUTPATIENT BENEFITS		
Alcohol and Substance Abuse	10% of covered charges	40% of UCR plus any charges above UCR Limit 2 stays per lifetime
Allergy Testing	10% of PPO rate	40% of UCR plus any charges above UCR
Ambulance	10% of PPO rate	40% of UCR plus any charges above UCR
Durable Medical Equipment	10% of PPO rate	40% of UCR plus any charges above UCR
Emergency Room/Urgent Care:	10% of covered charges	40% of UCR plus any charges above UCR
Immunizations	10% of PPO rate	40% of UCR plus any charges above UCR
Infertility Treatment	Not covered	Not covered
Laboratory and Radiology	No co-pay 10% of PPO rate	40% of UCR plus any charges above UCR
Maternity Care, Tests and Procedures	10% of PPO rate	40% of UCR plus any charges above UCR
Mental Health Services	10% of PPO rate, if any, or 20% of UCR	40% of UCR plus any charges above UCR
Outpatient Surgery	10% of PPO rate	40% of UCR plus any charges above UCR
Physician Care	10% of PPO rate	40% of UCR plus any charges above UCR

[2] UCR is defined on page ___ of this booklet.

Prenatal/Postnatal Office Visits	10% of PPO rate	40% of UCR plus any charges above UCR
Physical Examination (routine)	Rate applicable to provider performing the examination for one physical every 12 months up to $300 per examination, inclusive of laboratory and radiology work	40% of UCR plus any charges above UCR
Therapy (physical, speech, rehab)	10% of PPO rate	40% of UCR plus any charges above UCR
Well Baby Care	10% of PPO rate; for preventive care up to your 5th birthday (first 60 months)	40% of UCR plus any charges above UCR
Rx Retail-Brand	10% or $5, whichever is greater, for up to a 30 day supply	Non-participating pharmacies are not covered
Retail-Generic	10% or $5, whichever is greater, for up to a 30 day supply	" " "
Mail Order-Brand	10% or $5, whichever is greater, for up to a 90 day supply	" " "
Mail Order-Generic	10% or $5, whichever is greater, for up to a 90 day supply	" " "
For each prescription, the co-payment will be $5.00 or 10% of the cost of the prescription whichever is higher plus the difference between Brand and Generic if a Brand is dispensed when a Generic is available.		
Mammogram	10% of PPO rate One routine mammogram is covered each year.	40% of UCR plus any changes above UCR One routine mammogram is covered each year.
Hearing	Hearing Aid Examination no more than once in a 24 month period, up to $85.00 each. Plan pays 80% of the cost of a hearing aid, with a maximum benefit of $2,500 per ear over any five year period.	Twenty-four visits per injury
Chiropractic/Acupuncture	Twenty-two visit limit $120 for x-rays taken in association with these forms of treatment per injury.	90% of UCR (60% at non-PPO)

1

[1]This table summarizes the general benefit rates, limitations, and conditions for particular kinds of care under the self-funded PPO Plan. Please note, however, that this table is a summary only and is presented only as a convenience. It does not describe in full the medical benefits of the PPO Plan. It is not intended to supersede the summary or Formal Benefit Rules which appear later in this booklet. **If there is any discrepancy between this table and the summary or Formal Benefit Rules, the Formal Benefit Rules prevail**. Please also note that you are eligible only for the benefits of the medical benefits option in which you have properly enrolled, and only if you satisfy the conditions of payment of that option. For more detailed information about the benefits available under the PPO Plan, the conditions of treatment and/or payment, and the claims review and adjudication procedures, please refer to the more detailed summaries that follow, and to the Formal Benefit Rules of the PPO Plan.

IV. MEDICARE SUPPLEMENTAL PLAN

Active and retired Employees and their dependent spouses who are age sixty-five (65) and over, or who are totally and permanently disabled, or who have end stage renal disease (kidney failure), are entitled to obtain benefits under the federal government's medical program, known as Medicare. There are two parts to Medicare that relate to this Plan. They are hospital insurance (Medicare Part A) and medical insurance, such as for the cost of physicians and outpatient care (Medicare Part B). 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. You will, however, have to make copayments under a schedule established by Medicare. Medicare Part B is partly financed by monthly premiums paid by those who enroll. Medicare sets the Part B premiums each year.

If you are still working at 65 and you or your enrolled dependent is eligible for Medicare, the Plan remains your primary medical coverage. You should enroll in Medicare as soon as possible, however, because Medicare will pay secondary benefits (up to its limits), which will reduce or possibly eliminate your costs for many medical services.

Once you or your spouse reach age 65 and become eligible for Medicare, you or your spouse must enroll in Medicare and elect either the PPO Medicare Supplemental Plan or the HMO Medicare-Risk Program of Kaiser Permanente, called Senior Advantage. You and your spouse must either be 1) both in the PPO or 2) both be in Kaiser.

Although Medicare provides certain medical benefits, some charges are not covered under that program, such as private duty nursing fees and charges incurred outside the United States. To provide certain benefits which are not provided by Medicare, a specially designed Plan supplementing Medicare has been adopted, as outlined below. This Medicare Supplemental Plan applies to all persons for whom the Plan is permitted by law to be the secondary payer. **The regular schedule of benefits and other rules (such as the exclusions) of the PPO Plan apply to Medicare-eligible persons for whom the Plan is required to be primary**. The Plan provisions for the regular Plan for active employees apply to this Plan too.

Persons who are covered under the Medicare Supplemental Plan receive the same prescription drug benefits and vision care benefits as persons covered under the PPO Plan. A retiree is entitled to dental, vision care, hearing aid, where applicable, and death and dismemberment insurance benefits, regardless of which medical benefits provider he has selected.

IMPORTANT NOTE: To be eligible for either primary or secondary benefits under this Plan, **every Medicare-eligible member or dependent must be enrolled in Medicare Parts A and B.** If you fail to enroll in Medicare Part B, or you allow your Medicare Part B coverage to lapse, then your coverage under the Plan will terminate on the last day of the month preceding the month in which you were eligible for Medicare but failed to pay for Medicare Part B. You should enroll in Medicare within 3 months prior to your 65th birthday. For enrollment and eligibility information, call Social Security at 1-800-633-4227. You can also find Medicare information on the Internet at www.medicare.gov.

The Medicare Supplemental Plan covers 100% of the Medicare hospital deductible. It pays 80% of the charges not covered by Medicare for Hospital services and Medicare-qualified Skilled Nursing Facilities expenses. For Medical Services, there is a $50 deductible each calendar year.

After you pay that, the Plan pays 80% of the UCR charges for services from licensed physicians and registered nurses, and 50% of the UCR charges by a licensed practical or vocational nurse for services provided within 60 days of an accident or within 60 days of the last day of a period of hospital confinement.

If a service is not covered by Medicare, the Plan will not cover any portion of it.

V. CLAIMS PROCEDURES

A. PPO Plan and Medicare Supplemental Plan

You may use the Plan's claim form for any claim or you may use your provider's own form. In order to speed up the processing of your claims, the Trustees suggest you use the following procedure when using the Plan's forms:

1. Part I must be completed and signed by the member. If the claim resulted from an accident, please give complete information including the date, time and place.

2. The attending physician must either complete Part II of the Plan's claim form or attach his own form, or an itemized statement which contains an ICDA code. The Plan does not require a claim form completed by a lab technologist, radiologist, or consulting physician who assisted in, or performed, a procedure which is billed by your attending physician.

3. A new claim form is required for each accident. If more than one family member has a claim related to an accident or other occurrence, a separate claim form is required for each family member.

4. Please identify all subsequent bills with your Local Union or your policy number.

5. An authorized representative may submit a claim on behalf of a claimant.

6. For a claim involving urgent care, a health care professional with knowledge of your medical condition may act as the authorized representative of the claimant.

B. When to File a Claim

You should file a claim as soon as you or one of your eligible dependents have incurred covered medical expenses for which the Plan provides benefits. You should not wait until the end of the year to submit your claim. **Claims which are submitted more than twelve (12) months after the charges are incurred are not payable**.

C. Having Your Provider Paid Directly

Payment of the benefits to which you are entitled under the Plan will be paid directly to you unless you have assigned them to the physician, provider, or hospital. If you so assign your benefits, you will be notified of the payments made by the Trust Fund Office on your behalf so that you will know the amount paid toward your bills by the Plan and the balance, if any, for which you are responsible.

D. Where to File a Claim

Claim forms are available from the Trust Fund Office or the Union Office. All claims should be sent to the Trust Fund Office at the address below:

United Administrative Services
P.O. Box 5057
San Jose, California 95150-5057
Telephone: (408) 288-4400

E. Other Benefits

No claim form is required for any other benefit, except Death Benefits, Accidental Death or Dismemberment Insurance, and Weekly Disability Benefits. Claim forms for these benefits are available from the Trust Fund Office or the Local Union. The Trust Fund Office may assist you in completing any of these forms, but you are ultimately responsible for submitting your own claims for these benefits. Submit insurance claims directly to the insurance company, at the address on the form. Special claims and appeal procedures apply to claims for Weekly Disability Benefits. See pages 89-92 for these procedures.

VI. OPTIONAL HMO COVERAGE – KAISER

The Board of Trustees has made arrangements for members to elect hospital, medical and surgical coverage through a health maintenance organization ("HMO"), in place of the self-funded PPO Plan. The HMO option currently offered to active Employees and pre-Medicare retirees is the Kaiser Foundation Health Plan ("Kaiser"). For Medicare-eligible retirees, the option is the Kaiser Senior Advantage Plan. A separate booklet describing this program is available at no charge from the Trust Fund Office.

To elect coverage through Kaiser, you must complete a Plan election card and the enrollment packet of the HMO. You may elect HMO coverage when first eligible under the Plan or at the open enrollment period established by the Board of Trustees. Currently there is an annual open enrollment election period in October of each year, to be effective on January 1 of the next year. If you do not actively enroll in an HMO, you will automatically be enrolled in the PPO Plan or, if you are retired and eligible for Medicare, the Medicare Supplemental Plan. Electing HMO coverage will have the following effects on the benefits you and your family receive:

1. If you elect hospital, medical and surgical coverage through Kaiser, neither you nor your dependent(s) is eligible for hospital, medical, or surgical benefits from the self-funded Plan.

2. To have your eligible dependents receive benefits from your HMO, you must enroll them when you enroll; or for a new dependent, you must enroll him or her within 30 days of the marriage, birth, adoption or other event which qualifies the person as an eligible dependent under the Plan. Failure to enroll a dependent in your HMO in a timely fashion may result in loss of coverage for that dependent until the next open enrollment date, unless late enrollment is accepted by the HMO.

3. If you elect Kaiser coverage, you will receive prescription drug and hearing aid coverage only from Kaiser. Vision Care may be obtained through Kaiser or VSP.

4. All Participants who elect coverage through an HMO remain eligible for dental benefits, life insurance, and accidental death and dismemberment insurance. All active Employees remain eligible for weekly disability benefits.

The following Kaiser summary is presented for your convenience only. Please refer to the Evidence of Coverage booklet for more details. Benefit amounts are likely to change after this booklet is published.

KAISER SUMMARY

GENERAL CHARGES	KAISER
Office Visit Copayment	$20 copayment
Deductible	Not Applicable
Annual out of Pocket Limit	$1500 per person/$3000 per family
Lifetime maximum	Not Applicable

SPECIFIC CHARGES	KAISER PARTICIPANT PAYS:
INPATIENT BENEFITS	
Alcohol and Substance Abuse	No charge (detox only) (Limited to two stays per lifetime)
Anesthesia	No charge
Blood	No charge
Inpatient Hospital Benefits	No charge
Inpatient Rehabilitation Care	No charge
Maternity Care (including delivery or C-section)	No charge
Mental and Nervous Conditions	No charge up to 45 days per year
Newborn Care	No charge
Physician Visit	No charge
Surgeon/Assistant Surgeon	No charge
Skilled Nursing Facility	No charge; limited to 100 days per year
OUTPATIENT BENEFITS	
Alcohol and Substance Abuse	No charge (detox only) (Limited to two stays per lifetime)
Allergy Testing	$3 copayment
Ambulance	No charge
Durable Medical Equipment	No charge
Emergency Room/Urgent Care at Participating Facility	$15 copayment; waived if admitted
Hearing Aids	Balance (if any) over $1,000 allowance per device, 2 devices every 36 months

Immunizations	No charge
Mental and Nervous Conditions	No charge up to 45 days per year
Infertility Treatment	$15 per visit
Laboratory and Radiology	No charge
Maternity Care, Tests or Procedures	$15 copayment
Mental Health Services	$10 copayment per visit; 20 visits per year
Outpatient Surgery	$15 copayment
Physician Care	$15 copayment
Prenatal/Postnatal Office Visits	$15 copayment
Routine Physical Exam	$15 copayment
Therapy (physical, speech, and rehabilitation)	$15 copayment
Vision benefits	VSP
Well Baby Care	$15 copayment
Rx Retail-Brand	$20 for a 100 day supply
Retail-Generic	$10 for a 100 day supply
Mail Order-Brand	Option at some facilities
Mail Order-Generic	Option at some facilities

*whichever is greater, for up to a 30 day supply **whichever is greater, for up to 90 day supply[3]

VII. PRESCRIPTION DRUG BENEFITS (Non-Kaiser Participants)

A. General

The Board of Trustees has implemented an integrated mail/retail prescription drug and formulary program through for all persons covered for medical benefits through the self-funded Plan. **Persons who are covered through Kaiser receive prescription drug benefits only through Kaiser**.

The prescription drug program is a $5/10% copayment program. For each prescription, the Participant's copayment will be $5 or 10% of the cost of the prescription, whichever is higher, plus the difference between brand and generic, if a brand is dispensed when a generic is available. To be eligible for prescription drug benefits, Participants must use either the Script Care mail order program or the Script Care retail network of pharmacies.

[3]This table summarizes the general benefit rates, limitations, and conditions for particular kinds of care for the HMO options currently available under the Plan. Please note, however, that this table is a summary only and is presented only as a convenience. It does not describe in full the benefits of any of the medical benefit options of the Plan. It is not intended to supersede the formal Evidence of Coverage documents of the HMOs ("EOC"), which are binding contracts. **If there is any discrepancy between this table and the EOC of an HMO, the EOC prevails**. Please also note that you are eligible only for the benefits of the medical benefits option in which you have properly enrolled, and only if you satisfy the conditions of payment of that option. There may also be changes in the future. For more detailed information about the benefits available under the option in which you are enrolled, the conditions of treatment and/or payment, and the claims review and adjudication procedures, please refer to the more detailed summaries which follow, and to the Evidence of Coverage documents of your HMO.

Effective January 1, 2014, your prescription drug benefit will be administered by ***Script Care, Ltd. Script Care*** has been providing pharmacy benefit management services nationally since 1989 and has over 64,000 retail pharmacies. To access the ***Script Care*** Pharmacy Locator, please visit www.scriptcare.com. You may also call the ***Script Care*** Help Desk toll free at (866) 807-0072 to determine if a pharmacy is in the network. The following information is an overview of the U.A. Local 467 Health and Welfare Plan prescription drug benefit being administered by ***Script Care***.

Copays, the portion of the drug cost that you are responsible to pay, are listed in the table below.

30-Day Retain & Specialty Medications			**90-Day DrugSource, Inc. Mail Order**	
	Generic	*Brand*	*Generic*	*Brand*
Copay	$5 min. or 10%	$5 min. or 10%	$5 min. or 10%	$5 min. or 10%

Note: in most situations, Brand drugs are more costly than Generic Drugs.

For information on your prescription drug benefit refer to your Summary Plan Description or contact the Trust Fund Office at (408) 288-4400.

Script Care ID Card
Script Care will provide you with a prescription ID card.

Drug Source, Inc. (Mail Order)
Mail Order services will be provided through an affiliate company, DrugSource, Inc., located in Elk Grove Village, Illinois. Mail Order is a convenient way to receive maintenance prescription drug medications. For individuals currently using the mail order program, Script Care will provide you with information on the transition to Drug Source. More information on mail order will also be included with the ID card in early December.

SCL Specialty Pharmacy Program (Script Care Specialty Pharmacy Program)
Specialty medications help patients with complex chronic conditions like multiple sclerosis, cancer, or rheumatoid arthritis. The SCL Specialty Pharmacy Program must be used to obtain specialty medications. Please contact the SCL help desk at (866) 443-1991 for assistance with these medications. If you are currently receiving a specialty medication, Script Care will be sending a separate mailing with information on how to make the transition.

Questions and Concerns
If you have a question, concern, or need assistance regarding your prescription drug benefit, please contact the Trust Fund Office at (408) 288-4400, or call the ***Script Care*** Customer Service Help Desk at (866) 807-0072.

The mail order program is designed for the dispensing of maintenance prescription drugs. Participants may obtain a 90-day drug supply with a $5/10% copayment through the mail order program, versus a 30-day supply with a $5/10% copayment through the retail program. (Maintenance drugs are prescription drugs used on a long term, regular basis. The Plan considers any prescription which is in excess of a 30-day supply to be a maintenance drug, unless it is clearly established to be an acute drug. Acute drugs are prescription drugs taken for a short period of time.)

Both the mail order and retail programs will have an automatic generic substitution system. A generic drug is a drug that has the same therapeutic effect, same active ingredients and can do the same job as a brand name drug. If a Participant's prescription has a generic equivalent, the generic equivalent will be dispensed, unless the prescribing physician believes such substitution is inappropriate and specifically states on the prescription that there be no generic substitution. This generic substitution system is not new; it is a very effective cost-control method and generics can help save the Plan up to 50% on the cost of prescription drugs.

Both the mail order and the retail programs have a Formulary program. The Formulary program is similar to the automatic generic substitution system, but is a non-generic substitution for more expensive brand name drugs that do not yet have generic equivalents. This program is a cost-control program specifically for non-generic drugs. The Formulary is a list of non-generic drugs based on effectiveness, safety and cost. Drugs are only classified as Formulary drugs if they are:

1. As therapeutically effective as brand name drugs,
2. As safe as brand name drugs, and
3. More cost effective than other brand name drugs.

A nationally renowned Pharmacy and Therapeutics Committee decides on which drugs should be on the Formulary list. The Formulary program is not a new concept. Formulary programs have been around since the 1980's, so most physicians are aware of such programs.

B. Formulary Program

Here is how the Formulary program works:

1. Each member and pharmacist will be provided a condensed list of Formulary drugs. **(Participants are encouraged to show this list to their physicians.)** A Formulary drug list is available upon request from the Trust Fund Office.

2. If a non-Formulary drug is prescribed to a Participant, the pharmacist will contact the prescribing physician and inform the physician of the existing Formulary program. The Physician can then choose to prescribe the more cost effective drug. If the physician is of the opinion that the Formulary drug is not appropriate, the original prescribed brand name drug will be dispensed to the Participant.

The Plan has an "Open" Formulary program. This means that Participants can receive any covered brand name drug, whether or not it is a Formulary drug. However, please keep in mind that the Formulary program will help reduce the operating cost of the Plan and your copayment.

Members must submit their enrollment forms to the Trust Fund Office for the prescription drug benefit to apply to eligible dependents. If members do not submit their enrollment cards, Script Care will have no record of the dependents' eligibility and may not dispense prescriptions to the dependents through the Health and Welfare Plan.

C. How to Use the Mail Order Prescription Drug Program

Prescriptions ordered through the mail order prescription drug program will be paid at 100% after the Participant pays his $5/10% copayment. Prescriptions will be delivered to a Participant's home, postage paid, within 10-14 working days of the order. If you have questions about the cost of your prescription, you may contact Script Care at 866-807-0072.

To order prescriptions by mail:

1. Ask your physician to prescribe needed medications for a 90-day supply plus three refills. If you are presently taking medication, ask your doctor for a new prescription and tell him you are going to be using a mail order program for your prescriptions. If you are starting a new medication, ask your doctor for **2 prescriptions, one for a 14-day supply** which you can have filled at a local pharmacy and the **second prescription for the 90-day supplies,** which you will send to Script Care to be filled.

2. Complete the patient profile questionnaire with your first prescription order.

3. Send the complete profile questionnaire and your original prescription(s) to Script Care using the pre-addressed envelope.

4. Script Care will process your order and return your medication immediately.

YOU ALSO MAY ORDER ON LINE AT www.scriptcare.com.

D. How to Use the Retail Prescription Drug Program

Prescriptions ordered through the Script Care retail prescription drug program will be paid at 100% after the Participant pays the $5/10% copayment. Here is how the retail program works.

1. Each member will receive a prescription drug card which will be coded for the status (such as single or married) of that member. This drug card can be used when obtaining prescriptions for any of a member's eligible dependents. **(The drug card eligibility information will be based on the enrollment card information you provide to the Trust Fund Office.)**

2. When a person takes in a prescription and the drug card to a pharmacist, the pharmacist will check for a match between the eligibility information for the member on the drug card, and the eligibility information of the person the prescription is for (as shown on the pharmacy's records), to ensure that the prescription is for a person covered under this Plan, before dispensing under the terms of this Plan's prescription drug benefit.

Your participating pharmacy's eligibility records are based on information provided on a monthly basis by the Trust Fund Office, and the Trust Fund Office's records depend on the information you provide. If you do not accurately report your eligible dependents, or you do not inform the Trust Fund Office of any changes (such as newborns), your dependents may be denied prescription drug benefits.

Your local pharmacy should be able to advise you whether or not it is a member of the network. A list of participating pharmacies and a list of formulary drugs is distributed from time to time, and is available any time from the Trust Fund Office on request, free of charge to Plan Participants and beneficiaries. If you do not use a participating pharmacy, the Plan will not pay for your prescription.

VIII. DENTAL BENEFITS

Dental benefits are provided through a contract with Delta Dental Plan of Californian (Group Number: 79-0001). These benefits are provided to all Participants and eligible dependents, regardless of which medical benefits option they have selected. A separate booklet is available from your Local Union Office or the Trust Fund Office which will summarize in more detail the Plan's dental benefits in detail.

When you use a Delta Dental Participating Dentist, you pay the designated portion of the covered charges, and payment will be made directly to the dentist by Delta Dental. Delta Dental Participating Dentists have agreed with Delta Dental not to charge you for any amount above the agreed charges for covered services and supplies, or for any sums owing by Delta Dental under this Plan. You may call 800-765-6003 for a list of Delta Dental dentists. **This rule does not apply to non-Delta dentists, so you will be responsible for any charges by a non-Delta dentist that the Plan does not pay**.

A. Summary of Dental Benefits:

Your dental plan covers several categories of Benefits, when the services are provided by a licensed dentist, and when they are necessary and customary under the generally accepted standards of dental practice. Please review the limitations and exclusions on pages 37-39.

After you have satisfied any Deductible requirements, Delta Dental will provide payment for these services at the percentage indicated up to a Maximum of $7,500 for each Enrollee in each calendar year.

Payment for Orthodontic Benefits for a dependent child is limited to a lifetime Maximum of $1,000.

An agreement between the Trust and Delta Dental is required to change Benefits during the term of the Contract.

The following Benefits are limited to the applicable percentages of dentist's fees or allowances specified below. You are required to pay the balance of any such fee or allowance, known as the "Enrollee co-payment." If the dentist discounts, waives or rebates any portion of the Enrollee co-payment to the Enrollee, Delta Dental only provides as Benefits the applicable allowances reduced by the amount that such fees or allowances are discounted, waived or rebated. There is an annual maximum dental benefit of $7,500.

I. DIAGNOSTIC AND PREVENTIVE BENEFITS

80% for Primary Enrollees and their enrolled spouses
100% for dependent children

Diagnostic – oral examinations; x-rays; diagnostic casts; examination of biopsied tissue; palliative (emergency) treatment of dental pain; specialist consultation

Preventive – prophylaxis (cleaning); fluoride treatment; space maintainers

II. BASIC BENEFITS

80% for Primary Enrollees and their enrolled spouses
100% for dependent children

Oral surgery – extractions and certain other surgical procedures, including per- and post-operative care

Restorative – amalgam, silicate or composite (resin) restorations (filings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)

Endodontic – treatment of the tooth pulp

Periodontic – treatment of gums and bones that support the teeth

Sealants – topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing dental decal

Adjunctive General Services – general anesthesia; office visit for observation; office visit after regularly scheduled hours; therapeutic drug injection; treatment of post-surgical complications (unusual circumstances); limited occlusal adjustment

III. CROWNS, INLAYS, ONLAYS AND CAST RESTORATION BENEFITS

80% for Primary Enrollees and their enrolled spouses
100% for dependent children

Crowns, Inlays, Onlays and Cast Restorations are Benefits only if they are provided to treat cavities which cannot be restored with amalgam, silicate or direct composite (resin) restorations.

IV. PROSTHODONTIC BENEFITS

80% for Primary Enrollees and their enrolled spouses
100% for dependent children

Construction or repair of fixed bridges, partial dentures and complete dentures are Benefits if provided to replace missing, natural teeth. This includes implant coverage.

V. ORTHODONTIC BENEFITS

100% for dependent children only
(up to a lifetime maximum of $1,000)

Procedures using appliances or surgery to straighten or realign teeth, which otherwise would not function properly.

Deductible (does not apply to diagnostic and preventative benefits)

Per patient per lifetime	$50
Per family per lifetime	$200

B. Limitations and Exclusions

There are certain procedures not covered by Delta Dental. Thus, you should refer to the list of exclusions in the Delta Dental booklet. They include:

LIMITATIONS

1. An oral examination is a Benefit only twice in any calendar year.

2. Full-mouth x-rays are a Benefit once in a five-year period.

3. Bitewing x-rays are provided on request by the dentist, but no more than twice in any calendar year for children to age 18 or once in any calendar year for adults age 18 and over.

4. The Plan pays for two cleanings or a dental procedure that includes a cleaning each calendar year.

5. Fluoride treatments are covered twice each calendar year.

6. Periodontal scaling and root planning it's a Benefit once for each quadrant each 24-month period.

7. Sealant Benefits are limited to eligible dependent children under age 14. Sealant Benefits include the application of sealants only to permanent posterior molars without caries (decay), without restorations and with the occlusal surface intact. Sealant Benefits do not include the repair or replacement of a sealant on a tooth within three years of its application.

8. Crowns, Inlays, Onlays and Cast Restorations are Benefits on the same tooth only once every five years, while you are eligible under any Delta Dental Plan, unless Delta Dental determines that replacement is required because the restoration is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the replacement of the restoration.

9. Prosthodontic appliances are Benefits only once every five years, while you are eligible under any Delta Dental Plan, unless Delta Dental determines that there has been such an extensive loss of remaining teeth or a change in supporting tissues that the existing appliance cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under a Delta Dental Plan will be made if it is unsatisfactory and cannot be made satisfactory.

10. Delta Dental will pay the applicable percentage of the dentist's fee for a standard partial or complete denture. A standard partial or complete denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth that are made from accepted materials and by conventional methods.

11. Implants (appliances inserted into bone or soft tissue in the jaw, usually to anchor a denture) are not covered by your Plan. However, if implants are provided along with a covered prosthodontic appliance, Delta Dental will allow the cost of a standard partial or complete denture toward the cost of the implants and the prosthodontic appliances when the prosthetic appliance is completed. If Delta Dental makes such an allowance, we will not pay for any replacement for five years following the completion of the service.

12. If you select a more expensive plan of treatment than is customarily provided, or specialized techniques, an allowance will be made for the least expensive, professionally acceptable, alternative treatment plan. Delta Dental will pay the applicable percentage of the lesser fee for the customary or standard treatment and you are responsible for the remainder of the dentist's fee.

    For example: a crown where an amalgam filling would restore the tooth; or a precision denture where a standard denture would suffice.

13. Orthodontic coverage is limited to eligible dependent children.

14. If orthodontic treatment is begun before you become eligible for coverage, Delta Dental's payments will begin with the first payment due to the dentist following your eligibility date.

15. Delta Dental's orthodontics payments will stop when the first payments is due to the dentist following either a loss of eligibility, or if treatment is ended for any reason before it is completed.

16. Delta Dental will pay the applicable percentage of the Dentist's fee for a standard orthodontic treatment plan involving surgical and/or non-surgical procedures. If the Enrollee selects specialized orthodontic appliances or procedures chosen for aesthetic considerations an allowance will be made for the cost of standard orthodontic treatment plan and the Enrollee is responsible for the remainder of the Dentist's fee.

17. X-rays and extractions that might be necessary for orthodontic treatment are not covered by Orthodontic Benefits, but may be covered under Diagnostic and Preventive or Basic Benefits.

EXCLUSIONS/SERVICES NOT COVERED

Delta Dental covers a wide variety of dental care expenses, but there are some services for which we do not provide Benefits. It is important for you to know what these services are before you visit your dentist.

Delta Dental does not provide benefits for:

1. Services for injuries or conditions that are covered under Workers' Compensation or Employer's Liability Laws.

2. Services which are provided to the Enrollee by any Federal or State Governmental Agency or are provided without cost to the Enrollee by any municipality, county or other political subdivision, except Medi-Cal benefits.

3. Services for cosmetic purposes or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.

4. Services for restoring tooth structure lost from wear (abrasion, erosion, attrition, or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Examples of such treatment are equilibration and periodontal splinting.

5. Any single procedure, bridge, denture or other prosthodontic service which was started before the Enrollee was covered by this Plan.

6. Prescribed drugs, or applied therapeutic drugs, premedication or analgesia.

7. Experimental procedures.

8. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.

9. Anesthesia, except for general anesthesia given by a dentist for covered oral surgery procedures.

10. Grafting tissues from outside the mouth to tissues inside the mouth ("extraoral grafts").

11. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joints or associated muscles, nerves or tissues.

12. Replacement of existing restoration for any purpose other than active tooth decay.

13. Intravenous sedation, occlusal guards and complete occlusal adjustment.

14. Charges for replacement or repair of an orthodontic appliance paid in part or in full by this plan.

C. General

To obtain your benefits for covered dental care, tell your dentist of your eligibility under this Plan at the time of treatment, and provide the following information:

Delta Dental Group No: 79-0001
Group Name: U.A. Local Union No. 467
Social Security Number

Delta Dental insures the benefits payable through the Plan. This means that the final decision on whether or not to pay a claim is up to Delta. To object to their initial decision on a claim, you must appeal under Delta's own procedures. If you have questions about a claim, you may call Delta at the following toll-free customer service number:

Delta Dental Customer Service
(888) 335-8227 (toll free)
or go to its website at www.deltadentalca.org

IX. VISION CARE BENEFITS

The Trustees of U.A. Local Union No. 467 Health and Welfare Plan have adopted a vision care benefits program through Vision Service Plan ("VSP") for eligible Participants and dependents who are not enrolled in the Kaiser Plan, which has its own vision coverage. Vision Service Plan supplies brochures which may be obtained at the Trust Fund Office or your Local Union office. Your VSP-participating optometrist can obtain eligibility and benefits information by phoning VSP directly and providing the Participant's name and Social Security Number. The Vision Service Plan website can be found at www.vsp.com. The phone number is 800-877-7195. A separate booklet, which has been provided to you, is available at the Plan Office with complete benefit coverage, limitations, and exclusions.

Vision Services Plan (VSP)
One Market Plaza, Suite 2625
Steuart Street Tower
San Francisco, CA 94105

Member Services:
(800) 877-7195
(800) 428-4833 (toll-free TTY for the hearing/speech impaired)
http://www.vsp.com

The Vision Service Plan (VSP) covers each eligible Participant and Dependent for a regular examination and lenses and frames when necessary for proper visual function or correction.

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

VSP will pay the doctor directly. Except as otherwise provided in this section, you are responsible only for the applicable co-payment **and any additional costs for items only partially covered or not covered. No co-payment applies for contacts**.

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

2. **Services and Materials:**

a. **One Vision Examination per 12 month period.** The Plan provides for a comprehensive examination of your visual functions once every 12 months, including the prescription of corrective eyewear where indicated.

b. **Lenses and Frames**. If the vision examination indicates that new lenses or frames or both are necessary for the proper visual health of a covered person, the Plan provides:

(1) Lenses - Actives: **available once each 12 months** if a prescription change is warranted, Single vision, lined bifocal and lined trifocal lenses are covered.

Retirees: **available once each 12 months** if a prescription change is warranted, Single vision, lined bifocal and lined trifocal lenses are covered.

(2) Frames - Actives: **available once each 12 months** if replacement is necessary; frames of your choice are covered up to $120.00 plus 20% off any out-of-pocket expenses.

Retirees: **available once each 24 months** if replacement is necessary; frames of your choice are covered up to $120.00 plus 20% off any out-of-pocket cost if replacement is necessary.

3. **Contact Lenses Care:** When you choose contacts instead of glasses, your $120.00 allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluation). This exam is in addition to your VISION exam to ensure proper fit of contacts. Current soft contact lens wearers may qualify for a special contact lens program that includes a contact lens evaluation and initial supply of replacement lenses. Learn more from your doctor or vsp.com.

4. **Your Co-Pays (subject to change): $15.00**

Schedule of Benefits (VSP Provider)

Exam	Covered up to VSP allowances every 12 months.
Lenses	Covered up to VSP allowances every 12 months.
Frames	Covered up to VSP allowances every 24 months.
Contact Lenses (necessary)	Exam and materials covered every 24 months.
Contact Lenses (elective)	Covered up to **$120** every 24 months; in lieu of lenses and frames.

Schedule of Benefits (Non-VSP Provider)

Exam	Up to $45
Lenses:	
Single Vision	Up to $45
Bifocal	Up to $65
Trifocal	Up to $85
Lenticular	Up to $125
Frames	Up to $47
Contact Lenses (necessary)	Up to $210
Contact Lenses (elective)	Up to $105

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

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

7. **VSP Grievance Procedures:** If a Participant has a complaint/grievance (hereafter 'grievance') regarding VSP service or claim payment, the Participant may communicate the grievance to VSP by using the form which is available by calling VSP Customer Service Department's toll free number (800) 877-7195 Monday through Friday 6:00 a.m. to 6:00 p.m. Pacific Standard Time. Grievances may be filed in writing within 180 days with VSP at 3333 Quality Drive, Rancho Cordova, CA 95670.

If you are dissatisfied with the results after exhausting VSP's grievance procedures, you may file a written appeal with the Plan's Board of Trustees, as provided in the Claims and Appeals Procedures described in section B, page 82.

The California Department of Managed Health Care ("Department") is responsible for regulating health care service plans and receiving complaints regarding VSP (and similar programs). If you need the Department's help with a complaint involving an emergency grievance or with a grievance that has not been satisfactorily resolved by VSP, you may call the Department's help center toll-free at 888-466-2219. The hearing and speech impaired may use the California Relay Service's toll-free telephone number 1-877-688-9891 (TDD) to contact the Department. Health plan complaint forms and instructions are available online at the Department's website, http://www.dmhc.ca.gov/dmhc_consumer/pc/pc_complaint.aspx.

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

X. DEATH BENEFITS, ACCIDENTAL DEATH AND DISMEMBERMENT AND DISABILITY BENEFITS

The Plan provides death benefits for Employees and dependents, and accidental death and dismemberment benefits for Employees only. The Plan also provides weekly disability benefits, which are self-funded and which are payable in accordance with the rules set out below.

To file a claim for death benefits or Accidental Death or Dismemberment Insurance, call the Trust Fund Office at (408) 288-4508. To file a claim for Weekly Disability Benefits, call the Trust Fund Office at (408) 288-4400.

A. Death Benefits for Active and Retired Members (Except Owners)

The amount of the death benefit is shown below. The amount that will be paid to your beneficiary in the event of your death from any cause on or off the job while covered is:

Active member under age forty (40)	$60,000
Active member age forty (40) to forty-five (45)	50,000
Active member age forty-six (46) to fifty (50)	40,000
Active member age fifty-one (51) to fifty-five (55)	30,000
Active member age fifty-six (56) to sixty (60)	20,000
Active member age sixty-one (61) to sixty-five (65)	10,000
Active member age sixty-six (66) and up	5,000
Retired member under age seventy (70)	4,000
Retired member age seventy (70) and up	1,000

Owners who participate in the Plan are excluded from this benefit.

B. Beneficiary

Your beneficiary may be any person or persons you name. You may change your beneficiary at any time by making a written request upon a form available at the Trust Fund Office or the Local Union Office. A change of beneficiary form must be returned to the Local Union Office to be effective. If you do not name a beneficiary, benefits will be paid to your estate, or at the option of the Trustees to your surviving spouse, child or children, mother, father, sisters or brothers.

C. Death Benefit for Dependents

If one of your covered dependents dies, the amount of benefit then in effect on the life of that dependent (see following schedule) will be paid to you as beneficiary:

Spouse	$1,000
Children fourteen (14) days but less than six (6) months	200
Children six (6) months but less than two (2) years	400

Children two (2) years but less than three (3) years	800
Children three (3) years of age and up	1,000

Note: Any dependent who is in full-time military, naval, air force, coast guard or national guard service is not covered by this insurance, and the insurance on any such dependent will terminate on the date of his entry into the armed forces.

D. Accidental Death and Dismemberment Benefit

An additional benefit will be paid for any of the following losses occurring on or off the job through purely accidental means, if the loss occurs within one hundred twenty (120) days from the accident.

The full amount of your Accidental Death and Dismemberment benefit, which is $8,000, will be paid for the loss of:

Life	One hand and one foot
Both hands or both feet	One hand and sight of one eye
Sight of both eyes	One foot and sight of one eye

One-half of the amount of your Accidental Death and Dismemberment benefit or $4,000 will be paid for the loss of one hand, one foot or the sight of one eye.

The death benefit is payable to your beneficiary. The dismemberment or loss of sight benefit is payable to you.

LIMITATIONS

Payment for all losses due to any one accident may not exceed the full amount of your benefit. However, the benefits paid for one loss will not prevent further payment for losses resulting from subsequent accidents.

The Plan provides that **no benefits are payable for any loss resulting from**:

1. Infirmity of the mind or body, or illness or disease (other than a bacterial infection resulting from accidental cuts or wounds), or intentionally self-inflicted injuries, suicide or attempted suicide while sane or insane.
2. War or any act of war, or service in the armed forces of any country engaged in war or police duty.
3. Participation in, or in consequence of having participated in, the commission of a felony (no criminal charge or conviction is required).

E. Weekly Disability Benefits for Active Employees

The Plan will pay a weekly benefit of $40 to any Participant who is covered as an active Employee and who becomes disabled as a result of accident or illness so that he cannot perform his regular work. This weekly benefit will be paid in addition to any weekly indemnity the Participant is entitled to under the State Disability Insurance Law or any Workers' Compensation Law or Act.

Benefits will commence with the first day of disability due to an accident, or the eighth consecutive day of disability due to illness, and will continue for a maximum of twenty-six (26) weeks for any one disability. If the Participant is not disabled for a full week, one-seventh of the weekly benefit will be paid for each day the Participant is disabled.

A Participant does not have to be confined to home to collect benefits, but must be under the care of a physician.

A Participant may receive these benefits any number of times, up to an overall limitation of twelve (12) months of benefits in a twenty-four (24) month period, provided that he returns to active work for at least two (2) full weeks between periods of disability from the same cause. Periods of disability due to different causes will be considered different periods of disability if they are separated by return to active full-time work.

There are special claims and appeal procedures governing claims for Weekly Disability Benefits.

I. FORMAL RULES OF THE HEALTH & WELFARE PLAN [PLAN DOCUMENT]

A. RESTATEMENT OF THE PLAN

1. **Restatement of Plan**: The Board of Trustees restates the U.A. Local 467 Health, Welfare and Vacation Plan as of January 1, 2015. The Plan's medical benefits are offered through Blue Cross of California (hereafter "Blue Cross") or Kaiser Permanente (HMO) (hereafter "Kaiser"). The Plan does self-fund certain other benefits as listed below in subsection 4a of this section. The provisions of this Plan are effective as of January 1, 2015, although certain provisions have different effective dates as provided herein.

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 the Plan.

2. **Election of Health Maintenance Organization (HMO) Benefits**: The Board of Trustees may from time to time offer Participants the option to elect enrollment by the eligible Participant and his or her eligible Dependents in one or more Health Maintenance Organizations (HMO). Currently, the Plan offers PPO benefits through Blue Cross and HMO benefits through Kaiser.

An HMO uses a group of doctors and other health care professionals who emphasize preventive care and early intervention. HMO services are prepaid and a designated premium covers services. You do share costs, however, by paying a fee called a co-payment for some services and products.

To be eligible to enroll in an HMO, you must live within the HMO's service area. Moreover, services may not be covered unless preauthorized by your Primary Care Physician (PCP). For medical services to be covered you must follow the HMO procedures and you must use an HMO

network provider. You are required to include a residence address (rather than a P.O. Box) when you complete your Enrollment Form. If you move out of the geographic area of the HMO, you may be required to change your coverage under the Plan. You and your family members are required to have the same coverage selection (for example, one family member cannot select Kaiser and the other Blue Cross).

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

3. **Incorporation of HMO Contracts as Part of 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, such contract(s) shall be incorporated in this Plan effective as of the date of such contract, provided same has been executed by the Board of Trustees or a duly authorized representative of the Board of Trustees.

4. **Consequences of Election of HMO Plan by Participant:**

a. **Benefits Not Part of HMO**. Benefits payable to an Employee, Participant and/or eligible Dependent(s) who has elected enrollment in an HMO shall be determined solely in accordance with the contract between the Trustees and the HMO except for Life Insurance and Accidental Death and Dismemberment (through an Insurance Company) (Actives only).

b. **HMO 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 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 reserves 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. Any such amendment, modification, revocation or termination of the Plan shall be made by a resolution adopted by the Board of Trustees. No individual Trustee, Union representative, or Employer

representative is authorized to interpret this Plan on behalf of the Board of Trustees, or to act as an agent of the Board of Trustees.

C. PLAN AND OPERATION

1. **Board of Trustees Responsibilities**: The Plan is administered by a Board of Trustees comprised of up to eight Trustees. One-half of the Trustees, called "Employer Trustees," are selected by the Employer Associations signatory to Collective Bargaining Agreements with U.A. Local 467 one-half of the Trustees, called "Union Trustees," are selected by U.A. Local 467. The current Trustees are listed on page vi of this booklet.

The Trustees have many powers and functions including investing the Plan's assets, interpreting Plan provisions, amending the Plan, answering policy questions, and contracting with advisors and consultants, such as an auditor, legal counsel, and investment manager.

Only the Board of Trustees and its authorized representatives are authorized to interpret the Plan's benefits described in this booklet. No one else can interpret this Plan or act as an agent for the Board of Trustees -- this includes Employers, Employer Associations, the Union and their representatives. The Board of Trustees (and persons or entities appointed or so designated by the Board of Trustees) has the full discretionary authority to determine eligibility for benefits and to construe the terms of the Plan (and other documents pertaining to the Plan and Trust) and any rules adopted by the Board of Trustees.

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

2. **Standards of Interpretation**: The Board of Trustees, and/or persons appointed by the Board, shall have the full discretionary authority to determine eligibility for benefits and to construe the terms of this Plan and any regulations and rules adopted by the Board. Only the Fund Manager 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 HMO are subject to that HMO's rules and procedures.

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

4. **Employer Contributions:** Employer contributions are made to the Plan pursuant to the terms of Collective Bargaining Agreements with U.A. Local 467. 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.

There is no minimum age for participation as your Employer must contribute to this Plan for all of your hours of employment as long as you are employed and covered by the Collective Bargaining Agreement.

Your Employer is required to make monthly contributions for your Covered Employment and mail such payments to the bank depository 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. Each monthly payment made by your Employer is accompanied by a transmittal form that contains the names, Social Security numbers, and hours of work performed by each Covered Employee together with a payment to the Plan. The Employer Contributions to the Plan are not subject to withholding for FICA, FUTA, or state or federal taxes.

The Plan Office checks the Employer's transmittal report for mathematical accuracy and notifies the Employer if there is any error in the Employer's computations which requires correction.

IMPORTANT NOTICE:

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

The amount of Employer Contributions made to the Plan for non-bargaining unit employees (such as employees of the Union, the JATC and others not working under a collective bargaining agreement) will be governed by individual Subscription Agreements entered into with the Plan and any rules adopted by the Board of Trustees.

5. **Loss of Eligibility if no Contributions**: You may lose eligibility with the Plan if Employer Contributions are not timely received by the due date for Employer contributions by the Plan Office.

6. **Availability of Fund Resources**: Benefits provided through the Plan Office can be 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. In the event that 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.

There shall be no liability upon the Board of Trustees, individually or collectively, or upon any Employer, the Union, Signatory Associations or other person or entity to provide benefits established hereunder if the Plan does not have sufficient assets to make such benefit payments.

7. **Funding Methods and Benefits**: The Board of Trustees may provide benefits either by insurance or HMO or by any other lawful means or methods upon which they may determine. The coverage to be provided shall be determined in the sole discretion of the Board of Trustees and limited to such benefits as can be purchased with the funds available.

8. **Plan Year**: The Plan Year commences January 1 of each year and ends on December 31 of the following year.

9. **Grandfathered Plan:** The Board of Trustees believes this Plan is a "grandfathered health plan" under the federal law known as the Patient Protection and Affordable Care Act ("Act"). As permitted by the Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Act that apply to other plans, for example, requiring the provision of preventive health services without any cost sharing; however, grandfathered health plans must comply with certain other consumer protections in the Act, such as the elimination of lifetime limits on Plan benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Employee Benefits Security Administration, U.S. Department of Labor (DOL) at 1–866–444–3272 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 Act's provisions began with the July 1, 2011 Plan Year.

D. YOUR RESPONSIBILITIES

1. **Your Mailing Address**: It is your responsibility to keep the Plan Office advised of changes to your address so that you continue to receive notices of important Plan changes that may affect your coverage or continue to receive Plan information if you leave the Plumbing and Pipefitting Industry or your Local Union so that you may. Changes must be made in writing by completing the appropriate Enrollment Form or Change of Address Form, both of which are available on the Plan's web page for the Plan at https://www.ua467benefits.com. Please note: neither Kaiser nor Blue Cross will accept a PO Box address as a mailing address or place of residence. All Plan Participants must provide a street address to enroll in either health plan.

2. **Enrollment Form**: Full completion and return of the Enrollment Form is mandatory for all Plan Participants for enrollment, changes and upon request by the Plan Office. You are required to complete a new Enrollment Form and submit to the Plan required proof when you have a change in life circumstances (such as a marriage, separation, divorce, birth of child, Dependent status changes, Medicare eligibility or QMCSO). All Plan Participants must provide a street address to enroll in either Health Plan. Generally, any changes will be effective the first day of the following month after your updated Enrollment Form is received.

3. **Change in Dependent Status**. Keep your enrollment form updated by adding a new Spouse or Child with any required proof, such as a marriage or Domestic Partner registration certificate, birth certificate or legal adoption papers. You must also notify the Plan Office if a Dependent ceases to quality as a Dependent, for example, due to divorce, death or the attainment of age 26.

IMPORTANT NOTICE: WARNING ABOUT FRAUD AGAINST PLAN

It is the Participant's and Dependent's responsibility to notify the Plan Office immediately when a Dependent's status changes. This includes a Spouse no longer residing with the Participant, divorce/final dissolution of marriage, legal separation, death, a Dependent child over 25, and any other events which would make your Dependent not eligible for further coverage. If claims are paid for, or premiums are paid on behalf of any Dependent and it is later found that the Dependent was not eligible, you and the Dependent will be responsible for reimbursing the Plan for the actual amount paid out in benefits by the Trust plus interest and any costs and attorney's fees incurred to recover the money.

4. **Beneficiary Form:** You should complete a Beneficiary Form at the time of initial enrollment. If you decide to change your Beneficiary, you must complete a new Beneficiary Form.

5. **Protected Health Information (PHI)**: There are Privacy Rules to protect you based on the federal legislation known as the Health Insurance Portability Accountability Act of 1996 ("HIPAA"). If you wish to authorize someone other than yourself to access information from the Plan Office on your behalf, you must complete the Protected Health Information Authorization Form (available at the Plan Office) and return it to the Plan Office. The Plan's Notice of Privacy Practices is attached as Appendix 1.

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

II. FORMAL ELIGIBILITY RULES

A. Employee Eligibility

1. Each Employee covered under the Plan as an active Employee shall have a Reserve of Hours account consisting of all hours worked by him for Individual Employers under a Collective Bargaining Agreement with U.A. Local Union No. 467 of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States of America and Canada, AFL-CIO (the "U.A.") or under other U.A. Collective Bargaining Agreements under which contributions are made to this Plan, except for those hours for which contributions are transferred to another health and welfare Plan under a valid reciprocity agreement.

2. Every Employee and all dependents now eligible shall continue to be eligible subject to these Eligibility Rules.

3. Every Employee who is not eligible shall become eligible for Employee and dependent benefits whenever such Employee's Reserve of Hours account has first been credited with six hundred fifty (650) or more hours within any period of twelve (12) consecutive calendar months or less.

4. Once eligible, an Employee shall continue to be eligible for Employee and dependent benefits so long as he has at least one hundred thirty (130) hours in his Reserve of Hours account. The Reserve of Hours account shall be charged with one hundred thirty (130) hours for each calendar month in which the Employee remains eligible. If the Employee works more than the required one hundred thirty (130) hours in any one calendar month, his Reserve of Hours account shall be credited with the excess, but if he works less than the required one hundred thirty (130) hours, his Reserve of Hours account shall be debited with the difference. No Employee shall be credited with more than three hundred ninety (390) hours in his Reserve of Hours account at any one time.

5. The Reserve of Hours account of any Employee who accepts employment by any contractor not a party to a Collective Bargaining Agreement with U. A. Local Union No. 467 or who connives with any Employer paying into the Trust Fund less than the full contract rate of contribution for each hour worked by him, shall be terminated immediately and the Employee and dependents shall not again be eligible except upon compliance with the requirements for initial eligibility of Subsection 3 of this Section.

B. Termination of Employee Eligibility

An Employee's eligibility under this Plan shall terminate:

1. At the end of the month in which the Employee's Reserve of Hours account falls below one hundred thirty (130) hours.

2. Upon the failure of a covered individual to make a timely payment which is required for the individual's coverage.

3. On the day the Plan is terminated.

4. On the day the Employee enters full-time active duty in the Armed Forces of the United States.

5. On termination for cause. For purposes of this Plan, it shall be deemed cause for termination of coverage for a covered Employee to accept any employment of any duration of the type of work covered by a U. A. Collective Bargaining Agreement from an Employer not signatory or otherwise party to any such Agreement or to engage in business in the Plumbing and Pipefitting Industry for his own account without being signatory or otherwise party to such Agreement. The coverage of any Employee who performs such employment shall be terminated as of the date of commencement of such employment. The Employee shall not again be eligible for any benefits or for any of the rights incident to eligibility until he has ceased such employment and reestablished eligibility under Section A (Employee Eligibility), Subsection 3.

C. Dependent Eligibility

Eligible dependents include the following:

1. Spouse. Lawful spouse, including a same-sex spouse, of an eligible Employee or eligible retiree.

2. Children. Children includes natural, legally adopted children and stepchildren of an eligible Employee or eligible retiree who have not reached their 26th birthday. Coverage terminates as of the last day of the month in which the child attains age 26.

3. Disabled Children. Unmarried dependent children, age twenty six (26) or over, of an eligible Employee or eligible retiree, who are incapable of support because of physical or mental incapacity that commenced prior to reaching age twenty six. A physician's certificate as to such incapacity must be submitted within six (6) months following the twenty sixth birthday.

A person who is an eligible dependent of an Employee shall become eligible for benefits when the Employee becomes eligible for benefits or upon becoming an eligible dependent, if later, except that an otherwise eligible dependent who is Medicare-eligible shall be eligible only if he or she enrolls in Medicare Parts A and B.

D. Termination of Dependent Eligibility

Under the following conditions and subject to COBRA, a dependent will not be eligible:

1. Lack of Eligibility. Eligibility of all of an Employee's dependents ends upon termination of eligibility of the Employee.

2. Divorce or Legal Separation. A spouse ceases to be eligible upon the first day of the month following the entry of an order of dissolution of marriage to, or legal separation from, the Employee.

3. Maximum Age of Child. A dependent child's eligibility shall terminate on the first day of the month following the month when the child reaches age 26.

E. Reinstatement of Employee Eligibility

An Employee whose eligibility has been terminated because his Reserve of Hours has fallen below one hundred thirty (130) hours shall be reinstated as of the first day of the third calendar month following any calendar month within the next twenty-four (24) calendar months in which his Reserve of Hours has again totaled one hundred thirty (130) hours or more, if the Employee has remained continuously on the out-of-work list of U. A. Local Union No. 467 and actually available for work, unless the Employee has, at any time during his period of inactivity, accepted employment of the type covered under the Collective Bargaining Agreement of U. A. Local Union No. 467 from any Employer not signatory to a Collective Bargaining Agreement with the United Association or any of its affiliated Local Unions, or been engaged in business in the Plumbing and Pipefitting Industry in any capacity without being party to such a Collective Bargaining Agreement.

F. Self-Payment Program for Unemployed Employees

An Employee who is unemployed and whose Reserve of Hours account has fallen below one hundred thirty (130) hours may continue to be eligible for Employee and dependent benefits as follows:

1. The Employee must pay each month into the Fund the amount determined by the Board of Trustees.

2. The required payment is to be made on or before the twentieth (20th) day of the calendar month following the calendar month in which the Employee's Reserve of Hours account first fell below one hundred thirty (130) hours.

3. The Employee must remain continuously registered for employment on the out-of-work list of the Local Union and must not refuse more than two offers of dispatch within any period of twelve (12) consecutive calendar months.

Continued eligibility under this Section and Section G (Extended Benefits for Total Disability) combined is limited to a total of twelve (12) calendar months in any twenty-four (24) consecutive calendar month period.

If an Employee receives twelve (12) months of coverage under this Section or Section G (Extended Benefits for Total Disability) combined, the Employee must work under a Collective Bargaining Agreement of U. A. Local Union No. 467 for a minimum of three hundred ninety (390) hours to become eligible again for self-payment under this Section.

Employees who qualify for, and make payments, under this Section shall be covered under the same schedule of benefits as applies to active Employees. Coverage for medical and hospital benefits, without dental coverage, is available only through COBRA Continuation Coverage, described elsewhere in this booklet. In no event may dental benefits be elected without medical and hospital benefits.

G. Extended Benefits for Total Disability

If an Employee is totally disabled on the date his eligibility for medical coverage terminates under Section B (Termination of Employee Eligibility), Subsection 1, medical care benefits will continue to be available during the uninterrupted existence of such disability, subject to the following conditions:

1. The provisions of the Plan will be applicable to such benefits just as if eligibility had not terminated.

2. This extension of medical care benefits will not apply to any charges which are incurred after the occurrence of the first of the following events:

(a) The expiration of twelve (12) months immediately following termination of eligibility under Section B (Termination of Employee Eligibility), Subsection 1;

(b) The date total disability terminates; and

(c) The date the individual becomes covered under any other group health Plan.

3. This extended coverage is limited to a total of twelve (12) calendar months in any twenty-four (24) consecutive calendar month period, counting coverage provided under this Section and Section F (Self-Payment Program for Unemployed Employees) combined. To reestablish eligibility for this extended coverage after use of this form of coverage, a Participant must return to active employment under a Collective Bargaining Agreement of U. A. Local Union No. 467 for a minimum of three hundred ninety (390) hours.

4. If a Participant retires under the U.A. Local 467 Defined Benefit Pension Plan while being entitled to health and welfare benefits under this Plan because of a disability, such health and welfare benefits terminate under this Section G as of the effective date of his retirement. The Participant shall then be entitled to retiree health and welfare coverage under Section H below, if he is eligible, as of the effective date of his retirement.

H. Retired Employees Who Are Members of the Union and Their Dependents

1. In order to be eligible for benefits under this Plan upon retirement, a retiree must satisfy the following requirements:

(a) The retiree must be qualified to receive, and actually be receiving, retirement benefits under the U.A. Local Union No. 467 Defined Benefit Plan;

(b) The retiree must have qualified for welfare benefits as a retiree before January 1, 2007 under the rules then in effect, or have been continuously eligible for benefits under the Health and Welfare Plan as an active Employee, either through the Reserve of Hours, or the Self-Payment Program for forty four out of the forty eight months immediately preceding the month of retirement. In determining whether an individual has met the forty four out of the forty eight months requirement, the period of January 1, 2011 through December 31, 2012, will not be considered (unless the Participant would be eligible for retiree benefits by using such months) so long as the Participant is on U.A. Local 467's out-of-work list and is available for work (and has not turned down covered work);

(c) The retiree must be a member in good standing in U. A. Local Union No. 467 as of his retirement; and

(d) The retiree must have accrued at least ten years of Benefit Credit in the U. A. Local Union No. 467 Defined Benefit Plan.

2. To remain eligible, the retiree must satisfy the following requirements continuously from the date of retirement:

(a) The retiree must make payments in such amounts as the Board of Trustees determines at the Board's discretion, commencing with the later of:

(1) the first month of retirement, or
(2) the first month in which his Reserve of Hours account is insufficient to maintain eligibility for benefits;

(b) The retiree must maintain membership in good standing in U. A. Local Union No. 467; and

(c) If the retiree is eligible for Medicare, the retiree must enroll in, and maintain coverage under, both Part A and Part B of Medicare.

FAILURE TO SATISFY ANY OF THE RULES ABOVE WILL RESULT IN THE PERMANENT LOSS OF COVERAGE.

3. A retiree or dependent who is eligible for Medicare shall be eligible only for the Medicare Supplemental Plan unless the Plan is required by law to be the primary payer for the retiree.

4. If a covered retiree becomes covered under another group health Plan as an Employee, while working in employment which does not cause the suspension of benefits under the U. A. Local Union No. 467 Defined Benefit Plan, and the retiree has informed the Trust Fund Office of other coverage in advance, the retiree's coverage under this Plan may be maintained as secondary to coverage under the other Plan. If a retiree fails to inform the Trust Fund Office of such other coverage, then coverage under this Plan will be suspended until coverage under that other Plan terminates, and will only be restored if the retiree has made full premium payments continuously after retirement and commencement of benefits under the U. A. Local Union No. 467 Defined Benefit Pension Plan.

5. A covered retiree's eligible dependent(s), as defined in Eligibility Rule C, shall be eligible for benefits whenever the retiree is eligible, subject to each dependent's continuous enrollment in Medicare Parts A and B, if Medicare-eligible.

I. Termination of Retiree Coverage

Termination of a retiree's eligibility will result under the following conditions and at the following times:

1. On the day that the retiree returns to covered employment or to employment in the Plumbing or Pipefitting Industry which would cause the suspension of benefits under the U. A. Local Union No. 467 Defined Benefit Plan,

2. On the last day of the last month for which the required payments were made, if the retiree or dependent fails to make a required payment when due,

3. If and when the Plan is terminated, or retiree benefits are terminated under the Plan,

4. On the last day of the last month in which a retiree was a member in good standing of U. A. Local Union No. 467, if the retiree fails to maintain membership in U. A. Local Union No. 467, or

5. Upon the failure of the retiree to enroll in, or to remain enrolled in, Medicare Parts A and B.

J. Surviving Spouses, Dependents of Deceased Employees and Retirees

1. The surviving spouse and dependents of a deceased Employee or retiree who was eligible as of the date of death shall remain eligible without charge for a period of six (6) calendar months commencing with the first day of the month following or coincident with the date of the death, or if the Employee had an hour bank remaining at his death, the first day of the month following the exhaustion of the Employee's hour bank coverage.

2. The surviving spouse may maintain eligibility after the end of the six (6) month period by making application in writing to the Trust Fund Office for continuing coverage, before the end of the sixth (6th) month and paying into the Fund on or before the fifteenth (15th) day of that month and the fifteenth (15th) day of each month thereafter the full charge for complete coverage under the Plan, subject to the following conditions:

(a) Eligibility of the spouse and dependents shall terminate immediately upon failure of the spouse to make any payment promptly and in full, and cannot thereafter ever be reinstated;

(b) Eligibility of the spouse and dependents shall terminate, upon eligibility of the spouse for Medicare Part B if the spouse does not apply for Medicare Part B;

(c) Eligibility of the spouse and dependents shall terminate upon the spouse's remarriage;

(d) In the event the spouse is or may hereafter become eligible for coverage under any other group Plan, this Plan shall be secondary thereto; or

(e) The coverage of the spouse and dependents shall be subject to annual verification of eligibility status of the spouse in accordance with these rules and shall be terminated forthwith upon failure of the spouse either to verify eligibility or to respond within ten (10) calendar days following the date of mailing to the spouse (at her last known address) of the request by the Trust Fund Office for such verification.

K. Individual Employers

1. The following persons, upon compliance with the rules, requirements and procedures set forth in this section, shall be covered and eligible for benefits under the Health and Welfare Plan:

(a) Self-employed persons, sole proprietors, and bona fide members of partnerships or other unincorporated associations, and officers, directors and shareholders of corporations who or which are engaged in the Plumbing and Pipefitting Industry, up to a maximum of two persons per signatory contractor, if the following apply:

(1) the person or company has its main office in San Mateo County; regularly employs persons in covered employment; is signatory, or otherwise party, to a Collective Bargaining Agreement with U. A. Local Union No. 467; and regularly obtains its Employees for work covered thereby through the Employment Office of the Union; and

(2) the person requesting coverage is employed on a full-time basis in a management or related position for a signatory contractor. Documentary proof of full-time employment in a form satisfactory to the Board of Trustees may be requested from time to time as a condition of continued coverage under this Section.

(b) Dependents of any of the persons described in Subsection 1(a) above.

2. Individual Employers must make application for coverage on or before the fifteenth (15th) day of the month next following the month in which they became a party to a Collective Bargaining Agreement with U. A. Local Union No. 467.

3. New Individual Employers must name in the application all eligible persons included within the classifications defined in Subsection 1(a), and pay upon behalf of each and every one of them six (6) monthly premium charges in such amounts as shall from time to time be fixed by the Board of Trustees. However, if the Individual Employer had an accrued hour bank as an Employee under the Plan when he became an Individual Employer, then hour bank credit may be applied on a month-for-month basis in lieu of the required cash deposit. Hour bank credit is not available for coverage while applied as a deposit. Payment may be made at the option of the Individual Employer in six (6) equal monthly installments or in one lump sum. The first payment of the six (6) monthly installments, or the lump sum, whichever is elected, must be made at the time of application, and the subsequent payments, if so elected, on or before the fifteenth (15th) day of each of the five (5) consecutive months thereafter remaining. Upon punctual completion of the full six (6) months of monthly premium charges for all persons covered, each person covered shall become eligible as of the first day of the month next following.

4. Initial eligibility, once established, may be maintained thereafter only by continuing to comply with all of the eligibility rules, requirements and procedures set forth in this Section K.

5. Coverage of an Individual Employer who is in default of any monthly payment required by these rules and/or by his Collective Bargaining Agreement with U. A. Local Union No. 467 shall cease and terminate as of the first day of the month next following the month of default, in which event the eligibility of all persons covered by Subsection 1 hereof shall also cease and terminate.

Persons covered under Subsection 1 of these rules may continue coverage through application of their Reserve of Hours accounts, if any, if the Individual Employer is party to a current Collective Bargaining Agreement with U. A. Local Union No. 467 and is current with all the contributions required thereunder.

6. In the event that an Individual Employer has failed to establish eligibility under Subsections 2 or 3, or has terminated coverage under Subsection 10, or has lost it by default in payment under Subsection 6, such eligibility may be established, or re-established thereafter, only by filing an application with the Trust Fund Office. Such applications may be filed only in the month of December of any year and must be accompanied by the equivalent of the lump sum payments required by Subsection 3. If the application should be allowed, eligibility shall be established, or re-established as of the first day of the calendar month next following, subject to

the exclusions contained in Subsection 4 above, and may be maintained thereafter only by making the payments herein above provided. If the application should be denied, the initial payment tendered with the application shall be returned.

7. The terms "dependents" and "benefits" as used herein shall have the same meaning as in the Eligibility Rules for Employees excepting only that the term "benefits" shall not include disability benefits or death benefits.

8. An Individual Employer, and his or her eligible dependents, may remain eligible for coverage after retirement if the Individual Employer had been continuously covered under the Plan for at least one hundred twenty (120) months immediately prior to retirement, and was at least sixty (60) years of age at the time of retirement. However, such coverage is available to only one Individual Employer per contributing entity. Coverage is contingent on continued timely payment of the required premium for coverage as an Individual Employer, and if the Individual Employer or dependent is eligible for Medicare, the maintenance of eligibility under Parts A and B of Medicare. Notwithstanding the above, coverage will terminate on the occurrence of any of the events listed in Section I (Termination of Retiree Coverage), Subsections 1 - 5.

9. If an Individual Employer notifies the Trust Fund Office of its intent to terminate coverage of all individuals under this Section, the Individual Employer may elect between the following options:

(a) If the Individual Employer did not have an hour bank as an Employee when he or she became an Employer, the Individual Employer may request extended coverage for all Employees then covered under this Section, including himself or herself, by applying the total pre-paid amount to the then-current monthly charges for coverage until there is an insufficient amount to purchase a full month's coverage for all persons covered under this rule. If this option is elected, coverage shall terminate on the last day of the month for which the Individual Employer's credited amount is sufficient to pay for coverage. If the Individual Employer had an hour bank as an Employee when he or she became an Employer, the pre-paid credit, if any, shall be applied to the other Employees then covered, and his or her hour bank shall be available for coverage on the first day of the month following the notice of termination.

(b) The Individual Employer may receive a refund of the pre-paid amount (without interest) less the cost of any late-submitted claims for Employees covered under this Section through the Plan's self-funded Plan. Such a refund shall be made after the first day of the twelfth (12^{th}) month after the Trust Fund Office receives notice of the termination, unless the Trustees determine that the circumstances of an Individual Employer's termination warrant a different refund date. If the Individual Employer had an hour bank when he became an Employer, his refund shall not include any amount attributable to the hour bank, and the hour bank shall be canceled.

10. Notwithstanding any other provision of this section, coverage under this section shall not be available to any person who acted as an Individual Employer (as defined in Subsection 1(a), above) in a company that has gone out of business leaving a debt to the Trust Funds that remains uncollected for any reason. Coverage is also unavailable to dependents or office clerical Employees of any such person.

L. Qualified Medical Child Support Orders

The Plan will comply with a Medical Child Support Order ("MCSO") with which it is properly served and which is a Qualified Medical Child Support Order ("QMCSO") under applicable federal law. No QMCSO may require the Plan to provide benefits to a person who is not a "dependent child" as defined in the Plan and whose Participant-parent is not then eligible for benefits, or to provide benefits in excess of those provided in the terms of the Plan.

The Trust Fund Office and/or the Plan's legal counsel will review the MCSO under procedures adopted by the Board of Trustees, and determine within a reasonable time whether the MCSO is a QMCSO. The determination that a MCSO is not a QMCSO is subject to the Plan's Appeals Procedures.

If the Employee is a Participant in the Plan, the QMCSO may require the Plan to provide coverage for the Employee's Dependent Child(ren) and to accept enrollment for the Child(ren) from a parent who is not a Plan Participant. The Plan will accept enrollment of the Dependent Child(ren) specified by the QMCSO from either the Employee or the custodial parent. Coverage of the Dependent child(ren) will become effective as of the first of the month following the date the enrollment is received by the Plan, and will be subject to all terms and provisions of the Plan, as is permitted by applicable law.

Coverage of a Dependent Child under a QMCSO will terminate when coverage of the Employee-parent terminates for any reason, subject to the dependent Child's right to elect COBRA Continuation Coverage if that right applies. No eligible Employee's child covered by a QMCSO will be denied coverage on the grounds the child is not claimed as a dependent on the Employee's federal income tax return or does not live with the Employee.

If a National Medical Support Notice is received, the Trust Fund Office will notify the Employee of the requirements for compliance.

If you would like to obtain the Plan's procedures governing QMCSOs, contact the Trust Fund Office.

M. Special Coverage Under the Family and Medical Leave Act

If an Employee works for an Individual Employer which is required to provide health and welfare Plan coverage under the Family and Medical Leave Act ("the FMLA") during a qualifying leave under the FMLA, and the Employee is eligible for, and takes, such leave, then the following special rules apply:

1. The Individual Employer is required to make contributions to this Plan on behalf of the Employee for every period of FMLA leave. The amount of the contributions for each month of FMLA leave shall be equal to the COBRA rate which would apply to the Employee for full family coverage. If the period of FMLA leave is less than a month, the amount of contributions shall be pro-rated accordingly.

2. The Individual Employer shall report the number of hours of FMLA leave and make the required contributions with its regular monthly reports. The Individual Employer shall

also provide evidence in a form satisfactory to the Trustees that the leave is one for which contributions to this Plan are required by the FMLA.

3. For each month of FMLA contributions, an Employee's Reserve of Hours account shall be credited with the same number of hours as he would have been required to perform to receive a full month of coverage. If the period of FMLA leave is less than a month, the amount of hours credits shall be pro-rated accordingly. All other Plan rules concerning Reserve of Hours remain in effect during FMLA leave.

4. Crediting of hours for an Employee, and the Individual Employer's obligation to contribute, shall terminate under these rules upon termination of the Employee's FMLA leave. The Individual Employer shall inform the Trust Fund Office in writing when an Employee's FMLA leave terminates. If an Employee does not return to work for the Employer at the termination of his FMLA leave, then the Employee shall be eligible for COBRA Continuation as provided below.

N. COBRA Continuation Coverage

In addition to other forms of Extended Coverage provided above, an Employee or dependent who would otherwise lose coverage because of a qualifying event may elect to continue coverage upon payment of the requirement monthly premium (102% of the cost of medical coverage), under the following rules. These rules are intended to comply with, and conform to, 29 U.S.C. § 1161-1167 (the federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 or COBRA), and are to be construed in a manner consistent with that intent.

1. Qualifying Events and Coverage Periods

(a) If you are an Employee enrolled in this Plan and you lose health and welfare coverage because of: (1) a reduction in hours, or (2) termination of your employment (through resignation, layoff, firing (except for gross misconduct), retirement, strike or lockout), you are entitled to continue your health coverage by paying for it yourself for up to eighteen (18) months. For purposes of this rule, termination of an Employee's FMLA leave, without the Employee returning to the Employer's employment, shall be deemed the termination of the Employee's employment. An Employee is entitled to an additional eleven (11) months of coverage upon payment of 150% of the applicable monthly premium if within sixty (60) days of the reduction in hours or termination of employment, the Employer or a dependent are disabled such that either qualifies for Social Security Disability benefits and obtains a Social Security Disability award to that effect within the initial eighteen (18) months of COBRA coverage.

(b) If you are the spouse of an Employee who is enrolled in this Plan, you are also covered by the Plan, and you lose your coverage because: (1) your spouse has died, (2) you and your spouse have divorced or legally separated or (3) your spouse loses coverage because of a reduction in hours or termination of employment as a result of resignation, layoff, firing, retirement, strike or lockout, or your spouse qualifies for Medicare, you are entitled to continue your health coverage by paying for it yourself for up to (A) eighteen (18) months: if your spouse loses coverage because of a reduction in hours or termination of employment; (B) twenty-nine (29) months: if you or the Employee obtain a Social Security Disability award within the initial eighteen (18) months of COBRA coverage which finds disability within sixty (60) days of the

initial qualifying event; or (C) thirty-six (36) months: if your spouse dies, becomes eligible for Medicare, or divorces you.

(c) If you are the dependent child of an Employee enrolled in this Plan, you are also covered by the Plan, and you lose your coverage because: (1) your parent covered by the Plan has died, or (2) your parent covered by the Plan has lost his benefits because of a reduction in hours or termination of employment as a result of resignation, layoff, firing, retirement, strike or lockout, or (3) you cease to be a dependent under the provisions of the Plan or (4) your parent covered by the Plan lost his coverage because he qualified for Medicare, then you are entitled to continue health coverage by paying for it yourself for up to: (A) eighteen (18) months: if your covered Employee parent loses coverage because of reduction in hours or termination of employment; (B) twenty-nine (29) months: if you or a covered parent obtain a Social Security Disability award within the initial eighteen (18) months of COBRA coverage which finds disability within sixty (60) days of the initial qualifying event; or (C) thirty-six (36) months: if your covered Employee parent dies, if you no longer qualify as a dependent under the terms of the Plan, or if your covered Employee parent lost coverage because of qualification for Medicare.

(d) The total period of COBRA coverage provided shall run from the initial qualifying event. **Furthermore, the period of time for which you would otherwise be eligible for COBRA Continuation Coverage shall be reduced by one month for every month of other continuation, self-paid or extended coverage you received after the termination of coverage under the Reserve of Hours system**.

2. Notice Requirements and Deadlines

(a) You and your dependents must inform the Trust Fund Office where you want the notices regarding your "COBRA rights" sent. Notify the Trust Fund Office whenever you or your dependents change your address or if you acquire a child while on COBRA coverage.

(b) You must notify the Trust Fund Office within sixty (60) days after you lose coverage because of: (1) disability, (2) divorce or (3) the end of a dependent child's dependent status. Forms for this purpose are available through the Trust Fund Office.

(c) An Employer must notify the Trust Fund Office in the event of an Employee's termination, reduction of hours or Medicare eligibility. An Employer or a family member eligible for COBRA coverage must notify the Trust Fund Office in the event of an Employee's death. The Trust Fund Office maintains records of your eligibility under the Reserve of Hours bank, and will advise you of your loss of eligibility under that system. However, the Trustees urge you to contact the Trust Fund Office yourself to protect your rights to COBRA continuation coverage following one of these events.

(d) After receipt of notice from you or your Employer that a COBRA "qualifying event" has occurred, the Trust Fund Office will notify you of your rights and obligations for COBRA continuation coverage. You will be asked to choose between:

(i) "core coverage" - medical care only, or

(ii) "core plus non core coverage" - medical care, vision and dental coverage. "Core plus non core coverage" will, of course, require a higher monthly payment than "core coverage" only.

(e) You must pay for COBRA continuation coverage retroactive to the date you lost coverage under the Plan within forty-five (45) days after you have elected to have COBRA continuation coverage.

(f) After your continuation coverage has commenced, you must make a monthly payment, in amounts, and at the times, fixed by the Trustees, for every month of continuation coverage. If you do not make timely payment for your coverage, coverage for you and your covered dependents will be terminated, and you will not be allowed to elect any form of extended or continuation coverage under the Plan.

3. Automatic Coverage for Dependents of Covered Employees Choosing Continuation Coverage

When a covered Employee chooses to continue coverage, coverage for his or her spouse and dependents will continue automatically unless the spouse independently declines coverage. But, if the covered Employee chooses not to continue coverage, his spouse and eligible dependents may still choose coverage. In all circumstances, anyone electing continued coverage must pay for it.

4. Transfer Rights

A person who elects COBRA Continuation Coverage shall have the same options for types of medical coverage, and shall be subject to the same open enrollment procedures, as an active Employee. However, if you: (a) are covered by a regional Plan (like an HMO that covers a limited geographic area), and (b) relocate to another area where the covered Employee's Employer has an active workforce, then you are entitled to elect the coverage available to active Employees working in that area. Under no circumstances shall a transfer prolong the period for which you are eligible for COBRA Continuation Coverage.

5. Conversion Privilege

At the end of your COBRA Continuation Coverage period, you may be entitled to enroll in an individual conversion Plan provided by your health maintenance organization. Such conversion coverage may cost more and provide fewer benefits than your group health coverage under this Plan.

6. Termination of COBRA Coverage

In addition to the times listed above, COBRA Continuation Coverage will terminate for any individual at the following times:

(a) when the Trust Fund ceases to provide any coverage;

(b) when the full premium is not paid in a timely fashion;

(c) when the individual becomes covered under another group health Plan which does not contain a pre-existing condition exclusion or limitation which would apply to the individual;

(d) when the individual becomes entitled to Medicare; or

(e) if the individual is covered after the 18th month because of the disability of the individual or a family member of the individual, then on the first day of the month following the month in which the person who was disabled is no longer disabled.

O. Special Eligibility Rules for Covered Persons Who Are in Military Service, and Their Dependents

If a covered person enters any form of military service, his other eligibility for benefits shall terminate immediately. If a person is an active Employee covered under the Reserve of Hours, and he enters military service in the Armed Forces of the United States and gives notice to the Trust Fund Office or to U.A. Local Union No. 467 of his entry into military service, he shall then be eligible to elect among the following options for coverage of his dependents.

1. To freeze his Reserve of Hours, and have all benefits terminate for his eligible dependent(s);

2. To freeze his Reserve of Hours, and pay for COBRA coverage for his dependents while he is in military service; or

3. To apply his Reserve of Hours for coverage for his dependents, followed by COBRA coverage.

If a person elects Option 1 or 2, his Reserve of Hours shall be available to provide eligibility after his military service if, and only if the person returns to covered employment, or registers for work and is actually available for work, at Local Union No. 467 within the time required by USERRA for the length of the person's military service.

If a person fails to give notice of his entry into military service, he shall be deemed to have elected Option 3.

P. Special Eligibility Rules Under Children's Health Insurance Program Reauthorization Act of 2009 (CHIP) and Medicaid

The Children's Health Insurance Program Reauthorization Act of 2009, extends and expands the state children's health insurance program (CHIP). CHIP created a new special enrollment period that applies to group health plans, similar to those currently in effect for the loss of eligibility for other group coverage or qualifying life status changes. Under CHIP, group health plans must permit employees and dependents who are eligible but not enrolled for coverage to enroll in two additional circumstances:

1. Lose eligibility for Medicaid or CHIP Coverage, or
2. Become eligible to participate in a premium assistance program under Medicaid or CHIP.

In both circumstances, the Participant must request special enrollment within 60 days of the loss of Medicaid or CHIP, or after eligibility for a premium assistance subsidy is determined.

III. FORMAL RULES FOR PAYMENT OF MEDICAL BENEFITS OF THE SELF-FUNDED PPO PLAN

PARTICIPANTS AND DEPENDENTS
WHO ARE NOT MEDICARE-PRIMARY

A. Amount of Benefits Payable

The Plan will pay benefits for Covered Charges up to the following amounts, subject to any exclusion, limitation, deductible, or special benefit rate provided below:

1. Preferred Providers: 90% of the contracted rate for covered PPO hospital, nursing home and medical charges from Preferred Providers, until Stop-Loss benefits take effect. The remaining 10% is your co-payment after the deductible.

2. Non-Preferred Providers: You may choose to go outside the PPO network to obtain your medical services and pay more for such services. The Plan's reimbursement rate drops from 90% to 60% of UCR.

A separate schedule of benefits applies under the Medicare Supplemental Plan to persons who are eligible for Medicare, and for whom the Plan is secondary.

Special Benefit Rates

If a covered person is receiving care in a PPO hospital, and his physician and surgeon, as applicable, are Preferred Providers, then the following special benefit rate applies to care provided by a Non-Preferred anesthesiologist, radiologist, or assistant surgeon:

90% of Covered Charges, until Stop-Loss Benefits take effect

B. Usual Customary and Reasonable ("UCR")

For providers who are Participants in the Plan's Preferred Provider Organization ("PPO"), UCR means the agreed PPO rate for the service or supply. For other non-PPO providers, UCR means the table of covered fees provided by Medical Data Research in effect at the time of the claim, but in no event shall any amount be paid unless:

1. It is within the range of fees which are usually charged and received for the given treatment by doctors of similar training within the appropriate geographic area;

2. It is customarily charged by the provider for the services or supplies rendered, or if higher than the customary fee, it is justifiable due to a level of treatment which is superior to that customarily provided; and

3. It is reasonable in light of all circumstances.

C. Stop-loss Benefits

Special stop-loss benefit rates apply for "stop-loss covered care" for the remainder of any calendar year to any person for whom $2,050 of "stop-loss covered co-payments and deductibles" have been paid in that calendar year. "Stop-loss covered care" means care rendered by Preferred Providers, by Non-Preferred Providers to a person who is outside the PPO Service Area or who did not have reasonable access to a Preferred Provider either because of an emergency or by a Non-Preferred Provider covered under the section entitled *Special Benefit Rates*. "Stop-loss covered co-payments and deductibles" means co-payments and deductibles paid for "stop-loss covered care." **Co-payments and deductibles paid for all other care rendered by Non-Preferred Providers are not counted toward the $2,050 out-of-pocket limit**. The benefit rates for "stop-loss covered care" are as follows:

Preferred Providers, or Non-Preferred Providers covered under the Special Benefit Rates rule:	100% of Covered Charges
Non-Preferred Providers:	60% of Covered Charges, up to 60% of the UCR rate

D. Deductible Requirement

Payment of any benefits from the Plan is subject to each covered person's satisfying the Plan's "deductible" requirement. The basic deductible amount is $50 per covered person, up to a maximum of $150 per family. All Covered Charges are subject to the deductible requirement except Covered Charges for medical care which are due to injuries sustained in an accident, and Covered Charges which are due to a second surgical opinion which meets the specified conditions.

A covered person may also satisfy the deductible requirement during a calendar year in any of the following ways:

1. Covered charges incurred within the last three (3) months of a calendar year may be used to satisfy the deductible requirements for the next calendar year if Medical Benefits are not payable for the charges because of the deductible requirement and if the deductible requirement is satisfied within a period of not more than twelve (12) consecutive months.

2. If two (2) or more covered persons in the same family unit are injured in the same accident, with respect to Covered Charges due to that accident, all of them need satisfy only one deductible requirement for the calendar year in which the accident occurs and the next following calendar year.

3. After three (3) covered persons in the same family unit have satisfied their respective deductible requirement during the same calendar year, all covered persons in that family unit will be deemed to have satisfied their respective deductible requirement for Covered Charges incurred during the rest of that calendar year.

E. Covered Charges

Covered Charges means the Usual, Customary, and Reasonable ("UCR") charges in the area where incurred for the following services and treatment when medically necessary and when ordered by a licensed physician and surgeon:

F. Covered Hospital Charges

1. Charges made by a hospital during each day of a period of confinement for room and board only up to the daily room and board rate regularly charged for a semiprivate room; however, if intensive care is required, the actual expenses incurred in such accommodations will be considered Covered Charges.

2. Charges made for outpatient treatment.

3. Charges for pre-admission X-ray or laboratory examination.

G. Covered Convalescent Nursing Home Charges

1. Charges by a convalescent nursing home subject to the confinement beginning within fourteen (14) days after a hospital confinement of at least three (3) days. The covered nursing home charges will be limited to one hundred (100) days.

H. Covered Medical Charges

1. Charges made by a physician, professional anesthetist, physiotherapist, radiologist, qualified speech therapist, chiropractor, acupuncturist, podiatrist, laboratory, or any person who is licensed to practice under the State Business and Professions Code or similar law who performs such services which are payable under this Plan and which are recognized by such Code or law to be within the scope of his license.

2. Charges made by a registered professional nurse (R.N.) or a licensed practical nurse (L.P.N.).

3. Charges made by a professional ambulance service, railroad or commercial airline for transporting a Covered Person from the place where he requires hospitalization for an illness to the nearest hospital equipped to treat such illness.

4. Charges made by any other person or institution for the following:

(a) Drugs or medicines administered by a physician or under a physician's direction.

(b) Blood or blood plasma which has not been replaced on the Covered Person's behalf.

(c) Artificial limbs or eyes for the initial replacement of natural limbs or eyes; casts; splints; prosthetic devices to replace all or part of internal body organs; trusses; braces; and crutches.

(d) Oxygen and the rental of equipment for its administration; or rental of a wheelchair, hospital-type bed, or iron lung or other mechanical equipment required to treat respiratory paralysis.

5. Charges for Home Nursing Care after confinement in a hospital or convalescent nursing home during the first one hundred (100) days, or such longer period as may be necessary to provide one hundred (100) visits in any twelve (12) consecutive months.

6. Charges made by any free-standing surgical facility for medical care, which would have been Covered Hospital Charges if performed as inpatient services in a hospital.

I. Covered Hearing Benefits

1. Charges made for treatment of hearing loss or related conditions, including the following charges, no more than once in a twenty-four month period:

(a) an initial examination by a physician no more than once in a 24 month period, with a maximum benefit of $85;

(b) a hearing aid examination, no more than once in a twenty-four month period, with a maximum benefit of $85; and

(c) 80% of the cost of a hearing device per ear, with a maximum benefit of $2,500 per ear over a five year period.

J. Specific Coverage Rules

The following items are Covered Charges only up to the limitations and under the conditions stated below:

1. Mental and Emotional Conditions Limitation - For a PPO, 90% of the contracted rate; for a non-PPO, 60% of UCR, subject to Plan deductibles and subject to the following limitations:

(a) When hospital confined:

(1) Thirty (30) days maximum per hospital confinement; and

(2) Two (2) hospital confinements maximum per lifetime, with a minimum of twelve (12) months between hospital confinements.

(b) When not hospital confined:

(1) One (1) visit per day; and

(2) Twenty-five (25) visits maximum per calendar year.

Treatment of Mental or Emotional Conditions, within the limitations of rules (a) and (b), is stop-loss covered care, and co-payments apply to the annual out-of-pocket limit, only when care is provided by a Preferred Provider, or when otherwise provided in the Stop Loss Benefits rules.

For purposes of this rule, Mental or Emotional Condition means a condition that affects thinking, perception, mood and/or behavior. Such conditions are recognized primarily by psychiatric symptoms that appear as: distortions of normal thinking and/or perception; moodiness; sudden and/or extreme changes in mood; or depression and/or unusual behavior such as depressed, highly agitated, or manic behavior; or by physical manifestations. Any condition meeting this definition is a Mental or Emotional Condition for purposes of the Plan's limitations, no matter what the cause of the condition may be, whether physical, mental, organic, or environmental, or any combination thereof. Any condition meeting this definition is included within it regardless of whether it produces only emotional symptoms or only physical symptoms such as headaches, sweats, trembling, nausea, or hysterical paralysis, or a combination thereof. Examples of mental or emotional conditions include (but are not limited to) diseases or disorders which fall within diagnosis codes 290 through 290.9, 293 through 301.9, or 306 through 316 in the "International Classification of Diseases," 9th Revision, Clinical Modification, Volumes 1 and 2.

2. Newborn Infant

Charges are covered for a newborn infant if, before being discharged from the hospital, the infant contracts an illness, sustains an accident, is born prematurely, or has an abnormal congenital condition.

3. Well-baby Care

Charges are covered for preventative medical care of children up to the child’s fifth birthday (first sixty months). This benefit includes periodic physical examinations and immunizations.

4. Podiatry

Charges made for podiatry, or the medical care of the feet, except for: (a) treatment of weak, strained or flat feet, imbalance of foot, metatarsalgia, bunion(s), corn(s), callus(es), or toenail(s); and (b) orthopedic shoes or other supportive devices for the feet. Open cutting operation for metatarsalgia or bunion, or for a partial or complete removal of nail roots are Covered Charges.

5. Cosmetic Surgery

Charges incurred for cosmetic surgery, when performed by a licensed physician, for treatment relating to: (a) injuries sustained in an accident, if treatment is begun within ninety (90) days after the accident, or (b) a congenital anomaly of a child whose parent is covered, when the surgery is performed, under a form of coverage that included coverage for eligible dependents, or (c) a medically necessary mastectomy.

6. Speech Therapy

Charges made for the services of a qualified speech therapist if made for restoratory or rehabilitory speech therapy for speech loss or impairment (a) which is due to an illness (other than a nervous disorder), or (b) which follows surgery to correct a congenital anomaly.

7. Overseas Travel

Charges made for care provided outside the United States if made during the first sixty (60) days of an absence from the United States within a 12 month period.

8. Dental Benefit

Charges incurred for (a) surgery due to disease, other than a periodontal disease; (b) surgery for injury of the jaw or facial bones, removal of cysts, leukoplakia or malignant tissue; correction of harelip, cleft palate or protruding mandible; or freeing of muscle attachments; or (c) medical treatment of natural teeth injured in an accident if the treatment is begun ninety (90) days after the accident and the charges are incurred within one year after the accident.

9. Midwifery

Charges for midwifery services when the services are performed by a nurse-midwife who holds a "Certificate of Nurse-Midwife" issued by the State of California Board of Registered Nursing.

10. Registered Nurse/Nurse Practitioner

Charges made for services rendered if the Nurse Practitioner meets all the necessary requirements.

11. Pregnancy

Charges incurred as a result of pregnancy and related conditions for Employees and legal eligible spouses will be paid on the same basis as any other disability or sickness. Dependent children are not covered for pregnancy or related conditions.

12. Mammogram

One routine mammogram is covered each year.

13. Mastectomy

In addition to covering a medically necessary mastectomy, women who have had a medically necessary mastectomy will receive coverage for:

a. All stages of reconstruction of the breast on which the mastectomy has been performed;

b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;

c. Prostheses; and

d. Treatment of any physical complication of mastectomy, including lymphedemas.

The care covered under these rules is subject to the standard co-payment or co-insurance requirements which apply to other medical and hospital coverage provided by the Plan.

14. Residential Drug Treatment Programs

Charges incurred by a Participant or eligible dependent at a licensed residential drug treatment program **which has been approved in advance by the Board of Trustees**, are covered under the Plan under the following rules. Benefits for covered treatments are paid at 100% for the first stay during the person's lifetime, and 80% for the second stay for up to 90 days per stay, but in no event for more than the dollar limitation in effect under the provider's contract. No charges incurred during any further residential treatment of a covered person are covered charges under the Plan after that person's second stay.

15. Chiropractic and Acupuncture Limitations

Charges incurred for covered chiropractic and acupuncture treatments, up to the following amounts:

- Twenty-four visits per calendar year;
- $120 for x-rays taken in association with these forms of treatment per injury.

Chiropractic or acupuncture treatments which exceed these amounts for a single injury are not covered, unless approved in advance through the Trust Fund Office.

16. Physical Examinations

Charges incurred by a covered person for a physical examination are payable at the rate applicable to the provider performing the examination, for one physical examination every 12 months, up to $300 per examination.

K. Charges Not Covered (EXCLUSIONS)

No benefits will be paid by this Plan for the following services or supplies, nor will any of the following charges count toward satisfying the deductible or stop-loss requirements:

1. **Another Plan**. Those paid for or furnished, to the extent paid for or furnished, under any other group health Plan.

2. **War**. Those due to war or an act of war.

3. **Work-Related**. Those due to an accidental bodily injury arising out of or in the course of employment, or a sickness entitling the insured individual to benefits under a Workers Compensation Act or similar legislation.

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

5. **Outside the United States**. Those rendered outside the United States to an eligible individual during an absence from the United States for a period of more than sixty (60) days.

6. **Veterans**. Those rendered for treatment in a Veteran's Administration Hospital, either by the hospital or physician employed by it (a) unless the treatment is of an emergency nature, and (b) unless the eligible individual is not entitled to such treatment by reason of his status as a veteran or otherwise.

7. **Miscellaneous Procedures**. Charges associated with the following procedures or services:

- Radial Keratotomy
- Lasiek Surgery
- Organ Transplant
- Elective abortions
- Biofeedback and Hypnotherapy
- Myofunctional therapy (facial exercises)
- Behavioral training used for hyperactive children, weight counseling, and similar programs aimed at changing behavior
- Holistic medicine, therapeutic injections, chelation treatments
- Reversal of vasectomy and reversal of tubal ligation
- Routine office visits other than covered physical examinations (if claimant is not sick or injured)
- Cosmetic surgical procedures not specifically covered under the Plan
- Gender alteration procedures
- Temporomandibular Joint Syndrome (TMJ)

8. **Submitted More Than 12 Months Late**. Charges for otherwise covered claims submitted more than twelve (12) months after the services or supplies were rendered that are the basis of the claim.

9. **Crime**. Charges which result from an injury which arose in the commission of a crime or participation in a riot or insurrection. Whether or not injuries arose in the commission of a crime will be determined by the Board of Trustees in its sole discretion, and may include circumstances in which no criminal charges have been brought.

10. **Pregnancy of Dependent Children**. Charges for pregnancy and related conditions for dependent children.

11. **Fraud**. No benefits will be paid for fraudulent claims of service or supplies by a Participant, eligible dependent, or any other person. If a fraudulent claim has been paid on behalf of any person, both the Employee and any person on whose behalf a fraudulent claim was

submitted as a dependent of the Employee will be liable to the Plan for repayment of any benefits paid on behalf of the Employee or any eligible dependent of the Employee against the amount which was fraudulently paid on behalf of the Employee or the other person (and any fees and costs incurred in recovering such amount).

If an Employee or an eligible dependent of the Employee has any outstanding liability for fraudulently paid claims, neither the Employee nor the Employee's eligible dependents may assign any rights to benefits to a provider of services or supplies until all fraudulently paid benefits are repaid in full. If fraudulently paid benefits are not repaid in full, any purported assignment of benefits by an Employee or eligible dependent may be disregarded by the Plan, and payments of benefits by the Plan under a purported assignment is not a waiver of the right of the Plan to refuse to acknowledge other purported assignments. If any fraudulent claims have not been repaid when an Employee or eligible dependent incurs covered charges, the Employee 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.

12. **Not Medically Necessary**. Services or supplies that are not Medically Necessary as defined in Definitions and Experimental or Investigative procedures as defined in Definitions.

13. **Outside Dates of Coverage**. Services received before the Member's Effective Date or during an inpatient stay that began before the Member's Effective Date. Services received after the Member's coverage ends except as specifically stated under Extension of Benefits.

14. **Excess of UCR**. Any amounts in excess of the Usual, Customary and Reasonable allowance for professional services of non- Prudent Buyer Network providers.

15. **Services Not Listed**. Services not specifically listed as covered services.

16. **No Legal Obligation to Pay**. Services for which the Member is not legally obligated to pay and Services for which no charge is made to the Member. Services for which no charge is made to the Member in the absence of insurance coverage, except services received at a non-governmental charitable research Hospital. Such a Hospital must meet the following guidelines:

A. It must be internationally known as being devoted mainly to medical research;

B. At least ten percent of its yearly annual expenditure must be spent on research not directly related to patient care;

C. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;

D. It must accept patients who are unable to pay; and

E. Two-thirds of its patients must have conditions directly related to the Hospital's research.

17. **Governmental Services**. Any service provided by a local, state or federal government agency, including a Veteran's Administration Hospital.

18. **Entitled to Medicare**. Any services to the extent that the Member is entitled to receive Medicare benefits for those services, whether or not Medicare benefits are actually paid. Any services for which payment may be obtained from any other local, state or federal government agency (except Medi-Cal).

19. **Related or Live Together with Provider**. Professional services received from a person who lives in the Member's home or who is related to the Member by blood or marriage.

20. **Custodial Care and Related Changes**. Inpatient room and board charges in connection with a hospital stay primarily for environmental change, physical therapy or treatment of chronic pain. Custodial care or rest cures. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a Skilled Nursing Facility, except as specifically stated in Skilled Nursing Facility under Covered Expenses.

21. **Could Have Been Performed on Outpatient Basis**. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

22. **Learning Disabilities and Related Problems**. Treatment for hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation or autistic disease of childhood.

23. Cosmetic. Charges in connection with Cosmetic Surgery are covered only if

A. Within 12 months after and as the result of an injury sustained while insured under this plan;

B. For replacement of diseased tissue surgically removed while insured under the plan;

C. For the initial reconstruction of a breast after a mastectomy for which benefits are paid under this plan; and

D. Repair of bodily damage covered by disease and/or radiation treatment while insured under this plan.

24. **Obesity**. Services primarily for weight reduction or treatment of obesity. This exclusion will not apply to surgical treatment of obesity if:

A. Surgical treatment of obesity is necessary to treat another life-threatening condition involving obesity; and

B. It has been documented that non-surgical treatments of obesity have failed.

25. **Eyes**. Those for eye refractions or the fitting of eyeglasses, except through the Plan's vision benefits for Participants eligible for such benefits.

L. Claim Requirements

1. General Claims

A signed claim form is necessary in order to make sure you receive benefits under the PPO Plan or Medicare Supplemental Plan. You may use the Plan's claim form for any claim, or you may use your provider's own form. In order to speed up the processing of your claims, the Trustees suggest you use the following procedure when using the Plan's forms:

a. Part I must be completed and signed by the member. If the claim resulted from an accident, please give complete information including the date, time and place.

b. The attending physician must either complete Part II of the Plan's claim form or attach his own form, or an itemized statement which contains an ICDA code. The Plan does not require a claim form completed by a lab technologist, radiologist, or consulting physician who assisted in, or performed, a procedure which is billed by your attending physician.

c. Only one claim form is needed for each illness of a member or dependent per calendar year.

d. An authorized representative may submit a claim on behalf of a claimant.

e. In the case of a claim involving urgent care, a health care professional with knowledge of the claimant's medical condition may act as the authorized representative of the claimant.

2. When to File a Claim

You should file a claim as soon as you or one of your eligible dependents have incurred covered medical expenses for which the Plan provides benefits. You should not wait until the end of the year to submit your claim. Claims which are submitted more than twelve (12) months after the charges are incurred are not payable.

3. Having Your Provider Paid Directly

Payment of the benefits to which you are entitled under the Plan will be paid directly to you unless you have assigned them to the physician or hospital. If you assign benefits to a provider, you will be notified of the payments made by the Trust Fund Office on your behalf so that you will know the amount paid toward your bills by the Plan and the balance, if any, for which you are responsible.

4. Where to File a Claim

Claim forms are available from the Trust Fund Office or the Union Office. All claims should be sent to the Trust Fund Office at the address below:

United Administrative Services
P.O. Box 5057
San Jose, CA 95150-5057
Telephone: (408) 288-4400

5. Other Benefits

No Claim form is necessary for any other benefit, except Life Insurance, Accidental Death or Dismemberment Insurance, and Weekly Disability Benefits. Claim forms for these benefits are available from the Trust Fund Office or the Local Union. They may assist you in completing any of these forms, but you are ultimately responsible for submitting your own claims for these benefits. Submit life, accidental death or dismemberment insurance claims directly to the insurance company, at the address on the form.

6. PPO PLAN, MEDICARE SUPPLEMENTAL PLAN; DENIALS OF ANY SERVICE BASED ON LACK OF ELIGIBILITY

a. Notification of Failure to Follow Plan Claims Procedures: If, in filing a claim for benefits, the claimant fails to follow the Plan's procedures, the Trust Fund Office will notify the claimant as soon as possible, but within 5 days following the failure, or if the claim is for urgent care, within 24 hours of the failure. This notification may be oral, unless the claimant or authorized representative requests it in writing.

b. Notification

1. Time Limits and Requests for Additional Information.

(a) Urgent Care Claims: The Trust Fund Office will notify the claimant of its decision as soon as possible, but no later than 72 hours after the Trust Fund Office's receipt of the claim.

If the claimant fails to provide sufficient information to determine whether benefits are payable under the Plan, the Trust Fund Office will notify the claimant what information is necessary as soon as possible, but no later than 24 hours after the Trust Fund Office's receipt of the claim. The claimant will have 48 hours to provide the specified information. The Trust Fund Office will notify the claimant of its decision as soon as possible, but no later than 48 hours after the Trust Fund Office's receipt of the specified information. If the claimant fails to provide the information, the Trust Fund Office may notify the claimant of its decision at the end of the period given to the claimant to provide the information.

(b) Pre-Service Claims: The Trust Fund Office will notify the claimant of its decision as soon as reasonably possible, but no later than 15 days after the Trust Fund Office received the claim.

The above 15 day time period may be extended for up to one additional 15-day period, but only due to matters beyond the Trust Fund Office's control. If the Trust Fund Office needs a 15 day extension, it will notify the claimant of the following: the reason for the delay; the expected date of decision; and any additional information the Trust Fund Office needs to make the decision. If the Trust Fund Office requires additional information, the claimant will have up to 45 days to provide the specified information. Once the specified information is provided, the Trust Fund Office will notify the claimant of its decision within 15 days. If the claimant fails to provide the information, the Trust Fund Office may notify the claimant of its decision at the end of the period given to the claimant to provide the information.

(c) Post-Service Claims: The Trust Fund Office will notify the claimant of its decision as soon as reasonably possible, but no later than 30 days after the Trust Fund Office received the claim.

The 30-day time period may be extended for one additional 15-day period, but only due to matters beyond the Trust Fund Office's control. If the Trust Fund Office needs a 15-day extension, it will, before the end of the first 30-day period, notify the claimant of the following: the reason for the delay; the expected date of decision; and any additional information the Trust Fund Office needs to make the decision. If the Trust Fund Office requires additional information, the claimant will have up to 45 days to provide the specified information. Once the specified information is provided, the Trust Fund Office will notify the claimant of its decision within 15 days.

2. Contents of Notice: The Trust Fund Office will provide the claimant with written notice if his claim for benefits is denied. If the claim involves urgent care, the information described below may be given orally, so long as a written notification is provided within three days after the oral notification. The notice will include the following information.

(a) a statement of the specific reason(s) for the denial;

(b) reference to the specific Plan provision(s) on which the denial was based;

(c) if the Trust Fund Office's decision relied upon an internal Plan rule, guideline, protocol or similar criterion, the specific rule, guidance, protocol or similar criterion will be provided free of charge upon request;

(d) if the denial was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(e) a description of any additional information or documents that the claimant will need to submit if he wants the claim to be reconsidered, and an explanation of why that information is necessary;

(f) a description of the Plan's appeal procedures, including any expedited appeal procedures available if it is a claim for urgent care benefits; and

(g) a statement of the claimant's right to bring a civil action under ERISA §502(a), if the appeal is unsuccessful.

M. Appeal Procedures

1. Right to Appeal: If a claim for benefits has been denied, the claimant may appeal the denial to the Board of Trustees. The Board of Trustees hears appeals only regarding self-funded benefits and eligibility issues for non-self funded benefits. The Board does not hear appeals regarding unfavorable determinations by other Plan benefit providers.

2. Submission of Appeal: Appeals must be in writing, and state in detail the matter or matters involved. To submit an appeal, the claimant must send a letter, with any documents and information that he wants the Board to consider, to the Trust Fund Office. The claimant may view and receive copies of documents, records or other information relevant to the claim, upon request and free of charge.

3. Expedited Appeal Procedure for Urgent Care Claims: For claims involving urgent care, claimant may request an expedited appeal orally or in writing. In expedited appeals, all necessary information, including the decision on appeal, shall be transmitted between the Trust Fund Office and the claimant by telephone, facsimile, or other available similarly expeditious matter.

4. Time Limits for Filing Appeal: Claimants must submit their appeals within 180 days of receiving the denial of the original claim by the Trust Fund Office. If a claimant does not submit an appeal within 180 days of receiving a denial, he will be deemed to have waived any objection to the denial.

5. Standard for Review: The Board of Trustees has full discretionary authority to decide upon Plan benefits, to interpret the Plan language conclusively and to make a final determination of the rights of any Participant, beneficiary, assignee, or other person with respect to Plan benefits and rights. The Board of Trustees will take into account everything that the claimant submitted, even material that was submitted or considered in the initial benefit determination. The Board of Trustees will not give deference to the initial determination. Neither a person who made the initial determination nor such person's subordinate shall have a vote in the decision on appeal.

In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment is medically necessary or appropriate, the Board of Trustees shall consult with a health care professional. The health care professional shall not have participated in making the initial benefit determination. The Board of Trustees shall, upon claimant's request, identify the health care professional, regardless of whether the Board of Trustees relied on his advice in making the decision.

6. Notification of the Board's Decision on Appeal.

a. Time Limits for Board of Trustees' Determination on Appeal

(1) Urgent Care Claims: In the case of a claim involving urgent care, the Trust Fund Office will notify the claimant of the Board of Trustees' determination as soon as possible, but not more than 72 hours after receiving the claimant's request for an appeal.

(2) Pre-Service Claims: In the case of a claim made before the claimant has received care, the Trust Fund Office will notify the claimant of the Board of Trustees' determination within 30 days after receiving the appeal.

(3) Post-Service Claims: If the claim is made after the claimant has received care, the Board of Trustees will render a decision on the appeal at the meeting immediately following the filing of the appeal, unless the appeal is filed within 30 days of the meeting, in which case the decision may be made at the second meeting following the appeal. The claimant shall be notified of the time and place of the meeting. The Board of Trustees, in their exclusive discretion, may allow any information to be presented, and/or allow the aggrieved individual to appeal before them in person and/or by his representative or present witnesses. There is no right to appear in person before the Board of Trustees.

If special circumstances require further extension, the decision will be made no later than the third meeting following the filing of the appeal. In such cases, the Trust Fund Office will notify the claimant in writing of the extension, describing the special circumstances and the date the determination will be made, before the extension begins.

The Trust Fund Office will notify the claimant of the Board of Trustees' determination as soon as possible, but no later than 5 days after the decision is made. The Board of Trustees' response period will be extended by any additional time it takes for the claimant to provide requested information.

b. Contents of Notice Regarding Determination on Appeal: The Trust Fund Office will send the claimant written notice of the Board of Trustees' decision on appeal. If the appeal has been denied, the notice will include the following information:

(1) the specific reason(s) for the denial;

(2) reference to the specific Plan provision(s) on which the denial is based;

(3) if the decision relied upon an internal Plan rule, guideline, protocol or similar criterion, either the specific rule, or a statement that the specific rule was relied upon and that a copy of such rule will be provided free of charge upon request;

(4) if the denial was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(5) a statement that the claimant may view and receive copies of documents, records or other information relevant to the claim, upon request and free of charge;

(6) a statement that the claimant may submit additional written material in support of his grievance; and

(7) the claimant's right to bring a civil action under ERISA §502(a).

c. Sole and Exclusive Procedures: No Employee, dependent, beneficiary, provider, assignee, child named in a child support order or any other person shall have any right or claim to benefits under this Trust except as specified in the rules of the Trust or Plan. The procedures specified in this section shall be the sole and exclusive procedures available to any such individual who is dissatisfied with an eligibility determination or benefit award, or who is adversely affected by any action of the Trustees, the Trust Fund Office or any other Plan fiduciary. The Board of Trustees shall have full discretionary authority to interpret Plan language and to decide all claims or disputes regarding the right, type, amount or duration of benefits, or claim to any payment from this Trust.

d. Appointment of Standing Subcommittee: Appeals on matters within the jurisdiction of the Board of Trustees may be decided by a standing subcommittee of the Board of Trustees. The subcommittee shall be appointed by the Chair and Co-Chair and may be the Chair and Co-Chair. The decision of the standing subcommittee shall be final if the Board of Trustees has given such authority.

7. One Year to File Lawsuit. If your appeal has been denied or there has been a different form of adverse action taken against you, you have one year from the date of such denied appeal or adverse action to file a lawsuit. If you fail to do so, no lawsuit is permitted.

IV. FORMAL RULES OF THE PRESCRIPTION DRUG PLAN

A. The Plan pays benefits for Prescription Drugs prescribed by a licensed physician and dispensed by a licensed pharmacy or hospital pharmacy for expenses of non-hospital prescription costs, in accordance with the terms of the Plan's contract with its designated prescription drug benefits provider.

B. Prescription drug purchases of up to a thirty (30) day supply may be made at a participating pharmacy, or up to a ninety (90) day supply from the designated mail order provider, for a co-payment of $5 or 10% of the prescription cost, whichever is higher. Members will be issued membership cards for the Prescription Drug Plan by the Trust Fund Office. To be assured that purchases at participating pharmacies are covered, members and eligible dependents are required to use this card at the time of purchase. Purchases from the designated mail order provider, must be made on forms available from the Trust Fund Office.

C. If a Participant or eligible dependent has been prescribed a drug which has a generic equivalent, that generic equivalent will be dispensed instead of the prescribed drug unless the prescribing physician has specifically stated on the prescription form that no generic substitution may be made. If a Participant or eligible dependent has been prescribed a drug for which there is

no generic equivalent, but there is a reasonable substitute under the formulary program of the designated prescription drug benefit provider, the dispensing pharmacist will contact the prescribing physician to determine if the formulary drug may be dispensed instead of the originally prescribed drug, but no substitution will be made without the doctor's consent.

D. **Benefits under this Prescription Drug Plan are provided only to eligible Employees who have not elected to receive medical benefits from Kaiser Foundation Health Plan, and their eligible dependents. Persons who are covered through Kaiser receive prescription drug benefits only through Kaiser.**

V. FORMAL RULES OF THE MEDICARE SUPPLEMENTAL PLAN

PARTICIPANTS AND DEPENDENTS
WHO ARE MEDICARE-PRIMARY

A. Covered Charges in Coordination with Medicare

Benefits are payable according to the following schedule on behalf of, or to, any person for whom the Plan is permitted by law to be secondary, and who have satisfied the applicable requirements to be eligible for benefits. Notwithstanding the above, no benefits shall be paid on behalf of a person who is otherwise eligible for benefits under this schedule unless he is enrolled in Medicare Parts A and B. If a Participant is covered under this schedule, and the Participant's spouse or other eligible dependent is not eligible for Medicare, benefits shall be paid in accordance with the schedule of benefits of the PPO Plan, including the exclusions and other Plan provisions..

Any person covered under this schedule of benefits, or under a Plan HMO as a retiree or dependent of a retiree, shall also be eligible for Hearing Benefits as provided under the applicable plan, Prescription Drug Benefits as provided under the PPO Plan, and for dental, vision, and insurance benefits (but not Weekly Disability Benefits), except that Kaiser members shall receive their prescription drug benefits and vision benefits through Kaiser.

1. Covered Hospital Charges

   a. 100% of Medicare Hospital Deductible;

   b. 80% of the UCR portion of Excess Charges for Hospital Services not covered by Medicare, excluding private room charges in excess of semiprivate level; and

   c. 80% of the UCR portion of Medicare qualified Skilled Nursing Facility expenses not covered by Medicare, excluding private room charges in excess of semiprivate level.

2. Covered Medical Charges

   a. After a $50 Calendar Year Deductible, the benefits payable are 80% of the UCR portion of excess covered charges not paid by Medicare, including Licensed Registered Nurses' UCR fees and UCR charges incurred outside the United States during the first sixty (60) days in any 12 month period; and

b. 50% of the UCR charges for services of a licensed practical or vocational nurse provided such services are performed within sixty (60) days of an accident or termination of a hospital confinement.

IF THE SERVICE IS NOT COVERED BY MEDICARE, THE PLAN DOES NOT COVER ANY PORTION OF THE CHARGES FOR SUCH SERVICE.

3. Claim Requirements

The rules for submission of claims under Claim Requirements of the PPO Plan apply to benefits under this Medicare Supplemental Plan.

VI. FORMAL MISCELLANEOUS RULES

A. Definitions

Except for terms which are specifically defined herein, all terms shall be presumed to have the meaning, if any, given in the U. A. Local Union No. 467 Health and Welfare Trust Fund Trust Agreement, as amended. Wherever a single-gender pronoun is used herein, it shall be presumed to refer to Employees of either gender, so that it shall be understood that all covered Employees have equal rights to benefits under the Plan.

B. Cost of Plan/Benefits Limited to Assets of Plan

The entire cost of the Plan is paid by the Board of Trustees of U.A. Local Union No. 467 Health and Welfare Trust Fund from contributions made to the Trust Fund by Individual Employers pursuant to Collective Bargaining Agreements and from monthly payments required of certain classes of Participants. In no event shall the Plan be construed to require payment of benefits in excess of funds collected by the Trust Fund from these sources.

THERE IS NO VESTED RIGHT TO BENEFITS UNDER THIS PLAN.

C. Amendment and Termination of Plan

It is the intention of the Board of Trustees that this Plan continue indefinitely; however, the Board reserves the right to amend the Plan if, in its exclusive discretion, finds to be proper, and if the Board finds it necessary or appropriate under the circumstances then in effect, to terminate the Plan or any portion thereof, for any or all Participants and dependents, or to change the amounts required to be paid by any class of Participants and/or dependents.

The Board of Trustees expressly reserves 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;

2. alter or postpone the method of payment of any benefit;

3. amend, terminate or rescind any provision of the Plan;

4. merge the Plan with other Plans, including the transfer of assets;

5. terminate any insurance company or HMO;

6. restrict coverage to those living only in certain geographic areas; and

7. eliminate any benefits offered in the Plan at any time.

The authority to make any such changes to the Plan rests solely with the Board of Trustees. Any such amendment, modification, revocation or termination of the Plan shall be made by a motion adopted by the Board of Trustees. No individual Trustee, Union representative, or Employer representative is authorized to interpret this Plan on behalf of the Board of Trustees, or to act as an agent of the Board of Trustees.

D. Reservation of Power to Interpret

Except for benefits provided through health maintenance organizations and by group insurance policies, this booklet contains what is intended as the complete rules of all available benefits for current Employees and retirees, and their eligible dependents. In case of any question as to the meaning of any portion of this Plan, the Trustees reserve the power to interpret this booklet, the Plan and any portion thereof, and, in the event of conflict between the Summary Plan Description and this formal Plan text, this formal Plan text is controlling.

E. Identification Card

Each covered Employee will receive an identification card which will assist in establishing coverage under the Plan when entering a hospital or requiring other medical care.

F. Coordination of Benefits

This Plan coordinates benefits for any claim in accordance with the coordination rules of the National Association of Insurance Commissioners, as in effect at the time of the claim (including the "birthday rule" for payment of claims for dependent children of parents with coverage under different Plans). Under this provision, duplication of benefits is eliminated but recognition is given to the coverage provided by all Plans under which protection is provided.

This Plan, if primary, will pay its regular benefits in full or, if secondary, will pay a reduced amount which, when added to the benefits payable by other group Plans, does not exceed 100% of Usual, Customary, and Reasonable charges, as defined herein.

G. Subrogation/Third Party Recovery

The subrogation third party liability provision in the applicable Plan document for Kaiser or Aetna will apply to claims covered by such HMOs. This section applies to any other benefits

provided under this Plan. If the Covered Person is injured as a result of the act or omission of another person or party, Plan benefits are available provided:

1. Exclusion of Claims Caused by Third Party. The 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.

As a condition precedent to receiving Plan benefits, a Participant and Dependent is required immediately (within thirty days) to notify the Plan Office 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.

Charges incurred by a Participant or dependent for which a Third Party is or may be responsible are not covered charges under any benefits provided in this Plan; however, payments may be advanced to an otherwise eligible Participant or beneficiary, if the conditions of this section are met.

2. Agree to Reimburse. The Covered Person agrees to reimburse to the Plan immediately any amounts recovered by way of a judgment, settlement or otherwise (including receipt of proceeds under any uninsured motorists coverage or other insurance including the Participant's own or family or other insurance coverage.) arising out of any claims for damages by the individual or his assignees, representatives, 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 Covered Person who accepts payments from the Plan agrees that by doing so he is making a present assignment of his rights against such third party to the extent of the payments made by the Plan.

The Plan may require that any Covered Person execute an Agreement to Reimburse and/or Assignment of Recovery in such form or forms as the Plan may require. Any Covered Person who refuses to execute 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 Covered Person who receives benefits and later fails to reimburse the Plan as set forth above shall be ineligible for any future Plan benefit payments until the Plan has withheld an amount equal to the amount which the Covered Person has failed to reimburse, including reasonable interest on such unpaid funds.

3. May Intervene/Cooperation. By accepting payments from the Plan, any Covered Person agrees that the Plan may intervene in any legal action brought against the third party or any insurance company, including the Covered Person's own carrier for uninsured motorist coverage. By accepting payments from the Plan, any Covered Person further agrees that a lien shall exist in favor of the Plan upon the total recovery which is due to the Plan for benefits paid. The lien may be filed with the third party, the third party's agents, or the court. The Covered Person shall do nothing to prejudice the Plan's rights as described above without the Plan's written consent.

4. Settlement/Compromise of Claims. If the Covered Person 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 Covered Person 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. The Plan may offset any future claims incurred by the Participant and/or his family members against amounts owed to the Plan as a result of this Section.

H. Assignment Procedures for Hospital Admissions

A Participant may assign his benefits to a doctor or hospital so that they will be paid directly to your providers. Most hospitals will accept an assignment of your benefits in lieu of a cash deposit on admission. However, hospitals usually require evidence that you are covered and they want to know the amount they may expect to receive from your insurance. To have your benefits paid to the hospital:

1. Present your Identification Card to the hospital's admission clerk.

2. The hospital may contact the Trust Fund Office directly to verify your coverage is in force.

3. Sign the hospital's standard assignment form.

I. Extension of Coverage During a Labor Dispute

Subject to the provisions of the Trust Fund, your coverage for benefits provided through insurance policies may be continued up to a maximum of six (6) months during a labor dispute under the following conditions: (1) a monthly contribution rate approved by the Board of Trustees is paid through the labor union engaged in the labor dispute; (2) at least 75% of all eligible individuals elect to continue their coverage during the labor dispute; and (3) you do not accept other full-time employment.

J. HIPAA Privacy Rule: Protected Health Information

1. <u>General Rules</u>. The Board of Trustees and the Trust Fund office will use protected health information (PHI) in accordance with the Health Information Portability and Accountability Act (HIPAA). Specifically, the Board of Trustees will:

a. Protect your Protected Health Information ("PHI"). PHI means Health Information, including demographic and genetic information, that is (1) transmitted or maintained in any form or medium, (2) collected from an individual and created or received by a health care provider, health Plan, Employer, or health care clearinghouse, and (3) identifies the individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the individual involved. For example, you or your eligible dependents name, address, birth date, marital status, birth certificate, Social Security Number, and choice of health plan would be considered PHI.

b. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, received, maintains or transmits on behalf of the Plan;

c. Ensure that adequate separation between the Plan and Board, as required by this Article and by governmental regulations (45 CFR §164.504(f)(2)(iii)), is supported by reasonable and appropriate security measures;

d. Ensure that any Business Associate including its subcontractor or agent to whom the Board of Trustees provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

e. Report to the Plan any breach of unsecured PHI including, security incident of which it becomes aware.

2. Disclosure of Summary Health Information. The Trust Fund Office may disclose Summary Health Information to the Board of Trustees if the Board requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending or terminating the Plan.

3. Disclosure of Enrollment Information. The Trust Fund Office may disclose to the Board information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

4. Permitted Uses of PHI by the Board. PHI disclosed to the Board in accordance with this section may be used for the Plan administrative functions that the Board performs.

5. Obligations of the Board. In addition to the requirements state above, the Board also agrees to:

a. not use or further disclose PHI other than permitted in this section or as required by law;

b. ensure that any of its agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Board;

c. not use or disclose PHI for employment-related actions or in connection with any other benefit or Employee benefit Plan;

d. report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses and disclosures in this section;

e. make PHI available to individuals in accordance with HIPAA's requirements;

f. make PHI available for individuals' amendment and incorporate any amendments to PHF in accordance with HIPAA'S;

g. make the information available that will provide individuals with an accounting of disclosures in accordance with HIPAA;

h. make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services for purposes of determining the Plan's compliance with HIPAA;

i. if feasible, return or destroy all PHI received from the Plan that the Board maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Board will limit further its uses and disclosures of the PHI to those purposes that make the return or destruction of the information infeasible; and

j. ensure that adequate separation between the Plan and the Board is established and maintained.

6. **Disclosure Only to Designated Parties**. Pursuant to this section, the Plan will disclose PHI only to the Board and/or to individual Trustee and professionals advising the Plan.

7. **Disclosure Only for Designated Purposes.** Access to and use of PHI by the parties described in paragraph 8 shall be restricted to Plan administration function that the Board performs for the Plan. Such access or use shall be permitted only to the extent necessary for these individuals to perform their respective duties for the Plan.

8. **Non-Compliance.** If any person does not comply with the provisions of this section or the provisions of HIPAA, the Board will provide a mechanism for resolving the issue of non-compliance, which may include disciplinary sanctions.

9. **Your Individual Rights.** Under HIPAA you and your eligible dependents have the following rights:

a. Right to Request Restrictions on how this Plan will use or disclose your PHI.
b. Right to request that the Plan communicate with you about medical matters in a certain way or at a certain location.
c. Right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care, for as long as this Plan maintains the PHI.
d. If you believe that your health information records are inaccurate or incomplete, you may request that the Plan amend the records.
e. Right to request a list of certain disclosures of your health information that the Plan is required to keep a record of under the Privacy Rule, such as disclosures for public purposes authorized by law or disclosures that are not in accordance with the Plan's privacy policies and applicable law.
f. Right to receive and the Plan is required to provide a Notice to you, as soon as reasonably possible, but no later than 60 days after discovery of a breach of your unsecured PHI.

g. If you paid for services out-of-pocket, in full, and you request the Health Care Provider not disclose your PHI related to those services to the Plan, the Health Care Provider must accommodate your request, except where the Health Care Provider is required by law to make a disclosure.

10. Individual Authorization. Except as provided under the Plan's Notice of Privacy Practices or as permitted under HIPAA, the Plan will not disclose your PHI without your prior written authorization. Further, if you wish to authorize someone other than yourself to access information from the Trust Fund Office on your behalf, you must complete the Protected Health Information Authorization Form (available at the Trust Fund Office) and return it to the Trust Fund Office.

The Board of Trustees and the Trust Fund Office's uses and disclosure are more fully described in this Plan's Privacy Policy Statement and Notice of Privacy Practices. Copies of these documents can be requested from the Trust Fund Office.

K. Incompetence or Incapacity

In the event the Plan determines that the Covered Person is incompetent or incapable of executing a valid signature and no guardian has been appointed, or in the event the Covered Person has not provided the Plan with an address at which he can be located for payment, the Plan may, during the lifetime of the Covered Person, pay any amount otherwise payable to the Covered Person, to the spouse, or relative by blood of the Covered Person, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case 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 in accordance with this provision shall discharge the Plan and the Trustees hereunder to the extent of such payment.

U. A. LOCAL UNION NO. 467 VACATION PLAN

OVERVIEW OF THE VACATION PLAN

The Vacation Plan provides benefits to all Employees working under a Collective Bargaining Agreement of U. A. Local Union No. 467 for whom contributions are made to this Plan. Your benefits are based on the contributions made to your account, plus a proportional share of the net income earned by the Plan, after payment of the Plan's administrative expenses.

Distributions of vacation benefits are available at any time, up to one distribution monthly. To request a distribution, you must submit a Vacation Withdrawal Form. Forms are available from the U. A. Local Union No. 467 Business Office, and must be returned to that office in person (except in the case of extreme hardship). The address of the Union Business Office is:

U. A. Local Union No. 467
1519 Rollins Road
Burlingame, CA 94010

FORMAL RULES OF THE VACATION PLAN

ARTICLE I - EFFECTIVE DATE

Section 1. The Vacation Plan shall be effective January 1, 1985.

Section 2. The Plan year shall be from January 1 to December 31 of each year.

ARTICLE II - FUNDING AND ADMINISTRATION

Section 1. The Fund shall consist of all contributions made or required to be made to it by any Individual Employer by reason of his or its employment of any Employee under a Collective Bargaining Agreement with U.A. Local Union No. 467, all Employee taxes having been deducted from the Employee's regular wages and fully prepaid.

Section 2. The Fund shall be administered by the Board of Trustees of U.A. Local Union No. 467 Vacation Trust Fund under and pursuant to the provisions of the Trust Agreement of December 1, 1984.

Section 3. Contributions to the Fund shall be invested as directed by the Trustees as soon after receipt as possible.

Section 4. The cost of administration of the Fund shall be paid only out of interest on investment, before allocation to the individual account of the Employee, and out of accounts forfeited in accordance with the provision of Section 5 of Article IV.

ARTICLE III - EMPLOYEE ACCOUNTS

Section 1. The Trustees shall maintain separate accounts in the name of each Employee which shall reflect the proportional interest of each, based upon contributions paid in on his behalf, together with his share of the income profits and losses, less his proportional share of the expenses of administration.

Section 2. The proportional interest of each Employee shall be computed as of the 31st day of December of each year.

ARTICLE IV - WITHDRAWALS

Section 1. Ordinary withdrawals by the Employee may be made once a month without charge to the withdrawing Employee. Withdrawals by a spouse are not allowed.

Section 2. Special withdrawals may be made at any time with the consent of the Trustees.

Section 3. All requests for withdrawals shall be submitted to the Trustees on special forms to be supplied for that purpose.

Section 4. No part of the account of any Employee shall be liable to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by the Employee except that the Employee may authorize deductions for Union dues, Credit Union and Political Action, but only to the extent that funds are available in his account and in accordance with the restrictions otherwise imposed in this Article IV provided.

Section 5. If the account of any Employee remains inactive for a period of twenty-four months, it shall be forfeited and applied to the costs of administration of the Plan, but only after the Trustees have made an effort to contact the Employee at the Employee's last known address as shown on the records of the Fund. For purposes of this section, "inactive" means that no contributions or withdrawals have been made to or from the account.

ARTICLE V - DISTRIBUTION UPON DEATH OR INCOMPETENCE

Section 1. In the event of the death of any Employee, monies credited to his account shall, upon presentation of a Death Certificate, be paid over to the designated beneficiary, if any, of the deceased Employee, or, if none designated, to his estate.

Section 2. In the event of the adjudicated incompetence of any Employee, the monies in his account shall be paid over to his guardian or conservator upon presentation of certified copies of the Letters of Guardianship or Conservatorship of his estate.

SPECIAL CLAIMS AND APPEAL PROCEDURES FOR WEEKLY DISABILITY BENEFITS

Filing a Claim for Weekly or Supplemental Disability Benefits

1. To file a claim for Weekly Disability Benefits, the Participant must submit a completed Disability Application Form, with proof of disability, to the Trust Fund Office. The form must be submitted within a reasonable time of the onset of disability. Along with the claim form, the claimant may submit written comments, documents, records or other information relating to his or her claim. The Plan will provide access to and/or copies of all documents, records and other information relevant to the claim, upon request and free of charge. An authorized representative may act on behalf of the claimant in filing a claim for disability benefits under this Plan.

Notification Rules If The Claim For Benefits is Denied

2. Time Limits and Requests for Additional Information. If a claim for disability benefits is denied, the Plan will notify the claimant as soon as reasonably possible, but no later than 45 days after the Plan received the claim. That time period may be extended for up to two additional 30-day periods, but only due to matters beyond the Plan's control. If the Plan needs a 30-day extension, it will notify the claimant, within 45 days of receiving the claim, of the following:

a. the reason for the delay;
b. the expected date of decision;
c. the basis on which the decision will be made;
d. any unresolved issues preventing a decision now; and
e. any additional information the Plan needs to make the decision.

The claimant will then have up to 45 days to provide the specified information. The Plan's response period will be extended by any additional time it takes for the claimant to provide the requested information.

3. Contents of Notice. The Plan will provide the claimant with written notice if his claim for disability benefits is denied. The notice will include the following information:

a. a statement of the specific reason(s) for the denial;
b. reference to the specific Plan provision(s) on which the denial was based;
c. if the Plan's decision relied upon an internal Plan rule, guideline, protocol or similar criterion, either the specific rule, or a statement that the specific rule was relied upon and that a copy of such rule will be provided free of charge upon request;
d. a description of any additional information or documents that the claimant will need to submit if he wants the claim to be reconsidered, and an explanation of why that information is necessary;
e. a description of the Plan's appeal procedures. These will be found in a separate document, and must be followed in appealing the denial of benefits; and
f. a statement of the claimant's right to bring a civil action under ERISA § 502(a), if the appeal is unsuccessful.

Claim Denial

4. Time Limits. If a claim for disability benefits has been denied, the claimant may appeal the denial to the Board of Trustees. Appeals must be in writing. To submit an appeal, the claimant must send a letter with any documents and information that he or she wants the Board to consider, to:

U.A. Local Union No. 467 Health and Welfare Plan
c/o United Administrative Services
P.O. Box 5057
San Jose, California 95150-5057

To comply with Plan rules, claimants must submit their appeals within 180 days of receiving a denial of benefits. If a claimant does not submit an appeal within 180 days of receiving a denial, he will be deemed to have waived any objection to the denial.

5. Discretionary Authority. The Board of Trustees has full discretionary authority to decide upon Plan benefits, to interpret the Plan language conclusively and to make a final determination of the rights of any Participant, beneficiary, assignee, or other person with respect to Plan benefits.

6. Standard for Review. In deciding the appeal, the Board of Trustees will take into account everything that the claimant submitted, even material that was submitted or considered in the initial benefit determination. The Board of Trustees will not give deference to the initial determination. Neither a person who made the initial determination nor such a person's subordinate will take part in the decision on appeal.

7. Consultation with Health Care Professional. In deciding an appeal that is based in whole or in part on a medical judgement (including experimental, investigational, and medically necessary or appropriate decisions), the Board of Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The Board of Trustees will identify to the claimant any medical or vocational experts whose advice was obtained by the Plan in connection with the decision, whether or not the advice was relied upon in making the decision. The health care professional consulted on appeal will not be an individual who was consulted in connection with the initial benefit denial, or such a person's subordinate.

Notification of the Board's Decision on Appeal

8. Time Limits. The Board of Trustees will render a decision on appeal at the meeting immediately following the filing of the appeal, unless the appeal is filed within 30 days of the meeting, in which case the decision may be made at the second meeting following the appeal.

9. Special Circumstances-Delay. If special circumstances (such as the need for a hearing) require further extension, the decision will be made no later than the third meeting following the filing of the appeal. In such cases, the Plan will notify the claimant in writing of the extension, describing the special circumstances and the date the determination will be made, before the extension begins.

10. Notice of Decision-Time Period. The Plan will notify the claimant of the decision as soon as possible, but no later than 5 business days after the decision is made. The Plan's response period will be extended by any additional time it takes for the claimant to provide the requested information.

11. Contents of Notice. The Plan will send the claimant written notice of the Board of Trustees' decision on appeal. If the appeal has been denied, the notice will include the following information:

a. the specific reason(s) for the denial;

b. reference to the specific Plan provision(s) on which the denial is based;

c. if the decision relied upon an internal Plan rule, guideline, protocol or similar criterion, either the specific rule, or a statement that the specific rule was relied upon and that a copy of such rule will be provided free of charge upon request;

d. a statement that the claimant may view and copy any documents, records or other information relevant to the claim, upon request and free of charge;

e. if the decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the Plan's terms to the medical circumstances, or a statement that such explanation will be provided free of charge upon request;

f. a description of any further appeal procedures, and the claimant's right to receive information about the procedures, and the claimant's right to bring a civil action under ERISA § 502(a).

12. Sole Procedures/Discretionary Authority. The procedures specified in this Section shall be the sole and exclusive procedures available to any such individual who is dissatisfied with an eligibility determination or benefit award, or who is adversely affected by any action of the Trustees, the Trust Fund Office or any other Plan fiduciary. The Board of Trustees shall have full discretionary authority to interpret Plan language and to decide all claims or disputes regarding the right, type, amount or duration of benefits, or claim to any payment from this Trust. The decision of the Board of Trustees on any matter within its discretion shall be final and binding on all parties.

13. One Year to File Lawsuit. If your appeal has been denied or there has been a different form of adverse action taken against you, you have one year from the date of such denied appeal or adverse action to file a lawsuit. If you fail to do so, no lawsuit is permitted.

ADMINISTRATIVE INFORMATION

HEALTH AND WELFARE PLAN

This Plan is known as the U. A. Local Union No. 467 Health and Welfare Plan. The Internal Revenue Service Employer Identification Number (EIN) is 94-6415220, and the Plan Number is 516. The Plan Year runs from January 1 to December 31 of each calendar year. Reserve assets are held in trust by Reliance Trust Company, under the investment management of New Century Partners in a diversified portfolio of assets.

VACATION PLAN

This Plan is known as the U. A. Local Union No. 467 Vacation Plan. The Internal Revenue Service Employer Identification Number (EIN) is 77-6018224, and the Plan Number is 501. The Plan Year runs from January 1 to December 31 of each calendar year. Prior to distribution, Plan assets are held in trust in the name of the U.A. Local Union No. 467 Vacation Plan.

THE FOLLOWING INFORMATION APPLIES TO BOTH PLANS

PLAN ADMINISTRATOR:
The Plans are administered by a joint Board of Trustees consisting of four Employee Trustees appointed by U.A. Local Union No. 467 and four Employer Trustees appointed by the participating Employer associations. The address and other pertinent information are as follows:

U.A. Local Union No. 467 Health and Welfare Fund Board of Trustees
Trust Fund Office
c/o United Administrative Services
P.O. Box 5057
San Jose, CA 95150-5057
(408) 288-4400

TYPE OF ADMINISTRATION:

The Board of Trustees is assisted in the administration of the Plans by a contract administrator, United Administrative Services, at the address and phone number listed above. Certain benefits are provided through contracts of insurance or health service Plans, as described above. The Board is also assisted in the administration by U. A. Local Union No. 467, whose address is listed in Appendix 1.

AMENDMENT AND TERMINATION OF TRUST FUNDS:

Although there is no intention or expectation that this would occur, the collective bargaining parties have the power to terminate all contributions to the Plans. If this occurs, the funds already contributed shall be applied by the Board of Trustees, in their discretion, to provide benefits to covered individuals, either through these Plans or through other collectively bargained Plans offering similar benefits to Employees working in the Plumbing and Pipefitting Industry. In no event shall the termination of either Plan cause any contributions to revert to an Employer.

AGENT FOR SERVICE OF LEGAL PROCESS:

Richard K. Grosboll
Neyhart, Anderson, Flynn & Grosboll
369 Pine Street, Suite 800
San Francisco, CA 94104-3323
T: (415) 677-9440
F: (415) 677-9445

Service of legal process may also be made upon any of the Trustees, at his regular place of business, or on United Administrative Services.

FUNDING AND PLAN SPONSORSHIP:

This Plan is funded by contributions made pursuant to Collective Bargaining Agreements between U. A. Local Union No. 467 and the following Employers or Employer associations: Plumbing-Heating-Cooling Contractors Association of the Greater Bay Area, Inc., Northern California Mechanical Contractors Association and the Industrial Contractors, Inc., UMIC, as well as a number of individual Employers who are not affiliated with those associations.

A complete list of Employers, Employer associations, and labor organizations sponsoring the Plan may be obtained by Participants and beneficiaries upon written request to the Trust Fund Office, subject to payment of a reasonable copying charge, and is available for examination by Participants and beneficiaries, upon reasonable notice. A Participant or beneficiary may also request information as to whether a particular Employer, or Employer association, is a sponsor of the Plan, and if so, the sponsor's address. Copies of Collective Bargaining Agreements may be obtained by Participants and beneficiaries upon written request to the Trust Fund Office, subject to payment of a reasonable copying charge, and are available for examination by Participants and beneficiaries, upon reasonable notice.

YOUR RIGHTS UNDER ERISA

As a Participant in the U. A. Local Union No. 467 Health and Welfare Plan and/or the U. A. Local Union No. 467 Vacation Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that Plan Participants are entitled to:

A. Receive Information About Your Plan and Benefits

Examine, without charge, at the Trust Fund Office and at other specified locations, such as worksites and union halls, documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the Trust Fund Office, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Trust Fund Office may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report known as a Summary Annual Report ("SAR"). The Trust Fund Office is required by law to furnish each Participant with this Summary Annual Report.

B. Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health Plan, if you have creditable coverage from another Plan. You should be provided a certificate of creditable coverage, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

C. Prudent Actions by Plan Fiduciaries

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

D. Enforce Your Rights

If your claim for a health and welfare or vacation benefit is denied or ignored, 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 schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of certain Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court, although your right to sue may be limited if you have not used the Plan's appeal procedures. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a lawsuit. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. Any such claim shall be limited to benefits due to him under the terms of the Plan, or to clarify his rights to future benefits under the terms of the Plan, and shall not include any claim or right to damages, either compensatory or punitive. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If your appeal has been denied or there has been a different form of adverse action taken against you, you have one year from the date of such denied appeal or adverse action to file a lawsuit. If you fail to do so, no lawsuit is permitted. This rule applies to and includes any and every claim to benefits from the Fund, and any claim or right asserted under the Plan or against the Fund, regardless of the basis asserted for the claim, and 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 with the meaning of those terms as defined in ERISA.

E. Assistance with Your Questions

If you have any questions about your Plan, you should contact the Trust Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, which is the San Francisco Regional Office, 90 7th Street, Suite 11-300, San Francisco, CA 94103 (415) 625-2481.

Office of Participant Assistance
U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Avenue NW
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. For single copies of publications, contact the EBSA Brochure Request Line at 1-866-444-3272 or contact the EBSA field office nearest you.

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