U.A. LOCAL 467 HEALTH, WELFARE AND VACATION PLAN

SUMMARY PLAN DESCRIPTION
and
PLAN DOCUMENT

(Includes Residential Employees)

(Medical, Prescription Drug, Vision, Dental, Death, Accidental Death & Dismemberment Benefits, and Vacation Benefits)

Restated: May 2024

Keep this Summary Plan Description For Future Reference

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BENEFIT CONSULTANT **Jason Birkle and Brad Gates** **NWPS**	

IMPORTANT PROVIDERS AND KEY INFORMATION

Your Service Providers:		Phone Numbers /Websites:
Anthem Blue Cross PPO	For questions go to the website. Or phone the Plan Office at 408-288-4400.	www.anthem.com For a list of network providers: 1-800-688-3828 Nurse Line: 1-866-670-1565
Kaiser Permanente (HMO Plan)	For questions about health and mental benefit information or to obtain ID Cards. Refer to Group #937 for Residentials and Group #8052 for Actives and Retirees.	*Call Kaiser Permanente:* *Toll-Free: 1-800-464-4000* *or go online to:* *www.kaiserpermanente.org*
Delta Dental (Dental Benefits)	For questions about dental benefit information or to obtain ID Cards. Refer to Group #79-2001 if non-residential and Group #79-2002 if Residential.	*Call Delta Dental: 1-800-765-6003* *or go online to:* *www.deltadentalinscom*
Vision Service Plan (Vision Benefits)	For questions about vision benefit information or to obtain ID Cards. Refer to Group #00400600.	*Call VSP: 1-800-877-7195* *or go online to: www.vsp.com*

A. ESTABLISHMENT OF PLAN.

1. **Restatement of Plan:** The Board of Trustees restates the U.A. Local 467 Health, Welfare and Vacation Plan ("Plan") as of October 1, 2023. The Plan's medical (including hospital, mental health and substance abuse) benefits are offered to Actives through: (1) a self-funded portion of the Plan, using a network of providers and Joint Administrative Services Agreement with Anthem Blue Cross of California "Anthem Blue Cross") and (2) also through a Health Maintenance Organization, which is Kaiser Permanente (HMO) ("Kaiser"). Retiree medical benefits are offered through the following: (1) Kaiser Permanente Senior Advantage (HMO), (2) Anthem Blue Cross of CA Medicare Supplement Plan, (3) Kaiser Permanente HMO Plan for Early Retirees (non-Medicare) and (4) Anthem Blue Cross PPO Plan for Early Retirees (non-Medicare). If you enroll in the Kaiser HMO option, a separate Evidence of Coverage ("EOC") prepared by the HMO will be provided to you. Other benefits are provided as listed in section 6 on the next page of this booklet.

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. **Kaiser: Election of Health Maintenance Organization (HMO) Benefit Option:** The Board of Trustees provides the option to elect enrollment through Kaiser, an HMO.

An HMO uses a group of doctors and other health care professionals who emphasize preventive care and early intervention. HMO services are prepaid and a designated premium covers service. You share some costs, however, by paying a fee called a co-payment for some services and products. Benefits provided pursuant to the group insurance or HMO contract are paid by the applicable insurer or HMO. The Plan has no financial responsibility to pay any participant or dependent on any insured benefits. Instead, the Insurer or HMO is solely responsible for paying such benefits.

To be eligible to enroll in an HMO, you must live within the HMO's service area. 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 Kaiser, unless otherwise authorized by Kaiser. 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. The HMO is incorporated as part of the Plan. All rules regarding claims review and/or appeals are governed by Kaiser's rules and regulations without regard to similar rules and regulations that may be otherwise set forth in this Plan.

3. Self-Funded Preferred Provider Organization (PPO) Benefit Option: The Plan offers PPO benefits through the Anthem Blue Cross Plan. The Self-funded PPO benefits are provided only to the extent that the plan has adequate resources to pay for such benefits. The PPO network providers contracted by Anthem Blue Cross have agreed to accept negotiated rates for payment and you should not be billed for amounts beyond your applicable deductible (if any) and coinsurance payment.

If you choose to receive your care from a non-PPO provider, then you will be responsible not only for, if any, deductible and your portion of the coinsurance, but you may also be billed for the difference between what the plan pays and the actual charge made by the Non-PPO Provider. There are some exceptions for certain services or items covered under the No Surprise Act. The self-funded PPO option allows you to receive care from any of the doctors, other health care professionals, and hospitals within the plan's network, as well as outside of the network for covered services. If you do not have the Anthem Blue Cross PPO provider list, you may obtain a copy at no charge from the Plan Office or contact Anthem Blue Cross to assist you in choosing a doctor for you and your family.

To illustrate how the PPO option works, let's say you (Active) pay a co-payment (e.g., $15) at the time of your specialist office visit at a PPO Network provider. There is no deductible. However, if let's say you (Active) go to a Non-PPO Network provider for a specialist office visit then you also pay a co-payment (e.g., $15) but you will also have a yearly deductible (e.g., $250 individual or $500 family) to meet before the Plan starts paying your medical costs. After that, some services you receive may be 100% covered or you may have to pay a coinsurance (e.g., 10% if in-network provider or 40% of out-of-network provider) which is your share of costs calculated as a percentage of the allowed amount for your covered service. Please refer to your copy of the Summary of Benefits and Coverage ("SBC") for a more recent detail of the applicable cost-sharing amounts that may apply to you and/or your family members. For a copy, please contact the Trust Fund Office. The SBCs are also mailed to you annually.

4. **Open Enrollment.** The Plan offers an Open Enrollment period during mid-October (the dates vary) through November 30, with any changes to be effective as of January. (By way of example, Open Enrollment was from October 17, 2023, through November 2023 during 2023, with any change effective January 1, 2024.) You must return the Open Enrollment Election Form to U.A. Local 467 by the deadline (November 30). If you prefer to remain with your current Plan (Kaiser or Anthem Blue Cross), no action is required on your part.

5. **Additional Benefits:** The Plan provides the following types of additional benefits subject to certain eligibility provisions and exclusions to eligible Participants and their Dependent(s):

- **a. Life Insurance and Death Benefit** (Self-Funded)
- **b. Dental Care/Orthodontic** (through Delta Dental Plan of California)
- **c. Vision Care** (through Vision Service Plan ("VSP")
- **e. Residential Treatment Benefit for Chemical Dependency** (Beat it or through Kaiser)

U.A. LOCAL 467 HEALTH AND WELFARE PLAN

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IMPORTANT NOTICES

NO GUARANTEE OF PROVIDER

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

CAUTION – FUTURE PLAN AMENDMENTS

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

LIMITATION UPON RELIANCE ON BOOKLET AND STATEMENT

This booklet provides a brief, general summary of the Plan rules and is also the Plan document. You should review the Plan to fully determine your rights. **You are not entitled to rely upon oral statements of Employees of the Fund Office, a Trustee, an Employer, any Union officer or any other person**. As a courtesy to you, the Plan 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 or otherwise.

If you wish an interpretation of the Plan, you should address your request in writing to the Board of Trustees at the Plan 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 payment or on other matters which may be corrected upon an audit or review. **The Board of Trustees reserves the right to make corrections whenever any error and/or overpayment is discovered**.

NO VESTED RIGHTS

Benefits under this Plan are NOT vested. Thus, there is no guaranteed right to receive Plan benefits. The Board of Trustees may amend or otherwise change the Plan at any time including reducing or discontinuing certain or all benefits. Moreover, the Board of Trustees may require new or greater co-payments or other Employee contributions at any time. The Board of Trustees may change the eligibility requirements and any other Plan rules at any time.

IMPORTANT ARTICLES—Potential Loss, Reduction, or Delay in Payment of Benefits

See the Third Party Recovery/Subrogation Article (Article XVI), the Coordination of Benefits Article (Article XVIII) and Potential Loss of Coverage and/or Benefits Article (Article XX).

ONE YEAR TO FILE A LAWSUIT/FILE LAWSUIT IN NORTHERN DISTRICT OF CALIFORNIA/NO PARTICIPATION IN CLASS ACTION LAWSUITS

If a claim for benefits has been denied and you filed an appeal which is also denied or you have a different type of adverse determination, you have one year from the date of the denial of the appeal or the adverse determination to file a lawsuit. **Failure to do so means that you will not be able to file your lawsuit. Any**

such lawsuit has to be filed in federal district court in the Northern District of California. In addition, to minimize potential legal costs, the Plan contains a rule that a Participant is not permitted to join a Class Action lawsuit against the Trustees, the Plan or others associated with the Plan.

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, an 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 people 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 Plan 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 the decision of the Plan Office may appeal against it to the Board of Trustees. An appeal must be submitted in writing to the Plan Office within 180 days of the receipt of the notice of the adverse determination, or all objections to that determination are considered waived.

YOUR DUTY TO NOTIFY THE PLAN OFFICE

- **Important Duty to Notify the Plan Office of Your Address Change.** From time to time, the Plan Office may wish to communicate with You in writing to inform You of any changes in the Plan adopted by the Board of Trustees, or to obtain information related to Your benefits under the Plan or concerning administration of the Plan. **It is Your responsibility to notify the Trust Administrative Office in writing on any change of address.** The Plan and Board of Trustees cannot be held liable for failing to provide written notification if You change Your address and do not notify the Trust Administrative Office in a timely manner.

- **Important Duty to Notify the Plan Office to Preserve your Rights Under COBRA and USERRA.** To preserve your rights under COBRA and USERRA, you must meet certain notification, election, and payment deadline requirements. Under COBRA you or your dependents must inform the Plan Office within 60 days of a divorce, legal separation, or loss of dependent status (for example, your child turns age 26) or termination of domestic partnership with your domestic partner. The Plan Office will notify you of loss of coverage due to a reduction in hours or the expiration of extended coverage under the Plan's self-pay program, and your employer will provide notice for other Qualifying Events (such as the employee's death, termination of employment, reduction in hours, or Medicare becoming the employee's primary coverage). Regardless, you are encouraged to inform the Plan Office of any Qualifying Event to best ensure prompt handling of your COBRA rights.

- **Important Duty to Notify the Plan Office of Your Change in Family Situation for Special Enrollment Rights.** It is your responsibility to notify the Plan Office within thirty days of adding any new dependents by legal marriage, birth, or legal adoption. If you fail to notify the Plan Office within thirty days following the addition of a new dependent, should you subsequently enroll your dependent your dependent's coverage will not become effective until the first of the month after you have applied and provided any necessary documentation to establish their eligibility as a dependent.

I. INTRODUCTION

The Board of Trustees is pleased to provide you with this new Restated Plan Booklet, effective May 1, 2024, which incorporates prior amendments. This Booklet serves as the Summary Plan Description and Plan Document for the U.A. Local 467 Health, Welfare and Vacation Plan ("Plan"). The Plan includes Medical, Prescription Drug, Vision, Dental, and Chemical Dependency benefits through a Self-Funded Trust. Death benefits and Accidental Death and Dismemberment benefits are also provided.

Employer Contribution Rate. **Employers contribute to the Plan the amount required by the collective bargaining agreement for each hour worked by active employees. For the July 1, 2023-June 30, 2024, period, the employer contribution rate under the Collective Bargaining Agreement is $16.00 an hour, which includes a $1.00 an hour contribution to the HRA. (Other classifications provide greater contributions to the HRA.) There are different contribution rates for residential employees, apprentices and other categories.**

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

The Plan Office may respond in writing to your written questions. If you have an important question about your benefits, you should write to the Plan Office at the address below. As a courtesy to you, the Plan Office may respond informally to 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.**

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

You save money by using Network Providers. Several cost- saving features are available. **Failure to use these network providers will result in significantly higher charges to you and the Plan.** If you are contemplating a surgical procedure or a series of medical treatments, you should contact the contact the Plan Office if you have questions.

You are encouraged to use Generic Drugs. Prescription drugs have become an increasingly higher percentage of the total medical care costs incurred by your Plan. The Trustees have attempted to help reduce these costs, while maintaining the current level of benefits, by contracting with a Pharmacy Benefit Manager. **Additional savings may be realized using generic drugs rather than name brands.** You are urged to discuss with your physician using generic drugs if you are not already utilizing them.

CONTACT INFORMATION: **Benefits Website: www.ualocal467benefits.com**

Plan Office Address: **P.O. Box 5057, San Jose, CA 95150-5057**
Phone: (408) 288-4400 or (800) 541-8059 Website: *www.uastpa.com*

Union Office Address: **U.A. Local 467, 1519 Rollins, Burlingame, CA 94010**
(Website: www.ualocal467.org

If your spouse has separate coverage in addition to coverage under this Plan, you should review the Plan's COORDINATION OF BENEFITS rules (Article XVI on page 100). Moreover, if you or a family member is injured in an automobile accident or other type of incident in which a third party is liable, you should review the THIRD PARTY RECOVERY/SUBROGATION rules (Article XVII on page 88). In both situations, the Plan may not cover certain claims.

II. RECENT DEVELOPMENTS AND IMPORTANT INFORMATION

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. **COVID-19 Testing, Diagnostic Services, or Items Coverage.** During the declared period of the public health emergency (through November 11, 2023), the Plan covered charges for the following tests only to detect the SARS-COV-2 or COVID-19 or the diagnosis of the virus that causes COVID-19 (including serological tests a.k.a antibody tests for COVID-19 used to detect antibodies against the SARS-CoV-2 virus, and are intended for use in the diagnosis of the disease or condition of having current or past infection with CARS-COV-2, the virus which causes COVID-19) at no cost (meaning no copayment, deductible, or coinsurance) at both an in-network Provider or non-network Provider facilities:
   - tests approved, cleared, or authorized by the FDA,
   - a test that a test developer intends or has requested FDA authorization for emergency use,
   - a state authorized test and the state has notified the Department of Health and Human Services, and
   - other tests that the Secretary of Health and Human Services determines appropriate in guidance developed during the COVID-19 public health emergency period.

   (See Number 3 on the next page for the current rule.) This COVID-19 coverage extends to any diagnostic services or items provided during a medical visit such as in-person to a doctor's office, urgent care center, or an emergency room that results in an order for an administration of the SARS-COV-2 or COVID-19 testing or screening, but only to the extent such items and services relate to the administration of the test or to the evaluation of the need for a test. Prior authorization is not required for diagnostic services related to SARS-COV-2 or COVID-19 testing.

   Pricing of Out-of-Network Diagnostic Testing. Per Section 3202 of the CARES Act, the Plan or Insurer will pay or reimburse for covered COVID-19 diagnostic tests as follows: (a) an existing negotiated rate if there is one or (b) in the absence of a pre-existing negotiated rate, the cash price listed by the diagnostic test provider on the public internet website of such provider. **The Plan will not pay for the excess amount being charged for out-of-network tests**

2. **Telehealth and Telemedicine Coverage.** During the period of the declared COVD-19 public health emergency, the Plan will cover, subject to current Plan provisions relating to reimbursement of in-network and out-of-network providers, the following virtual services provided by a medical practitioner: (a) telehealth/telemedicine visits (a visit between a medical practitioner and a patient via two-way communication), (b) virtual check-in (a brief 5-10 minute check-in with a medical practitioner via telephone or telecommunication to decide whether an office visit is necessary), and (3) e-visits (a communication between a patient and medical practitioner through an online patient portal). The three (3) foregoing services must be performed consistent with guidelines published by the Centers for Medicare & Medicaid Services (CMS) to be covered (FACT SHEET March 17, 2020).

3. **COVID-19 Vaccination and Preventive Services Coverage.**
The Plan, through its medical providers and pharmacy benefit manager, throughout the duration of the COVID-19 public health emergency (through November 11, 2023), will cover approved COVID-19 vaccinations and immunizations. COVID-19 vaccinations are available to eligible participants and dependents at **no cost whether received in-network or out-of-network** and **without prior authorization** at a doctor's office, medical facilities or governmental health facilities, including participating pharmacies through the Optum RX pharmacy benefit manager.

   Subject to further government guidance, the cost of the vaccine itself will be covered by the federal government but the cost of the administration of the shots will be covered by the Plan. There can be no balanced billing of Participants. But, the Plan will not pay the full amount if obtained outside of the network (only the amount paid through a network facility). After the State of Emergency has ended, the Plan will continue to cover vaccinations in in network facilities.

4. **Venue and Time Period Restrictions For Lawsuits.** Any claim that you, your authorized representative, or your eligible dependent(s) may have related to or arising under the Plan may only be brought in the U.S. District Court for the Northern District of California. No other court is a proper venue or forum for you, your authorized representative, or a dependent's claim. Any such claims have to be filed within one year of a denial of an appeal or other adverse action

5. **Class Action Waiver.** The Plan and the Participants and Dependents agree that all Claims pursued against each other will be on an individual basis. To that end, the Participants and Dependents hereby waive their right to commence, to become a party to, or to remain a participant in, any group, representative, class, collective, or hybrid class/collective action in any court, arbitration proceeding, or any other forum, against the other.

6. **No Lifetime Maximum Benefit.** Pursuant to the Patient Protection and Affordable Care Act (the 2010 health care law), the Plan does not impose any lifetime maximum benefit.

7. **Dependent Child Eligibility.** The rules for Dependent Child Eligibility continue to comply with the Patient Protection and Affordable Care Act. A Dependent Child is eligible for coverage until the last day of the month in which the child attains age 26.

8. **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 may be directed to the Plan Office at 1-408-288-4400. You may also contact the Employee Benefits Security Administration, United States 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.

ARTICLE III. ELIGIBILITY RULES

A. ELIGIBILITY: Active Employees and Dependents (650 Hours in 12 month period)

1. Basic Eligibility Rules (including Hour Bank System): Non-Residential Employees.

When you perform an hour of Covered Employment under a Collective Bargaining Agreement of U.A. Local 467 for which your Employer contributes 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 12-month period. Once you have qualified for benefits, your Plan Hour Bank is charged 130 Hours for one month's coverage. Any excess Hour Bank credit is accumulated, up to three months of coverage (including the current month), to be used when you have had low hours of Covered Employment. (The Eligibility rules for Residential Classification Employees are set forth below in Section C.)

These amounts are set by the Board of Trustees, who have 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 number 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 Plan 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 cutoffs and therefore hours reported are based on ONLY those hours reported by your Employer and not necessarily all hours worked in each calendar month.*

Your eligibility for benefits depends on the continued and timely payment of Employer contributions on your behalf. If your Employer fails to contribute 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 us 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 770 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 contributions for required hours are received, Pat becomes insured on September 1. Coverage for September will "cost" 130 hours. Because of the double skip month eligibility system, Pat will also be charged for October coverage (another 130 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 us say Mike is an established member in good standing of U.A. Local 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 the U.A. Local 467 out-of-work list and must not refuse more than two offers of dispatch in a 12-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 467. After these forms of coverage run out, you may be eligible for COBRA coverage.

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: www.ualocal467benefits.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, if the Plan 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 12 months of self-paid or short-term disability coverage (combined) in a 24-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 24-month period.

b. If you have had 12 months of self-paid or disability coverage in a 24-month period, your Plan coverage will be reinstated if you work 390 hours of covered employment in that 24-month period.

c. If you have had 12 months of self-paid or disability coverage in a 24-month period, but have not performed 390 hours of covered employment in that 24-month period, you may only be reinstated as a new Employee after accumulating a new Hour Bank of 650 hours in a 12-month period. The Plan provides for a double skip month, with May hours providing coverage for August as provided below.

Sufficient Balance in the Qualifying Month of...	Provides Coverage for the Corresponding Month of...
May	August
June	September
July	October
August	November
September	December
October	January
November	February
December	March
January	April
February	May
March	June
April	July

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 (U.A.), or you go into business in the plumbing or pipefitting industry without being signatory to an agreement with a U.A. local union.

B. 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 Plan 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 the Local 467 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 Plan Office. Hours will be reciprocated to your Home Trust Fund within a reasonable period. **Hours cannot be reciprocated retroactively due to benefits already granted.**

C. Eligibility Rules for Residential Classification Employees and Dependents. Each Residential Classification employee covered under this Plan shall have a reserve hours account consisting of covered hours worked (up to a maximum of 450 hours) for individual employers required to make contributions on the employee's behalf under a Collective Bargaining Agreement with U.A. Local 467.

Each Employee covered becomes eligible for Employee and Dependent benefits once they work 450 hours (and the contributions for hours worked were received) within any period of twelve consecutive months or less.

Once eligible, an Employee and his dependents continue to be eligible for benefits so long as he has at least 150 hours in his reserve of hours account also known as an hour bank. The reserve of hours account is charged 150 hours for each calendar month the Employee remains eligible. If the Employee works more than the required 150 hours in any one calendar month, his reserve of hours account is credited with the excess; but if he works less than the required 150 hours, his reserve of hours account is debited by the difference. No Employee shall be credited with more than 450 hours in his reserve of hours account at any one time.

The reserve of hours account of any Employee who accepts employment from any contractor not a party to a Collective Bargaining Agreement with U.A. Local No. 467 or who connives with any employer paying into the Fund less than the full contract rate of contribution for each hour worked by him or her, shall be terminated forthwith and the Employee and dependents shall not again be eligible except upon compliance with the requirements of the Plan hereof for initial eligibility.

1. Termination of Eligibility for Residential Employees. A participant's eligibility under this Plan will terminate at the time of occurrence of any of the following events:

a. At the end of the month in which his or her reserve of hours account falls below 150 hours and he/she is no longer eligible under the continuance of eligibility provisions.
b. On the last day of the month for which any required contribution is not paid.
c. On the day the Plan is terminated.
d. On the day he/she enters full-time active duty in the Armed forces of the United States.

2. Cancellation of Residential Employees' Bank Hours. The reserve of hours account of any participant who accepts employment of any duration in the type of work covered by a Collective Bargaining Agreement from an employer not signatory or otherwise party to any such Agreement or engages in business for his own account without being signatory or otherwise party to such Agreement shall be terminated as of the date of commencement of such employment. The Participant shall not again be eligible for any benefits or for any of the rights incident to eligibility until he/she has ceased such employment and re-established eligibility under the Plan.

A Dependent child's eligibility will terminate when the child reaches the Plan's limiting age or when the Participant's eligibility terminates. Eligibility of the Participant's spouse terminates when his/her eligibility terminates or upon decree of final dissolution of marriage or legal

separation. Termination of eligibility for a Dependent spouse or child(ren) are subject to COBRA continuation coverage rights.

3. Reinstatement of Residential Employee Eligibility Within 12 months. A Participant whose eligibility has been terminated because his bank hours has fallen below 150 hours will be reinstated as of the first day of the calendar month following any calendar month within the next 12 calendar months in which his bank hours have again totaled 150 hours or more.

4. Self-Payment When Unemployed or Hour Bank is Below 150 Hours. A Participant who becomes unemployed and whose reserve of hours account falls below 150 hours may continue to be eligible for benefits as follows:

a. By paying each month into the Fund the amount determined by the Board of Trustees to be just and equitable.
b. The payment is to be made on or before the 20th day of the calendar month following the calendar month in which the Participant's reserve of hours account first fell below 150 hours.

No such Participant may continue his eligibility by such payments unless he/she remains continuously registered for employment on the out of work list of the Local Union and does not refuse more than three offers of dispatch within any period of 12 consecutive calendar months.

D. Dependent Coverage Rules

1. **Dependent Spouse**. A spouse becomes eligible as of the date of marriage, provided the Participant has submitted an updated Enrollment Form adding the spouse along with a certified marriage certificate within 60 days of the date of marriage. You are encouraged to provide proof of your marriage as soon as possible after you marry if you wish to add coverage for your new spouse. (There is no common law marriage in California. The Plan does not recognize common law marriages.)

A former spouse is not eligible for coverage under the Plan, except as required by COBRA. Eligibility and/or coverage terminates effective the last day of the month in which a divorce, legal separation, or annulment is final, subject to COBRA. The Participant is required to notify the Plan of any such change within 30 days of such change.

2. **Dependent Children Eligibility – Up to Age 26 (for children)**. Children include the employee's biological child, stepchildren, foster children, or legally adopted children, and any child for whom the Participant is the Court-appointed legal guardian.

Newborn eligible Dependents will be considered eligible from the date of birth for Benefits under the Plan, provided they are enrolled in the Plan **within 30 days** from the date of birth. Newly acquired Dependents become eligible on the date acquired, provided they are enrolled in the Plan within 30 days after the date the new Dependent is acquired.

NOTICE OF NEW DEPENDENT

Employees must provide written proof to the Fund Office of their legal Dependent for Dependents to be eligible for the benefits of this Plan. For example, a copy of your marriage certificate for a spouse, a copy of a birth certificate for a child, a copy of a decree of adoption for an adopted child and copy of court order showing legal guardianship should be submitted. Nothing in this Section is intended to modify the Plan's coordination of benefit provisions.

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.

Children under the age of 26 who are required to be covered by the Eligible Employee by a Qualified Medical Child Support Order (QMCSO) are also covered under the Plan. See Section 12.15 for the definition of a QMCSO.

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.

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 both the Participant's and Dependent's responsibility to notify the Plan Office immediately when the status of a Spouse, Child or other Dependent changes. This includes divorce/final dissolution of marriage, legal separation, death, a child attaining age 26 and any other events which would make your dependent not eligible for future coverage. If claims are paid for, or premiums are paid on behalf of any Spouse (or former spouse), child or other Dependent and it is later found that the individual was not eligible, you and the Dependent will be responsible for reimbursing the Plan for the amounts paid plus interest, attorney's fees and costs.

E. **<u>FAMILY MEDICAL LEAVE ACT (FMLA) Continuation of Health Coverage</u>:** If your Employer has at least 50 Employees, your Employer may be required to continue to pay for your health coverage on the same terms as if you had continued work, during any approved leave under the Federal Family and Medical Leave Act of 1993 (FMLA). In general, you may qualify for up to 12 weeks of unpaid FMLA leave per year 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 (except if you are requesting a Temporary Emergency Expanded FMLA leave pursuant to the Families First Coronavirus Response Act, as indicated below in Subsection 2.vi. the 1,250 hours requirement does not apply and instead an employee only must be employed for at least 30 calendar days); and

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

(i) Birth of a child and to care for the newborn child within one year of birth.
(ii) Placement of a child for adoption of foster care and to care for the newly placed child within one year of placement.
(iii) Care for your child, spouse or parent with a serious medical (including mental health) condition.
(iv) Your own serious health (including mental health) condition makes you unable to perform the essential functions of your job.
(v) Military Caregiver Leave (up to twenty-six (26) weeks during a 12-month period). 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
(vi) Any other purpose provided for by the FMLA.

A "Serious medical including mental health condition" means if it requires inpatient care, or continuing treatment by a health care provider.

Coverage will not be continued beyond the earlier of:

- Date contributions are not timely made.
- Date your Employer determines your approved FMLA leave is terminated; or
- Date your coverage involved discontinues as to your eligible class.

Details concerning FMLA leave are available from your Employer. If your Employer grants you an approved FMLA leave in accordance with FMLA, you may continue health coverage for you and your eligible dependents provided your Employer maintains the required contributions to the Plan on your behalf or you make any required contributions to the Plan. Requests for FMLA leave must be directed to your Employer. The Plan Office cannot determine whether you qualify.

If your coverage terminates because your approved FMLA leave is deemed terminated by your Employer or you fail to return to work after exhausting your FMLA leave, you may, on the date of such termination, be eligible for COBRA continuation coverage under Federal law, on the same terms as though your employment terminated, other than for gross misconduct, on such date. 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 may refund the corresponding COBRA payments to you. **NOTE:** 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. It is the responsibility of your Employer (not the Plan) to notify you of your rights under FMLA and to approve your request for FMLA leave. It will be your responsibility to notify your Employer that FMLA leave is being taken.

F. Loss of Dependent Coverage. Under the following conditions and subject to COBRA (See page 43 of this booklet), a dependent will not be eligible:

1. Lack of Eligibility. Eligibility of all 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.

G. Reinstatement of Employee Eligibility. An Employee whose eligibility has been terminated because his Reserve of Hours has fallen below 130 hours shall be reinstated as of the first day of the third calendar month following any calendar month within the next 24 calendar months in which his Reserve of Hours has again totaled 130 hours or more, if the Employee has remained continuously on the out-of-work list of U.A. Local 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 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.

H. Subsidized Self-Payment Program for Unemployed Employees (Prior to COBRA). 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 20th day of the calendar month following the calendar month in which the Employee's Reserve of Hours account first fell below 130 hours. The 2024 subsidized monthly premium for unemployed members is $1,584. This amount increases in most years.

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 12 consecutive calendar months.

Continued eligibility under this Section and Section H (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. This 12-month (or other) period reduces the time period available under COBRA (see Article IX beginning on page 45 of this booklet).

If an Employee receives twelve (12) months of coverage under this Section or Section H (Extended Benefits for Total Disability) combined, the Employee must work under a Collective Bargaining Agreement of U.A. Local 467 for a minimum of 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.

I. 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 Plan provisions 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 12 months following termination of eligibility under 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 12 calendar months in any 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 467 for a minimum of 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 H as of the effective date of his retirement. The Participant shall then be entitled to retiree health and welfare coverage under Section I below, if he is eligible, as of the effective date of his retirement.

J. 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 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 for each signatory company**.

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 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 an application for coverage on or before the 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 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 6 equal monthly installments or in one lump sum. The first payment of the 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 15th day of each of the 5 consecutive months thereafter remaining. Upon punctual completion of the full 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 Section J.

5. Coverage of an Employer who is in default of any monthly payment required by these rules and/or by his Collective Bargaining Agreement with U.A. Local 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 may continue coverage through application of their Reserve Hour accounts, if any, if the Employer is party to a current Collective Bargaining Agreement with U.A. Local 467 and is current with all the contributions required thereunder.

6. If an 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 only by filing an application with the Plan 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 Employer, and his or her eligible dependents, may remain eligible for coverage after retirement if the Employer had been continuously covered under the Plan for at least 120 months immediately prior to retirement, and was at least 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), Subsection 7.

9. If an Employer notifies the Plan Office of its intent to terminate coverage of all individuals under this Section, the 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 12th month after the Plan 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 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.

IV. MEDICAL BENEFITS and SCHEDULE OF BENEFITS

A. Two Medical Benefit Options and other Types of Benefits (Non-Residential Employees)

The Plan offers two medical benefit options for **non-residential classification employees.** The options currently offered to active Employees and to retirees who are not eligible for Medicare are the self-funded **Preferred Provider Organization Plan (PPO Plan) operated through Anthem 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 uses Anthem Blue Cross of California (Blue Cross or Anthem 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. **NOTE: Residential employees do not have access to the Blue Cross benefits. Residential employees are required to enroll in the Kaiser Foundation HMO.**

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 Navitus Pharmaceutical Service, and their vision care benefits through Vision Service Plan (VSP). Kaiser members have the option of having VSP benefits.

Coverage: Out-of-State Retirees under Age 65. Out-of-state retirees who are under age 65 may participate in the Blue Cross Preferred Provider Option in the same manner as in-state Participants have such rights.

B. Deductible, Benefit Payment Rates Under the PPO Plan: 90% for PPO Providers.

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 receives 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. BENEFIT TABLE FOR SELF FUNDED PLAN (Anthem Blue Cross PPO)

https://www.anthem.com/ca/find-care/

INPATIENT BENEFITS **PARTICIPANT PAYS:**

GENERAL CHARGES

Office Visit Copayment	**None.**
Annual Deductible	**$50 person/$150 family per calendar 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 more than the applicable contracted PPO rates.

Please see the Exclusions in Section P on pages 32-36 below.

There Is No Annual or Lifetime Maximum

ANTHEM BLUECROSS NURSE LINE
(866-670-1565)

24/7 Nurseline provides access to a registered nurse over the phone for assistance or just to hear a reassuring voice at no charge to you. The Nurse can help you decide how to handle a medical issue. Can the problem be treated at home? Do you need to see your doctor? Or should you head to the emergency room? Making the right call can help you avoid unnecessary worry and expense. The 24/7 Nurseline program phone number is (866)-670-1565. If you speak Spanish or another language other than English, bilingual nurses and translators are on call. If you have difficulty hearing or speaking, TTY/TDD services are available. This 24/7 Nurseline program provides:

- **A skill clinical team – RN license**
- **Bilingual RN's language line & hearing-impaired services**
- **Immediate physician support, as needed**
- **Personal health counseling**
- **Comprehensive Audiotape Library**

THE ANTHEM BLUE CROSS CHART BEGINS ON THE NEXT PAGE

SPECIFIC CHARGES **ANTHEM BLUE CROSS**

Subject to the $50.00 annual deductible. NOTE the exclusions in Section P below on pages 32-36.

	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
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 " " "

[2] UCR, which means "Usual, Customary, and Reasonable" is defined on page 19 of this booklet.

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 year 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)

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D. Stop-Loss Benefits

Stop-Loss Benefits are benefits paid by the Plan, more than 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. **You are encouraged to use Preferred Providers, which saves you money as well as the Plan**. 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.

E. 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

[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.

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 are 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 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.

F. Special Benefit Rates: Anesthesiologist, Radiologist, or Assistant Surgery (in PPO Facility)

If a covered person is receiving care in a PPO hospital, and his or her 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.**

G. Usual, Customary, and Reasonable (UCR)

For providers who are Participants in the Plan's 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 considering all circumstances.

H. Medically Necessary Services and Supplies

The Plan only recognizes charges for services and supplies which are "Medically Necessary" or provided due to Medical Necessity if the service and supply is determined by the Plan to be:

1. Appropriate and necessary for the symptoms, diagnosis, or treatment of an illness, injury, or c condition; and
2. Not experimental, educational or investigation; and
3. Not primarily for your convenience or the convenience of your physician or other provider; and
4. Within the standards of generally accepted medical practice and professionally recognized standards within the organized medical community in California; and
5. The most appropriate supply or level of service which can safely be provided; and
6. When applied to hospitalization, the symptoms or condition cannot safely and adequately be treated on an outpatient basis; and
7. The fact that a physician or other medical provider may prescribe, order, recommend or approve a service does not of itself make such a service or supply Medically Necessary, even though it is not specifically listed as an exclusion.

THE USE OF THE PREFERRED PROVIDER HOSPITALS and CONTRACT DOCTORS WILL REDUCE YOUR OUT-OF-POCKET EXPENSES

I. 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.

J. Covered Convalescent Nursing Home Charges

1. Charges by a convalescent nursing home subject to 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.

K. 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.

L. Hearing Aid Benefits.

1. Charges made for treatment of hearing loss or related conditions, including the following charges, **no more than once in a 24-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 24-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 year over a five-year period.**

M. 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.

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. 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 for Limited Period.** 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, legal eligible spouses, and eligible dependent children up to age 26 will be paid on the same basis as any other disability or sickness.

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.

14. **Alcohol and Drug Abuse: Residential Treatment Program: Beat it!** Charges incurred by a Participant or eligible dependent at a licensed residential drug treatment program that is contracted with Beat It! are covered under the Plan the same as any other medical benefit. The Board of Trustees has approved using the Beat It! Employee Assistance Benefits Program. Beat It! is a specialty program for the treatment of problems with alcohol and/or drug abuse. Benefits include 28-day inpatient treatment in a pre-approved facility or an outpatient counseling program with a pre-approved counselor.

PLEASE NOTE if you choose to seek treatment at a non-Beat It! Contracted facility, you must have Trustee approval **prior** to rendering the services.

The Beat-It! phone number should be used for direct connection to the alcohol and drug abuse treatment counselors: 408-436-2392 or 800-828-3939. Counselors will assist you with pre-treatment counseling and planning for care. **CALLS AND INFORMATION ARE CONFIDENTIAL.**

15. **Chiropractic and Acupuncture Limitations.** Charges incurred for 24 covered chiropractic and acupuncture treatments.

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

17. **Transgender Services.** Procedures or treatments for transgender services determined to be medically necessary by a licensed physician are covered.

18. **Contraceptive Coverage.** Coverage without cost-sharing of at least one form of contraception, as prescribed, in each of the methods (currently 18 methods) that the Food and Drug Administration ("FDA") has identified for men and women it its current Birth Control Guide, including the clinical services, patient education, and counseling needed for provision of the contraceptive method will be covered under the Plan. FDA-approved contraceptive methods prescribed by a licensed physician include:

- Barrier methods, like diaphragms and sponges.
- Hormonal methods, like birth control pills and vaginal rings.
- Implanted Device, such as an intrauterine device (IUD).
- Female and male condoms.
- Shot/Injection.
- Emergency contraception.

- Sterilization procedures; and
- Patient education and counseling.
- For a full list of the current FDA approved methods, visit **https://www.fda.gov/consumers/free-publications-women/birth-control.**

Reasonable Medical Management Techniques. Within each method, the Plan is permitted to use Reasonable Medical Management techniques to impose any cost-sharing on some items and services, to encourage individuals to use other specific items and services within the chosen contraceptive method. For example, the Plan may discourage use of brand name pharmacy items over generic pharmacy items or the use of one of the several FDA-approved intrauterine devices with progestin through the imposition of cost-sharing.

Exception Process. An exception will be made if an individual's health care provider has determined that a particular service or FDA-approved item, for which there is cost-sharing is medically necessary, then the Plan may accommodate the individual and waive the otherwise applicable cost-sharing for that service or item. When making the exception, the Plan or its delegates will make a determination of the claim according to the timeframe and nature of the claim per the Plan's claim procedure and will also consider the medical exigencies involved for a claim involving urgent care. Medical necessity may include considerations such as the severity of side effects, differences in permanence and reversibility of contraceptives, and ability to adhere to the appropriate use of the item or service, as determined by the attending licensed provider.

19. THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT. Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean delivery.

Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not more than 48 hours (or 96 hours). Also, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). Furthermore, plans and insurers may not set levels of benefit or out-of-pocket costs so that any portion of the 48-hour (or 96-hour as applicable) stay is treated in a manner that is less favorable to the mother or newborn than any earlier portion of the stay.

20. THE WOMEN'S HEALTH AND CANCER RIGHTS ACT. Your health plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services for eligible participants and dependents. This coverage will be provided in a manner determined in consultation with the attending physician and the patient, including:

a. All stages of reconstruction of the breast on which the mastectomy was performed (including coverage for nipple and areola reconstruction, nipple and areola repigmentation to restore the physical appearance of the breast, as a required stage of reconstruction).
b. Surgery and reconstruction to achieve symmetry between the breasts.
c. Prostheses, and
d. Physical complications resulting from all stages of a mastectomy (including lymphedema).

21. AUTISM SPECTRUM DISORDER. Charges for the diagnosis and treatment of medically necessary autism spectrum disorder including the evaluation or treatment of learning disabilities and minimal brain dysfunction, developmental learning and communication disorder, are covered when prescribed, provided or ordered by a certified or licensed health care professional. Benefits may include but are not limited to outpatient services such as psychotherapy, physical therapy, Applied Behavior Analysis (ABA Therapy) as well as inpatient treatment if medically necessary. Autism Spectrum Disorder includes any of the pervasive development disorders as defined in the most recent edition of the Diagnostic and Statis manual of mental disorders published by the American Psychiatric Association (such as autism, autistic disorder, Asperger syndrome and pervasive development disorder not otherwise specified (PDD-NOS).

When prescribed, provided or order by a licensed health care professional who determines the care to be medically necessary, treatment includes habilitative or rehabilitative, residential treatment, inpatient treatment, pharmacy benefits, psychiatric & psychological, intensive outpatient treatment and outpatient treatment

Benefits for autism are payable the same as any other covered illness under the Plan rules. No annual or lifetime dollar visit limits apply to the diagnosis and treatment of autism spectrum disorder.

22. EMERGENCY SERVICES means, with respect to an Emergency Medical Condition:

a. A medical screening examination (as required under Section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital or an independent freestanding emergency department, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and pre-stabilization services and treatment to stabilize an individual (regardless of the department of the hospital in which such examination or treatment is furnished), and
b. Such further medical examination and treatment (for emergency services furnished by a Non-preferred provider or Non-preferred emergency facility regardless of the department of the hospital in which such items or services are furnished), to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient also include post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

    1. The provider or facility determines that the participant or dependent is able to travel using nonmedical transportation or nonemergency medical transportation; or

    2. The participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Non-Contract provider with respect to the Plan, of the estimated charges for the treatment and any advance limitations that the Plan may put on such treatment, of the names of any Contract providers at the facility who are able to treat you, and that you may elect to be referred to one of the Contract providers listed; and

    3. The participant or dependent gives informed consent to continue treatment by the non-contract provider, acknowledging that the participant or dependent understands that continued treatment by the Non-Contract provider may result in greater cost to the participant or dependent.

The emergency of a hospital also includes an independent freestanding emergency department.

If you require Emergency Care as defined above and use the services of a non-PPO Hospital emergency facility or comparable facility, no additional Hospital deductible or reduction of benefits will apply to you. However, if you use the services of a non-PPO Hospital emergency facility or comparable facility and the condition for which you received treatment did not require Emergency Care (that is non-life threatening), an additional $150 Hospital deductible and reduction of benefits will apply. The following benefits are payable from the Plan when you obtain services in an emergency facility:

c. Emergency Services (as defined above) will be covered:

1. without prior authorization regardless of whether received in-network or out-of-network,
2. without regard as to whether the provider furnishing the emergency service is a contract provider or a contract emergency facility, as applicable, with respect to the services,
3. without conditions such as denials based on final diagnosis codes,
4. without regard to any other term or condition of the plan or health insurance coverage other than the exclusion or coordination of benefits, any permissible waiting periods, or applicable cost -sharing requirements,
5. without administrative requirements or limitations that are more restrictive than those applied to in-network emergency services and facilities,
6. any cost-sharing for out-of-network emergency items and services will not be greater than the in-network emergency services and facility,
7. any cost-sharing payments made by the participant or dependent will count towards the Plan's applicable deductible and out-of-pocket maximums as if the items and services were provided by a participating provider or participating emergency facility.

23. NON-EMERGENCY SERVICES: PROVIDER AT IN-NETWORK FACILITY

a. Medically necessary Non-Emergency items, services and visits that are otherwise covered by the Plan (which may include equipment, devices, telemedicine, imaging services, lab work, preoperative and postoperative services) performed by Non-contract providers at In-network facilities (for which the participant of dependent has not knowingly and voluntarily provided consent pursuant to the No Surprises Act patient consent and notice requirements) are covered by the Plan as follows:

1. Cost-sharing will not be greater than the in-network cost sharing amount that would apply if the non-emergency items and services had been provided by a contract provider.

2. Any cost-sharing payments made by the participant or dependent will count towards, if any, the Plan's applicable deductible and out-of-pocket maximums as if the non-emergency items and services were provided by a contract provider, and

3. Non-emergency Health Care Facilities include hospitals (as defined in the Social Security Act Section 1861(e)), hospital outpatient department, critical access hospitals (as defined in the Social Security Act section 1861(mm)(l) and ambulatory surgical centers (as defined in the Social Security Act Section 1833(i)(1)(A)).

b. Participants and dependent can knowingly and voluntarily agree to be balance billed including waiving the protections that limit cost-sharing for **Certain Non-emergency services** and **post-**

stabilization services provided the following informed Patient consent and Notice requirements under CAA Section 2799B-2(d) are met:

1. Notice and consent must be provided together and be physically separate from any other documents by the Provider/Facility.

2. Must be provided at least 72 hours prior to the scheduled appointment, or if same day no later than 3 hours prior to appointment.

3. Notice and consent must list the provider's name, good faith estimate for items or services reasonably expected to be provided, statement that patient is not required to consent (and may instead seek care from an available participating provider/facility and in-network cost sharing will apply in such cases), and must be available in 15 most common languages in the geographic region; and

4. A copy of signed consent must be provided to the patient (via in-person or through mail or email) in the method selected by patient.

c. However, providers/facilities **cannot** ask participants and dependent to give up protections not to be balance billed for:

1. Emergency services.
2. Air ambulance services.
3. Ancillary services at in-network hospital or ambulatory surgical center, such as emergency medicine, anesthesiology, pathology, radiology, neonatology, assistant surgeon care, hospitalist, intensivists and diagnostic care such as radiology and lab work; and
4. Non-emergency services, if no in-network provider is available or unforeseen urgent medical need or provider furnishes ancillary services that the patient typically does not select.

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

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

It is the intention of the Board of Trustees and the contracted insurers (Kaiser and Anthem Blue Cross) that the Plan's benefits be provided in compliance with the requirements of MHPAEA and lawful regulations issued thereunder. For more information on MHPAEA,

please visit the Department of Labor website at ***www.dol.gov/ebsa/mentalhealthparity/***. Refer to the EOC booklets provided to you by Kaiser or Anthem Blue Cross for a complete description of the mental health/substance use benefits available to you.

O. COVID-19 VACCINE AND RELATED COVERAGE

Effective November 12, 2023 (unless subject to change by law or subsequent government guidance), COVID-19 vaccinations will be covered at no-cost only for those **received in-network** (through Kaiser and Anthem Blue Cross) but COVID-19 vaccinations received out-of-network will either not be covered or will be subject to an applicable cost-sharing pursuant to the medical option policy (Kaiser or Anthem Blue Cross) you are enrolled in.

P. EXCLUSIONS: Charges Not Covered

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.

Experimental and/or Investigational means a service or supply that has been deemed as such by the Plan Administrator. The Plan Administrator or its designee has the discretion and authority to determine if a medical, surgical, diagnostic, psychiatric, substance abuse or other health care service, technology, supply, treatment, procedure, drug therapy or device is or should be classified as "Experimental" and/or "Investigational." A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan Administrator or its designee, based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for precertification under the Plan's Prior Authorization/Utilization Management program, any of the following conditions were present with respect to one or more essential provisions of the service or supply:

(a) The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law.

(b) In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical or scientific literature on the subject, or a preponderance of such literature published in the United States and written by experts in the field; that shows that recognized medical or scientific experts classify the service or supply as Experimental and/or Investigational or indicate that more research is required before the service or supply could be classified as equally or more effective than

conventional therapies.

Authoritative peer reviewed medical or scientific writings that will be considered include the following publications or sources of publications:

(i) "United States Pharmacopeia Dispensing Information;"
(ii) "American Hospital Formulary Service;"
(iii) "American Medical Association (AMA), Drug Evaluations" and "The Diagnostic and Therapeutic Technology Assessment (DATTA) Program," or similar publications of the AMA.
(iv) specialty organizations recognized by the AMA.
(v) the National Institutes of Health (NIH).
(vi) the Center for Disease Control (CDC).
(vii) the Agency for Health Care Policy and Research (AHCPR).
(viii) Opinions of other agency review organization, e.g., ECRI Health Technology Assessment Information Service or HAYES New Technology Summaries.
(ix) the American Dental Association (ADA), with respect to dental services or supplies; and
(x) the latest edition of "The Medicare Coverage Issues Manual."

(c) With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will not be considered Experimental and/or Investigational if it is approved by the FDA as an "investigational new drug for treatment use"; or classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease" as that term is defined in FDA regulations; or approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.

(d) prescribed service or supply is available to the Covered Individual only through participation in Phase I or Phase II clinical trials; or Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

5. **Outside the United States—More than 60 Days**. 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 Not Covered**. Charges associated with the following procedures or services:

- Radial Keratotomy
- Lasi~~k~~ 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 unless determined to be medically necessary by a licensed physician
- Temporomandibular Joint Syndrome (TMJ)

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

9. **Claims Resulting from the Commission of a 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 or participation in a riot or insurrection will be determined by the Board of Trustees in its sole discretion and may include circumstances in which no criminal charges have been brought**. A conviction is not required for the Board of Trustees to determine that this exclusion applies. The Board of Trustees may reasonably conclude that a crime occurred even though there is no charge or conviction.**

10. **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.

11. **Not Medically Necessary**. Services or supplies that are not Medically Necessary as defined in the Plan's Definitions and Experimental or Investigative procedures.

12. **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.

13. **Excess of UCR**. Any amounts more than the Usual, Customary and Reasonable allowance for professional services of non- Prudent Buyer Network providers.

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

15. **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.

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

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

18. **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.

19. **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.

20. **Could Have Been Performed on an 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.

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

22. **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 this 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.

23. **Obesity**. Services primarily for weight reduction or treatment of obesity. This exclusion will not apply to surgical treatment of obesity if: Surgical treatment of obesity is necessary to treat another life-threatening condition involving obesity; and it has been documented that non-surgical treatments of obesity have failed.

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

O. 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: Navitus is the Pharmacy Benefit Manager (PBM). The Plan has contracted with Navitus, the Plan's Pharmacy Benefit Manager, except Kaiser members who receive their prescription drugs through Kaiser. See pages 53-56 for a summary of the prescription drug program.

2. Death Benefits. The Plan provides certain death benefits for Participants, spouses, and eligible dependent children, as well as accidental death and dismemberment insurance for Participants only. The summary of these benefits is on pages 69-71.

3. Dental Benefits-Delta Dental Plan of California. The Plan 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 is on pages 56-65.

4. Vision Benefits-Vision Service Plan (VSP). The Plan 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 65-69.

V. KAISER OPTIONAL HMO COVERAGE AND BENEFITS

(Mandatory Coverage for Residential Classification Employees)

The Board of Trustees has decided 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 employees working in a Residential Employee Classification, the Kaiser HMO Plan is the only available option. (Thus, the Self-Funded Health and Welfare Plan through Anthem Blue Cross does not apply to Residential employees.)** 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 Plan Office. The Kaiser Group Numbers are: 8052 for Actives and Retirees. Group 937 for Residential employees.

To elect coverage through Kaiser, you must complete a Plan election card and the Kaiser HMO enrollment packet. You may elect Kaiser 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 next year. If you do not actively enroll in Kaiser, you will

automatically be enrolled in the PPO Plan or, if you are retired and eligible for Medicare, the Medicare Supplemental Plan. Electing Kaiser 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.

THE KAISER SUMMARY BEGINS ON THE NEXT PAGE

KAISER SUMMARY

A. Summary of Benefits.

Out-of-Pocket Maximum(s) and Deductible(s)

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Amounts Per Accumulation Period	**Self-Only Coverage** (a Family of one Member)	**Family Coverage** Each Member in a Family of two or more Members	**Family Coverage** Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$1,500	$1,500	$3,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$20 per visit
Most Physician Specialist Visits	$20 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling and consultations	No charge
Scheduled prenatal care exams	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	$20 per visit
Most physical, occupational, and speech therapy	$20 per visit

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$20 per procedure
Allergy injections (including allergy serum)	$3 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests (DiagnosticTests)	No charge
Covered individual health education counseling	No charge
Covered health education programs	No charge
Facility fee (e.g. ambulatory surgery center)	$20 per procedure
Physician/surgeon fees	No charge

Hospitalization Services	**You Pay**
Hospital Stay (including pregnancy)	$100 / admission/ No charge physician

Emergency Health Coverage	**You Pay**
Emergency Department visits	$50 per visit/$20 for Urgent Care

Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

Ambulance Services	**You Pay**
Ambulance Services	$50 per trip/$50 per visit

Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy or through our mail-order service	$10 for up to a 100-day supply
Most brand-name items at Plan Pharmacy or through our mail-order service	$25 for up to a 100-day supply

Prescription Drug Coverage	**You Pay**
Most specialty items at a Plan Pharmacy	$25 for up to a 30-day supply

Durable Medical Equipment (DME)	**You Pay**
DME items as described in the *EOC*	No charge

Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	Inpatient services $100 admission
Individual outpatient mental health evaluation and treatment	$20 per visit
Group outpatient mental health treatment	$10 per visit

Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	$200 per day
Individual outpatient substance use disorder evaluation and treatment	$20 per visit
Group outpatient substance use disorder treatment	$5 for other services

Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge

Other	**You Pay**
Hearing aid(s) every 36 months	Amount in excess of $1,000 Allowance per aid
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the *EOC*	No charge
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *Evidence of Coverage (EOC)*. The Plan provides all benefits required by law.

VI. 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) at any age, 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 Part B premiums each year. The basic 2024 Medicare Part B Premium is $174.70. This amount changes 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 UCR portion of excess charges not covered by Medicare for Hospital services and Medicare-qualified Skilled Nursing Facilities expenses, excluding private room charges more than semiprivate level.

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 Licensed 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.

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.

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

VII. FILING A CLAIM FOR BENEFITS

A. Claim Requirements

1. **General Claims.** A signed claim form is necessary 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. 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. An authorized representative may submit a claim on behalf of the claimant.

d. For 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—Immediate (Do not wait/12-month Period).** 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 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 Plan 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. **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 Plan 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.

B. Where to File a Claim. Claim forms are available from the Plan Office or the Union Office. Claim form should be sent to the Plan Office at the address below:

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

VIII. RETIREE COVERAGE

A. Retiree Eligibility (Coverage for 44 out of 48 months immediately before retirement, 10 years of Benefit Credit under the U.A. 467 Defined Benefit Pension Plan, among other requirements)

1. To be eligible for benefits upon retirement, a retiree must satisfy the following requirements:

(a) The retiree must be qualified to receive and be receiving retirement benefits from the U.A. Local 467 Defined Benefit Pension Plan.

(b) The retiree must have qualified for health and 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 **44 out of the 48-months immediately** preceding the month of retirement;

(c) Pursuant to the bargaining parties in their settlor role, the retiree must be a member in good standing in U.A. Local 467 as of his retirement (and continue such membership); and

(d) The retiree must have accrued at least 10 years of Benefit Credit in the U. A. Local 467 Defined Benefit Pension 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 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.

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 the cost of coverage for retiree benefits. Retirees eligible for coverage are required to pay a monthly premium to the Plan based on the Medicare status of the retiree and other eligible enrolled Dependents as determined by the Board of Trustees. The due date for your self-payment is the 20th of the month (received by U.A. Local 467 by that date).

If the Participant is permanently and totally disabled prior to age 65 entitling him to a disability pension benefit under the U.A. Local 467 Defined Benefit Pension Plan and has earned at least 25 Benefit Credits under the U.A. Local 467 Defined Benefit Pension Plan and not have performed any work for a non-signatory employer in the Plumbing and Pipefitting Industry (also known as the Pipe Trades Industry), he or she would be eligible for coverage under the Plan's Medicare Advantage Plan.

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 Plan 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.**

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.

B. MEDICARE COORDINATION--YOU ARE REQUIRED TO ENROLL.

1. **Summary of Medicare.** Medicare is our country's federal health insurance program for people who worked at least 10 years in Medicare Covered employment who are age 65 or older, for people under age 65 with certain disabilities, and for people of any age who have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). If you are receiving Social Security Disability Income (SSDI) benefits, you generally become eligible for Medicare coverage 24 months after your SSDI benefits begin. If you are not a citizen or permanent U.S. resident, you may not qualify for Medicare. **If you or your Spouse becomes eligible for Medicare, you should carefully read this section. It will tell you what your obligations are concerning enrolling in Medicare Part A and B, how the Plan pays when you are eligible for Medicare, and other important information you need to know.**

Medicare has four parts:

- **Medicare Part A** – **Hospital Insurance**. Part A covers inpatient care and certain skilled nursing facilities. Generally, there is no monthly premium, but there are annual deductibles and co-insurance/co-payments after certain lengths of stay.
- **Medicare Part B** – **Medical Insurance**. Part B covers medical and doctor services, outpatient hospital care and other services. Part B requires payment of a monthly premium, as well as deductibles and co-insurance/co-payments. The member pays an annual deductible and 20% coinsurance. Members continue to pay the Part B premium monthly out of their Social Security check.
  You should enroll in Part B when first eligible to avoid a financial penalty and a potential delay in your enrollment.

- **Medicare Part C** – **Medicare Advantage Plans**. Health plan options approved by Medicare and administered by private companies.
- **Medicare Part D** – **Prescription Drug Coverage**. Provided through plans run by insurance companies or other private companies approved by Medicare. There are monthly premiums, deductibles and co-insurance/co-payments.

If a person declines Part B when first eligible, the cost of enrolling in Part B later may be increased by 10% for each full 12-month period that they should have had Part B. The Part B penalty can be waived if a person is still actively employed, or their spouse is actively employed, and the person has health insurance coverage under an employer/union group health care plan. Contact the Administrator for more information.

Medicare Part A is financed by payroll taxes, and, if you are eligible to receive it based on your own or your spouse's employment, you do not pay a premium. Medicare Part B is partly financed by monthly premiums paid by individuals enrolled for Part B coverage. Most people are entitled to Part A when they turn age 65 and pay no premium because they or a spouse paid Medicare taxes while working.

The Plan coordinates benefits with Medicare as if you are covered under both Medicare Part A (hospital benefits) such as hospital inpatient care and skilled nursing facilities (but not custodial or long-term care) and Part B (medical benefits such as medical and doctor services, outpatient hospital care and other services). This means you must enroll in **both Medicare Part A and Part B** as soon as you are eligible for Medicare. If you do not enroll in Medicare (Part A and Part B), the Plan will not make up for the portion of expenses that Medicare would have paid, and you will be required to pay an additional Retiree Health and Welfare Premium.

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

IMPORTANT NOTICE: ENROLL IN MEDICARE

To be eligible for Retiree Health and Welfare benefits under this Plan you and/or your eligible Dependent(s) are required to enroll in both Medicare Parts A and B and pay the required premium (for part B) as soon as you and/or your eligible Dependent(s) are entitled to coverage. ***Note: Because Medicare benefits are assigned to your medical plan, you and/or your eligible Dependents can only enroll in one HMO Medicare Plan.***

It is important that you enroll in Medicare Part B when you first become eligible. If you do not, Medicare generally imposes penalties which will significantly increase your Part B premium once you do enroll. The cost of Medicare Part B premium will go up 10% for each full 12-month period an individual was eligible for Medicare Part B during the initial enrollment period but did not enroll. If you did not enroll when first eligible, and later choose to enroll, you must wait until the next Medicare Part B open enrollment period, which is January 1 through March 31 of each year. Your Medicare Part B will be effective on July 1 of the year you enroll. **For enrollment and eligibility information, you should call Social Security at (800) 772-1213. You can also find Medicare information on the Internet at www.medicare.gov.**

To avoid loss of protection, you (or your Dependents) must enroll for Parts A and B of the Federal program during the **three months** before the month in which you (or your Dependents) will become eligible for Medicare. Social Security will automatically enroll you in Medicare Parts A and B. If you have not received your Medicare Card within 2 months of your Medicare eligibility, you should contact the Social Security Administration. **Please remember that if you and/or your Dependent are under age 65 but eligible for Medicare, you and/or your Dependent must also enroll for Parts A and B.**

EXAMPLE: Below is an example of why it is important for Medicare-eligible individuals to enroll in Medicare Part B coverage.

Assume Bob, a Medicare-eligible Retiree, requires a medical service and most physicians charge $150.00 for it. Assume that Medicare's allowed amount for the services is $100.00, that Medicare would pay 80% of the allowed amount and that the Plan would pay the 20% co-insurance. If Bob is enrolled in Medicare Part B, and has satisfied the Part B deductible, the Plan would pay $20.00 because Medicare would have paid $80.00, and the claim would be considered paid in full. However, if Bob is eligible for but not enrolled in Medicare Part B, then the Plan will still pay $20.00, and Medicare will pay nothing. Consequently, Bob is responsible for $130.00 ($150.00 minus $20.00 paid by the Plan).

Effective January 1, 2006, Medicare eligible individuals were given the option of enrolling in the Medicare Part D prescription drug program. Prescription drug coverage in the Plan is not affected by the Medicare Part D prescription drug program and **it is not necessary for you to enroll in Medicare Part D**. The prescription drug benefits you currently receive under this Plan provide better coverage, at less cost to you, than the new drug program under Medicare Part D. As long as you are eligible for a prescription drug plan that has coverage that is equal to or better than what is offered under Medicare Part D, you are considered to have "Creditable Coverage"; therefore, if at some later date you choose to enroll in Medicare Part D, you will not be charged a late penalty for delayed enrollment.

3. Retirees who work part-time or full-time for a contributing employer are not entitled to pay a subsidized premium for retiree coverage under the Plan. Similarly, retirees who work for an approved government agency in which members of U.A. Local 467 perform work in the Pipe Trades Industry are also not eligible to pay a subsidized premium for retiree coverage under the Plan. Instead, both categories of employees are required to pay the full premium to the Plan for coverage while in retirement as determined by the Board of Trustees. Individuals who work or have previously worked for a non-contributing employer in the Pipe Trades Industry are not eligible to participate in the Plan as a retiree.

Any Participant who has incorrectly paid a premium at a subsidized or reduced rate but who should have been paying at the full rate or other rate shall be required to reimburse the Plan for the additional premiums that should have been paid. The Plan has the right to reduce and/or offset any amount owed by the Participant against any claims that the Plan would otherwise pay on the Participant's behalf.

4. 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.

5. 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 467 Defined Benefit Pension Plan, and the retiree has informed the Plan 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 Plan 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 467 Defined Benefit Pension Plan.

6. 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.

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

a. 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 467 Defined Benefit Pension Plan,

b. 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,

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

d. 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 467, or

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

8. Surviving Spouses, Dependents of Deceased Employees and Retirees

a. 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 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.

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

(i) 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.

(ii) 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.

(iii) Eligibility of the spouse and dependents shall terminate upon the spouse's remarriage.

(iv) 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

(v) 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 Plan Office for such verification.

ALERT: YOUR RETIREE BENEFITS MAY BE SUSPENDED IN CERTAIN SITUATIONS

If your pension is 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 Plan Office. In that situation, your benefits will recommence when your other coverage ends, but only if there has been no lapse in your retiree welfare payments to the Plan 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 any premium, or other conditions of retiree coverage, 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).

ARTICLE VIII. COBRA: CONTINATION OF COVERAGE

A. CONTINUATION OF COVERAGE - COBRA COVERAGE

A federal law, known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that the Plan offer covered Employees and their Dependents the opportunity to elect to pay for a temporary extension of health coverage (called COBRA Continuation Coverage) in certain instances (called qualifying events) where coverage under the Plan would otherwise end (time periods-18, 29 or 36 months--are set forth below). To receive this continuation coverage, the Employee, spouse and/or Dependent(s) must make timely monthly payments to the Plan. The 2023 COBRA monthly premium rate is $2,590 for Core benefits and $2,765 for full benefits. These rates increase in most if not all years.

When a Participant no longer has sufficient hours in his/her Reserve Hour Bank, the COBRA coverage will run concurrently with any continuation of coverage described in this booklet. In other words, the COBRA eligibility period is reduced by the number of months of free or subsidized coverage.

To maintain continued coverage, a Participant whose coverage has terminated because of a qualifying event (see Section B below) may elect to continue coverage as set forth below. Even if the Participant does not elect COBRA continuation coverage, your Spouse and each eligible Dependent have a separate right to elect it. (Moreover, a former spouse has a right to elect COBRA after a marital dissolution or legal separation.)

1. **CONTINUED COVERAGE** - Continued coverage means a Covered Person's coverage that the Covered Person keeps in force because of COBRA. The Covered Person's continued coverage options include:

a. FULL COVERAGE: provides coverage for medical and prescription drug coverage only, or
b. FULL AND NON-CORE COVERAGE: provides coverage for medical and prescription drug coverage but also for dental and vision.

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

B. QUALIFYING EVENTS - Continued coverage is required if one of the following qualifying events results in the Covered Person's coverage ending:

a. the Employee's death.
b. the termination of employment (including retirement) for a reason other than gross misconduct.
c. reduction of the Employee's work hours.
d. divorce or legal separation from your spouse.
e. becoming entitled to benefits under Medicare; or
f. a Dependent child ceasing to be eligible as a Dependent under this Plan (no longer meets the definition of a dependent, such as reaching age 26).

C. NOTIFICATION REQUIREMENTS - The Plan Office will provide you with COBRA coverage and enrollment information within 45 days of receiving written notification of a qualifying event entitling you and/or your Dependent(s) to COBRA coverage. This will include your right to continued coverage, the amount that shall be paid each month to continue the coverage and how, when, and to whom the monthly payments shall be made. You and your Dependent(s) must elect COBRA coverage within 60 days after your Plan coverage ends or the date you receive the election form, whichever is later. **Anyone electing COBRA coverage must pay for the COBRA coverage retroactive to the date he or she lost coverage under the Plan. Thus, the first payment will be for a much larger amount in most situations.** After the initial payment of the first premium, there is a 30-day grace period for making future COBRA payments. No benefit claim will be honored by the Plan Office (or Kaiser) unless the required COBRA premium payment is received.

You have the obligation to inform the Plan Office of a change in family status within 60 days after it occurs, such as a divorce or legal separation from your spouse or a child ceasing to be eligible as a Dependent under the Plan. Once you notify the Plan of a qualifying event, the Plan Office will notify you, within 14 days of your right to continued coverage, the amount that shall be paid each month to continue the coverage and how, when, and to whom the monthly payments shall be made.

Failure to give timely notification will end your eligibility for continued coverage due to the change in family status.

Notice that is given to a Covered Person's spouse (or former spouse) is deemed to be given to each child who lives with the spouse and whose coverage would end due to the same qualifying event.

D. REQUEST FOR CONTINUED COVERAGE - When a Covered Person has been given notice of the right to COBRA, you must request continued coverage in writing within 60 days after:

a. the date of the notice of the right to continued coverage; or
b. the date coverage under this Plan otherwise would end, whichever is later.

A request for continued coverage will be deemed to include Covered Dependents unless requested that it not include them. A request by a spouse may include Covered Dependents who live with the spouse. If you do not elect COBRA, each of your dependents may independently elect such coverage on his/her behalf and pay the required premiums. Payments should be mailed the Plan Office as follows:

United Administrative Services

6800 Santa Teresa Boulevard, Suite 100
San Jose, CA 95119-1205
(Phone : 408-288-4400)

Thereafter, the Covered Person shall pay monthly **IN ADVANCE** for the continued coverage. The monthly payment will be no more than 102% of the current full monthly cost for the coverage under this Plan except that during the additional 11 months of continued coverage provided for a disabled Employee, the monthly payments will be no more than 150% of the current full monthly cost for the coverage. **THE PREMIUMS FOR COBRA COVERAGE INCREASE IN MOST YEARS.** You have the option of changing Medical Plans while covered under COBRA, subject to residing within Kaiser's service area, and payment of the applicable COBRA payment for the Plan that you elected.

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

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

E. **TERMINATION OF CONTINUED COVERAGE** - Except as provided below, eligibility for continued coverage shall end on the earlier of the following:

1. **COBRA Time Period Ends.** The end of the 18-month period following the date of the qualifying event, if the event is the termination of employment or reduction of work hours unless the reason is for gross misconduct.

2. **COBRA Time Period Ends – 36 months Situation – Spouse or Dependents**. The end of the 36-month period following the: (a) death of the employee, (b) divorce or legal separation from spouse, (c) becoming entitled to benefits under Medicare, or (d) a child ceasing to be eligible as a Dependent under this Plan.

3. **Failure to Timely Pay COBRA Premium.** The date on which the full payment for continued coverage is not timely made. Payment is timely if it is received within 31 days after becoming due.

4. **Coverage Under Another Plan.** The date you or your dependent becomes covered under another group health plan.

5. **Entitled to Medicare.** The date you become entitled to Medicare after having elected COBRA.

6. **Employer No Longer Contributes.** The date your employer, who contributed on your behalf, ceases to be a contributing Employer.

7. **Disability Ends.** The person was receiving extended coverage for up to **29 months** due to his/her or another family member's disability, and Social Security determines that he or the other family member is no longer disabled.

F. CALIFORNIA INSURANCE MARKETPLACE (California Exchange)

In addition to COBRA continuation coverage, there may be other options for you and your family. The California Insurance Marketplace (known as the California Exchange) offers many health plans to choose from. Open enrollments will be held generally from October 15 through December 15 for coverage effective the following year. After Open Enrollment ends, you may have special enrollment rights under certain circumstances. More information is available from the California Exchange website at www.coveredca.com. In addition, you may be eligible for a tax credit that lowers your monthly premium if you are not eligible for coverage through the Plan. NOTE: If you enroll in COBRA coverage and then drop your COBRA coverage, you can only enroll in Exchange coverage during the Exchange Open Enrollment Period, effective January 1.

G. COBRA QUICK REFERENCE CHART

An illustration of circumstances under which health benefits can be continued, and the maximum duration of COBRA Continuation Coverage are summarized in the following chart:

Qualifying Event	Qualified Beneficiary	Maximum Continuation Period
(1) Reduction in eligible Employee's hours	Employee spouse and dependent children covered under Plan	18 mo. after Qualifying Event
(2) Termination of eligible Employee's employment except for gross misconduct	Employee, spouse and dependent children covered under Plan	18 mo. after Qualifying Event
(3) Death of eligible Employee covered under Plan	Spouse and dependent children	36 mo. after Qualifying Event
(4) Divorce or legal separation of eligible Employee	Former Spouse and dependent children covered under Plan	36 mo. after Qualifying Event
(5) Dependent child's loss of that status under Plan	Affected dependent child if covered under Plan	36 mo. after Qualifying Event
(6) Eligible Active Employee's entitlement to Medicare after a qualifying event described in (1) or (2)	Spouse and dependent children covered under Plan	36 mo. after initial Qualifying Event
(7) Eligible Active Employee's entitlement to Medicare before a qualifying event described in (1) or (2)	Spouse and dependent children covered under Plan	Later of: (1) 18 mo. from Qualifying Event or (2) 36 mo. from date of Employee's Medicare entitlement
(8) Employee's retirement, if all qualifications are met	Employee, spouse and dependent children covered under Plan	Retired Employee's Medicare entitlement

H. **EXCEPTIONS TO TERMINATION OF CONTINUED COVERAGE** - Section F above shall not be applicable in the following situations:

1. **If the Covered Person is Disabled.** For an additional premium equal to 150% of the cost of coverage, the maximum period of continued coverage shall be extended beyond 18 months for an additional 11 months if (a) the Covered Person is determined by the Social Security Administration to have been disabled within 60 days of the date of the qualifying event or the loss of coverage, (b) the Covered Person furnishes notice of Social Security's determination of disability to the Plan Office before the end of the initial 18 month period of continued coverage, and (c) the Covered Person remains disabled until the end of the combined 29 month period of continued coverage. The continued coverage shall stop, however, at the end of the month following any one of the additional 11 months during which the Social Security Administration makes a final determination that the Covered Person is no longer disabled.

2. **If Another Qualifying Event Occurs.** If a subsequent qualifying event occurs with a maximum period of 36 months of continued coverage while a Covered Person and his/her Covered Dependents are receiving 18 months of continued coverage due to an initial qualifying event, the maximum period of continued coverage for Dependents only shall become 36 months from the date of the initial qualifying event.

3. **If Medicare is Not a Qualifying Event.** If a Covered Person becomes entitled to benefits under Medicare, but that is not a qualifying event because coverage does not end for that reason, and subsequently, a qualifying event occurs entitling the Covered Person and his/her Covered Dependents to 18 months of continued coverage, the maximum period of continued coverage for Dependents only shall be 36 months from the date the Employee became entitled to Medicare.

Depending upon where you live, you may be eligible for assistance paying your employer health plan premiums. You may contact your State for further information on eligibility as follows:

Medicaid Phone: 1-800-992-0900

ALERT – COVERAGE AND BENEFITS CAN BE CHANGED

IN ALL CASES, INITIAL ELIGIBILITY AND CONTINUING ELIGIBILITY FOR RETIREE COVERAGE DEPENDS ON THE BOARD OF TRUSTEES CONTINUING RETIREE BENEFITS. THE BOARD OF TRUSTEES RESERVES THE RIGHT TO CHARGE FOR, MODIFY OR TERMINATE THE RETIREE BENEFITS AT ANY TIME. RETIREE BENEFITS ARE NOT A VESTED RIGHT.

I. **EMPLOYEE AND/OR DEPENDENT COST OF COVERAGE.** An Employee and his/her dependents may be required to contribute toward the cost of the coverage provided in the Plan.

J. **TERMINATION OF DEPENDENT ELIGIBILITY**. A Dependent's eligibility terminates when the Participant's coverage terminates or when the individual ceases to meet the Plan qualifications of an eligible Dependent. Terminations occur as follows:

1. The date the person ceases to be a Dependent as defined in the Plan.

2. The date that the Participant who has Covered Dependents ceases to be eligible under the Plan.

K. DEATH OF AN EMPLOYEE. Upon the death of an Employee with eligible Dependent(s), such Dependents shall continue to be eligible for benefits until the deceased Employee's reserve hours are exhausted. Such Dependents may then become eligible for Retiree coverage, provided the Retiree coverage eligibility requirements by the Employee are met as described in the Retiree Eligibility section (refer to section I).

Benefits terminate on the date the surviving spouse remarries, the Dependent child is no longer an eligible Dependent, or becomes eligible for coverage under any other group plan.

L. SPECIAL ENROLLMENT RIGHTS. Other than during Open Enrollment, the Plan is required under federal law to provide Special Enrollment Rights to you and your Dependents upon the following:

1**. Loss of Other Coverage:** If you did not enroll yourself and/or your eligible Dependents because you and/or your Dependents had other group health coverage or other health insurance, including COBRA continuation coverage, and showed the Plan Office evidence of such other coverage, you and/or your eligible Dependents may enroll in this Plan during a Special Enrollment period. This Special Enrollment period is a 30-day period which begins when you lose the other coverage. To take advantage of this Special Enrollment Right, you and/or your Dependents must enroll in the Plan within 30 days of exhausting COBRA continuation coverage or the termination of such other coverage as a result of a loss of eligibility for coverage (such as a divorce, legal separation, death, termination of employment, reduction in the number of hours, ceasing to reside, , or dependent ceasing to qualify as a dependent under the other plan).

2**. Acquire New Dependents:** Newly acquired eligible Dependents, including your legal spouse, newborn, adopted child(ren) or step child(ren), will be covered from the time of birth, adoption, placement for adoption, or marriage provided you complete and submit an Enrollment Form and appropriate documentation to the Plan Office as soon as reasonably possible from the date of the birth, adoption, placement for adoption, or marriage.

3**. Special Enrollment Allowed Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP):** The Children's Health Insurance Program Reauthorization Act of 2009 (CHIP) created a special enrollment period as group health plans must permit yourself and/or your eligible dependents with group health plan coverage to enroll in the Plan if they:

- Lose eligibility for Medicaid or CHIP coverage; or
- Become eligible to participate in a premium assistance program under Medicaid or CHIP

In both situations you and/or your eligible dependent must request special enrollment within 60 days (of the loss of Medicaid/CHIP or gaining eligibility for premium assistance under Medicaid or CHIP, as applicable. More information is available at *www.coveredca.net* or *www.dhcs.ca.gov/services/medi-cal*.

ARTICLE IX. HEALTH REIMBURSEMENT ACCOUNT ("HRA")

A. Health Reimbursement Account (U.A. Local 467 Extended Reserve Account) Rules. This Plan includes a Health Reimbursement Account (HRA) also known as the U.A. 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/Allocate Earnings & Expenses. 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. The Board of Trustees has the discretion to assess an administrative charge for the HRA Program and/or to share in the expenses and there is no requirement that earnings be credited to accounts.

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 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 on page 50 is a broader list of expenses which are reimbursable if not otherwise covered by the Plan (for a complete list, please view the IRS publication at www.irs.gov/pub/irs-pdf/p502.pdf):

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 the good cause shown, at the sole discretion of the Board of Trustees.

f. HRA Funds: Qualified expenses if Participant is enrolled in Different Plan (providing essential coverage). A Participant may use his or her HRA funds for qualified expenses for the Participant, the Participant's spouse and dependents pursuant to Internal Revenue Code Section 213d (such as co-payments, deductibles, and premiums) in a different group health plan if that group health care plan meets the minimum essential coverage of the Affordable Care Act (provides minimum value pursuant to Internal Revenue Code Section 36B(c)(2)(C)(ii)).

3. Other Plan Premiums: Self-Payments and/or COBRA Premiums. A Participant may use his or her HRA Account to make self-payments for coverage and/or for COBRA payments. A Participant's surviving spouse or surviving eligible dependent may use the HRA Account to make monthly required payments for Plan survivor benefits, or to pay premiums for COBRA coverage, if eligible.

4. 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.

B. HRA ELIGIBLE EXPENSES: What Expenses are Eligible Under IRS Rules?

The IRS defines eligible health care expenses as amounts paid for the diagnosis, cure, mitigation or treatment of a disease and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate a physical or mental condition or illness. The list below is not meant to be all-inclusive. Moreover, items could be on the list that are not covered by the Plan.

DENTAL SERVICES
Dental X-Rays
Dentures
Exams/Teeth Cleaning
Extractions
Fillings
Gum Treatment
Oral Surgery
Orthodontia/Braces

MEDICAL TREATMENTS/PROCEDURES
Acupuncture
Alcoholism & Drug Addiction (inpatient treatment)
Breast Reconstructive Surgery
Hearing Exams
Hospital Services/Surgeries/Inpatient
Infertility
In Vitro Fertilization
Norplant Insertion or Removal
Physical Examination (not employment-related)
Physical Therapy
Sterilization
Transplants (including organ donor)
Vaccinations/Immunizations
Vasectomy & Vasectomy Reversal
Weight Loss Program (prescribed by doctor)
Well Baby Care

OBSTETRIC SERVICES
Lamaze Class (child rearing classes excluded)
Midwife Expenses
OB/GYN Exams
OB/GYN Prepaid Maternity Fees (reimbursable after date of birth)
Pre & Postnatal Treatments

LAB EXAMS/TESTS
Blood Tests
X-Rays
Cardiographs
Laboratory Fees
Metabolism Tests
Urine/Stool Analysis

VISION SERVICES
Optometrist/Ophthalmologist/Optician
Eye Examinations
Contact Lenses
Laser Eye Surgeries
Artificial Eyes
Prescription Sunglasses
Radial Keratotomy/LASIK

MEDICATION
Insulin
Prescribed Birth Control & Vitamins
Prescription Drugs

PRACTIONERS
Allergist
Anesthetist
Chiropractor
Christian Science
Dermatologist
Homeopath
Naturopath
Neurologist
Orthopedist
Osteopath
Physician
Psychiatrist
Psychologist

MEDICAL EQUIPMENT, SUPPLIES & SERVICES
Abdominal/Back Supports
Ambulance Services
Arches/Orthopedic Shoes
Contraceptive, prescribed
Counseling
Crutches
Hearing Devices & Batteries
Hospital Bed & Services
Learning Disability (special school/teacher)
Medic Alert Bracelet or Necklace
Oxygen Equipment
Prescribed Medical/Exercise Equipment
Prosthesis
Splints/Casts or Support Hose
Syringes
Transportation Expenses (essential to medical care)
Tuition Fee at Special School for Disabled Child Weight Loss Drugs (to treat specific disease)
Wheelchair
Wigs (hair loss due to disease)

Ineligible Expenses

The IRS does not allow the following expenses to be reimbursed. This list is not meant to be all-inclusive.

Contact Lens or Eyeglass Insurance
Cosmetic Surgery/Procedures
Dancing/Exercise/Fitness Programs
Diaper Service
Electrolysis or hair removal
Funeral Expenses
Personal Trainers or Exercise Equipment
Hair Loss Medication
Hair Transplant
Health Club Dues
Insurance Premiums & Interest
Long Term Care Premiums
Marriage Counseling
Maternity Clothes
Vitamins or Nutritional Supplements
Swimming Lessons
Teeth Whitening/Bleaching
Tuition fees & deposits
Residential nursing homes
Piano, dancing, art, ballet lessons, etc.
Health care expenses for a dependent
Toiletries (e.g., toothbrush, toothpaste)
Weight loss programs

Internal Revenue Code Section 213d governs the eligible expenses. IRS Publication 502 is written to help taxpayers determine what qualified expenses can be deducted on their income tax returns. They should not be used as the sole determinant for what is reimbursable under these plans.

Expansion: Over the Counter (OTC) Medicines/Drugs and Menstrual Care Products

Pursuant to the Coronavirus Aid, Relief and Economic Security Act (known as the CARES Act), the type of qualifying medical expenses that may be purchased with funds or seek reimbursement from an HRA include 1) OTC medicines and drugs without a prescription and 2) menstrual care products (defined as tampons, pads, liners, cups, sponges and similar products used by the individual with respect to menstruation).

5. 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. The Board of Trustees reserves the right to assess an administrative charge against HRA Accounts. 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 the discretion to provide statements more often.

6. Forfeiture. An HRA Account will be permanently forfeited if any of the following occurs, 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 the amounts in your HRA, any unused balances in your HRA will be forfeited (this is pursuant to IRS requirements).

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 (CBA) with U.A. Local 467 or another U.A. Local Union.

c. The Participant is an owner of a company, business, or entity in the plumbing and pipefitting industry which is not signatory to a CBA with a U.A. Local Union.

ARTICLE X. PRESCRIPTION DRUG BENEFITS

(Navitus is the Plan's Pharmacy Benefit Manager)

A. Preferred Provider Arrangements for Prescription Drugs

The Board of Trustees has implemented an integrated mail/retail prescription drug and formulary program through Navitus 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 Plan has contracted with Navitus as the Plan's Pharmacy Benefit Manager (known as a PBM). The Plan's Trustees are committed to making prescriptions more affordable for you and your family. 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 (Navitus). **Well-known pharmacies such as CVS Pharmacy, Long's Drug Stores. and Safeway participate in the Navitus Pharmacy group. (Walgreens is excluded from coverage.) You may call toll-free at 844-268-9789 or go online to determine if a pharmacist is on our list. There are numerous other independent pharmacies throughout the nation that participate in the Navitus Pharmacy Network. The list can be found at**

www.navitus.com. Navitus Mail order is handled through Costco. The Costco Mail Order Pharmacy contact information is:

Customer Service: Phone: 1-800-607-6861/Fax: 1-877-258-9584
Monday-Friday: 5:00 am to 7:00 pm (PST)
Saturday: 9:30 am – 2:00 pm (PST)

1. **Ninety Day Supply at Participating Pharmacy or Through Designated Mail Order.** Prescription drug purchases of up to a Ninety (90) day supply may be made at a participating pharmacy or from the designated mail order provider, for a co-payment of the greater of **$5 or 10%** of the prescription cost**.**. Members will be issued membership cards for the Prescription Drug Plan by the Plan 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 Plan Office. You may purchase a Thirty Day supply for a Specialty** Pharmacy. The specialty program gives members with chronic conditions convenient access to specialty medications.

2. **Generic Equivalent or Reasonable Substitute under Formulary Program.** 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.

A generic drug is called by its chemical name; a manufacturer assigns a brand name. The products have the same ingredients. Choosing generic drugs is one of the best ways to lower your prescription expenses. Generics are clinically identical to their brand-name counterparts and go through the same rigorous U.S. Food and Drug Administration (FDA) process as brand name drugs. According to Navitas, they have the same safety, quality, strength and effectiveness as brand name medication. To get started simply ask your prescriber if a generic is available for your prescription. (Not all drugs have generic equivalents as some drugs are protected by patents and are supped by only one company; however, when the patent expires other manufacturers can produce its generic version.) Your pharmacist may be able to assist you.

3. **Benefits under this Prescription Drug Plan are provided only to eligible Employees who have not elected to receive medical benefits from Kaiser, and their eligible dependents. 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 Navitus mail order program (through Costco) or the Navitus retail network of pharmacies.

You may call the Navitus Customer Care number at 844-268-9789 to determine if a pharmacy is in the Navitus network. That phone number is available **24 hours a day, 7 days a week.** Or go on the website at: Navitus.com/members. There is also a convenient Navitus mobile app. See also the mail order section below.

The following information is an overview of the U.A. Local 467 Health and Welfare Plan prescription drug

benefit being administered by Navitus.

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

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

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

Navitus ID Card
Navitus will provide you with a prescription ID card.

(Mail Order)
Traditional Mail Order. The Navitus Mail Order program, which is through Costco (1-800-607-6861), is a convenient way to receive maintenance prescription drug medications. Costco's goal is to have your order delivered to you within 14 days after Costco received your order and payment. Please allow a few extra days when placing an order for the first time. More information on mail order is included with the ID card. You must provide Costco with a valid shipping address and valid payment information. Your physician must provide complete directions for use. Costco cannot dispense an order without valid instructions. "Use as directed' will not be accepted the maximum subscription cannot exceed 90 days. Costco offers free standard shipping. Expedited shipping is available for an additional fee.

Costco required payment with every prescription order. Your shipment will be delayed if Costco does not receive payment in full at the time of the order. **Costco accepts Visa, MasterCard and Discover credit cards**. **You may also make a payment by mailing a personal check with your order or supplying a voided check for Electronic Funds Transfer.**

Online Ordering. In addition to the traditional Mail Order Method described above, Costco also provides an Online Ordering service. Most communication between you and Costco Mail Order Pharmacy will be through email. When using this service, all orders for new prescriptions must be initiated online at **pharmacy.costco.com.**

To set up an account, visit pharmacy.costco.com, click Sign in/Register. Select Create Account and enter your email address and password. Each patient (self, spouse, dependent(s)), independent of whether they are covered by the Plan, must have his or her own unique email address. Toa create an online account. Enter all information including information regarding drug allergies, medical conditions, brand/generic preferences and other related information.

If you need to start your medication immediately or do not have enough to last you at least two weeks, request two prescriptions from your prescriber. One for an initial short-term supply of your maintenance medication that your local retainer pharmacy can ill immediately, and a second for a90-day supply, including refills that can be submitted to Costo Mail Order Pharmacy (online).

Refills. Phone: Call 1-800-607-6861, Costco's 24-hours automated telephone system, which guides you through the refill ordering process. You must have your prescription number available. Or you may obtain your refills Online: Visit pharmacy.costco.com and click the "Refill Prescriptions" link.

UALocal467CRX—International Drug Program. **www.crxintl.com (web ID: ua467)**

Prescription Drugs are also available through www.crxintl.com which is an international mail order option for eligible Employees, Retirees and their Dependents. **MEMBER COPAYMENTS HAVE BEEN WAIVED FOR THIS PRESCRIPTION DRUG PROGRAM ONLY.** There is a list of qualified maintenance medications available on the above website. You can also contact the Customer Service Representatives toll free at 1-866-488-7874. You may complete and sign the enrollment form and fax it to 1-866-215-7874. Faxed subscriptions are only accepted if sent directly from the physician's office. Or you may mail the completed form to P.O. Box 44650, Detroit, MI 48244-0650. Allow four weeks for delivery.; You may ask your physician for a prescription for a 3-month supply with 3 refills. Medications must be tried for 30 days before ordering.

SCL Specialty Pharmacy Program (Navitus Specialty Pharmacy Program)
Specialty medications help patients with complex chronic conditions like multiple sclerosis, cancer, or rheumatoid arthritis. The Lumicera Health Services full-service specialty pharmacy must be used to obtain specialty medications. If you are currently receiving a specialty medication, Navitus 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 Plan Office at (408) 288-4400, or call the Customer Service Help Desk at 800-541-8059.

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 more than 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 Plan 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 Plan Office for the prescription drug benefit to apply to eligible dependents. If members do not submit their enrollment cards, Navitus 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 or her $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 Costco at 800-607-6861. **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 Navitus 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 Navitus using the pre-addressed envelope.

4. Navitus will process your order and return your medication immediately.

YOU ALSO MAY ORDER ONLINE AT: pharmacy.costco.com

D. How to Use the Retail Prescription Drug Program

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

Each Participant will receive a prescription drug card which will be code for the status (such as single or married) of that Participant. This drug card can be used when obtaining prescriptions for any of a Participant's

eligible dependents. (The drug card eligibility information will be based on the enrollment card information that you provide to the Plan Office.)

Your participating pharmacy's eligibility records are based on information provided each month by the Plan Office. The Plan Office's records depend on the information you provide. If you do not accurately report our eligible dependents or you do not inform the Plan Office of any changes (such as a newborn), your dependent(s) 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 Plan 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.

ARTICLE XI. DENTAL CARE BENEFITS

Dental benefits are provided through a contract with Delta Dental Plan of Californian (Group Number: 79-2001 for non-residential and 79-002 for Residential employees). 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 Plan Office. **Visit a dentist in the Delta Dental PPO Network to maximize savings. You may find a PPO dentist at www.deltadentalins.com or you may phone Delta Dental at 800-765-6003.**

Set up an online account. You may also obtain information about your Plan at any time by signing up for an Online Services account at www.deltadentalins.com. This free service, available once you are eligible for coverage, permits you to check benefits and eligibility information as well as find a network dentist. Or you may call (800)-765-6003 for a list of Delta Dental dentists.

You may Check in With Your Dentist Without an ID Card. You do not need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date or Social Security Number. If your family members are covered, they will need your information. If you would like an ID Card, you can, if you wish, print an electronic ID card when you sign into the online services.

Coordinate Dual Coverage. If you have coverage under two plans (such as also being covered by your spouse's dental plan), ask your dental office to include information about both plans with your claim, and Delta Dental will handle the claim.

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. **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**.

Transition of Dental Care. If you started on a dental treatment plan before your coverage under this Plan started, you may not be covered for the remainder as generally, multistage procedures are only covered under the Plan if treatment began after your Plan's effective date of coverage. You can find this date by logging into Online Services.

Dentists located outside the United States. Dentists located outside the United States are not Delta Dental Dentists. Claims submitted by out-of-country dentists are translated by Delta Dental staff and the currency is converted to U.S. dollars. Claims submitted by out-of-country dentists for enrollees residing in California are referred to Delta Dental's Quality Assessment Department for processing. Delta Dental may require a clinical examination to determine the quality of the services provided and **Delta Dental may decline to reimburse for some or all of the benefits if the services are found to be unsatisfactory and/or too expensive.**

BENEFIT HIGHLIGHTS * DELTA DENTAL PPO

Deductibles Deductibles waived for Diagnostic & Preventative Benefits (D&P)	$50 per person/$200 per family lifetime For residential employees, the deductible is $100 per person.
Maximums D&P counts toward maximum?	$7,500 per person each calendar year Yes
Waiting Period(s)	Basic Benefits: None Major Benefits: None Prosthodontics: None Orthodontics: None

See the Limitations and Exclusions in Sections D and E below.

A. Primary Enrollee & Spouse

Benefits and Covered Services*	Delta Dentist PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D&P) Exams, cleaning, and x-rays	80%	80%
Basic Services Filings and posterior composites	80%	80%
Endodontics (root canals)	80%	80%
Periodontics (gum treatment)	80%	80%
Oral Surgery	80%	80%
Major Services Crowns, inlays, onlays, and cast restorations	80%	80%
Prosthodontics Bridges, dentures, and implants	80%	80%

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and the program allowance for non-Delta Dental dentists.

B. Dependent Children Coverage (Dependent Children are Covered at 100%.)

ELIGIBILITY	Eligible dependent children to the end of the month dependent turns age 26
Deductibles Deductibles waived for Diagnostic & Preventative Benefits	$50 per person/$200 per family lifetime For residential employees, the deductible is $100 per person.
Maximums D&P counts toward maximum?	$7,500 per person each calendar year Yes
Waiting Period(s)	Basic Benefits: None Major Benefits: None Prosthodontics: None Orthodontics: None

Benefits and Covered Services*	**Delta Dentist PPO dentists****	**Non-Delta Dental PPO dentists****
Diagnostic & Preventive Services (D&P) Exams, cleaning, and x-rays	100%	100%
Basic Services Filings, posterior composites, and sealants	100%	100%
Endodontics (root canals)	100%	100%
Periodontics (gum treatment)	100%	100%
Oral Surgery	100%	100%
Major Services Crowns, inlays, and cast restorations	100%	100%
Prosthodontics Bridges, dentures, and implants	100%	100%
Orthodontic Benefits Dependent Children	(No coverage for residential employees.) 50%	50%
Orthodontic Maximum	$2,000 Lifetime	$2,000 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and the program allowance for non-Delta Dental dentists.

As set forth in the charts above, the following Benefits are limited to the applicable percentage of a 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 you, Delta Dental only provides as Benefits the applicable allowances reduced by the amount that such fees or allowances are discounted, waived, or rebated. **The annual maximum dental benefit is $7,500. See the limitations and exclusions in Section D and E below.**

1. 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

2. BASIC BENEFITS
80% for Primary Enrollees and their enrolled spouses
100% for dependent children

Oral surgery – extractions and certain other surgical procedures, including 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

Periodontics – 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 decay

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

3. 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 covered only if they are provided to treat cavities which cannot be restored with amalgam, silicate, or direct composite (resin) restorations.

4. 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 covered if provided to replace missing, natural teeth. This includes implant coverage.

5. ORTHODONTIC BENEFITS (Not applicable for residential employees.)
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

If you opt to receive dental services that are not covered services under this Plan, your Delta Dental Dentist may charge you his or her Usual and Customary rate for those services. If you are uncertain whether a particular treatment or procedure is covered under the Plan, you may call Delta Dental at 800-765-6003 seeking guidance.

C. Residential (See the limitations/exclusions in Section D below.)

ELIGIBILITY	Primary enrollee, spouse, and eligible dependent children to the end of the month dependent turns age 26
Deductibles Deductibles waived for Diagnostic & Preventive (D&P)?	$100 per person lifetime No
Maximums D&P counts toward maximum?	$7,500 per person each calendar year Yes
Waiting Period(s)	Basic Benefits: None Major Benefits: None Prosthodontics: None

Benefits and Covered Services*	**Delta Dentist PPO dentists****	**Non-Delta Dental PPO dentists****
Diagnostic & Preventive Services (D&P) Exams, cleaning, and x-rays	80%	80%
Basic Services Filings, sealants, and posterior composites	80%	80%
Endodontics (root canals)	80%	80%
Periodontics (gum treatment)	80%	80%
Oral Surgery	80%	80%
Major Services Crowns, inlays, onlays, and cast restorations	80%	80%
Prosthodontics Bridges, dentures, and implants	80%	80%

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists, and the program allowance for non-Delta Dental dentists.

Residential Employees are not eligible for orthodontic benefits.

If you opt to receive dental services that are not covered services under this Plan, your Delta Dental Dentist may charge you his or her Usual and Customary rate for those services. If you are uncertain whether a particular treatment or procedure is covered under the Plan, you may call Delta Dental at 800-765-6003 seeking guidance.

1. Summary of Dental Benefits for Non-Residential

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 57-59. To illustrate the type of dental claims paid, the largest claims paid by the Plan during 2020 were for crowns and inlays, diagnostic services, preventive services, restorative, endodontics, oral surgery and implants.

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.**

D. 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:

1. An oral examination is a Benefit only twice in any calendar year. There may be additional benefits during a pregnancy.

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. If you are pregnant, there may be additional cleanings covered under the Plan.

5. Fluoride treatments are covered twice each calendar year.

6. Periodontal scaling and root planning is a Benefit once for each quadrant in 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, 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, the Plan 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 payment 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.

E. 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 (irrespective of whether a workers compensation or other claim is filed).

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 licensed 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.

F. <u>General</u>

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: 79-2001
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:

To get your benefits for covered dental care, inform your dentist of your eligibility under this Plan at the time of treatment, and provide the following information: (Toll free TTY for the hearing/speech impaired—800-428-4833)

Delta Dental Group No. 79-2001 or 79-2002 (Residential)
Group Name: UA Local 467
Your Social Security Number

Delta Dental ensures the benefits payable through the Plan. This means that the final decision on whether to pay a claim is Delta's. 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 their toll-free number: 888-335-8227.

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

G. DELTA DENTAL BENEFITS FOR RESIDENTIAL CLASSIFICATION EMPLOYEES

1. **Introduction.** When using 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 owed by Delta Dental under this Plan. 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. **The Limitations and Exclusions set forth above in Section D also apply to Residential Classification Employees.**

2. **Eligibility.** Participants eligible to participate in the Plan including their eligible dependent spouse and dependent children up to the end of the month the child turns age 26 are eligible for dental benefits.
   - **Deductibles.** There is a $100 per person lifetime deductible for each eligible member of your family which is waived for diagnostic and preventive services.
   - **Maximums.** There is a $7,500 per person each calendar year maximum. The diagnostic and preventive services count towards this maximum.
   - **No Waiting Periods.** There are no waiting periods for basic benefits, major benefits, and prosthodontics.

3. **How to go to the Dentist.** It is to your advantage to select a dentist who is a Delta Dental Participating Dentist in the PPO network, since his fees will have been accepted in advance by Delta Dental. A lower percentage of the Dentist's fees may be covered by this program if you select a Dentist who is not a Delta Dental Participating Dentist. During your first appointment with the Dentist, it is very important to advise your Dentist of the following information:

Group Number: 79-0002
Social Security Number or Enrollee ID
Name of Group Plan: U.A. Local Union No. 467 Health and Welfare Plan for Residential Tradesmen

- Set up an online account: Get information about your plan anytime, anywhere by signing up for an Online Services account at www.deltadentalins.com. This free service is available once your coverage kicks in, lets you check benefits and eligibility information, find a network dentist and more.
- Check in without an ID Card: You do not need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date, and enrollee ID or social security number. If your family members are covered under your plan, they will need your information.

5. Claims and Appeals for Delta Dental Claims. Delta Dental ensures the benefits payable through the plan. This means that the final decision on whether to pay a claim is up to Delta dental. To object to their initial decision on a claim you must appeal under Delta Dental's own claims and appeals procedures. If you have questions about a claim, you may call Delta Dental at the following toll-free customer service number:

Delta Dental Customer Service
(800) 765-6003 or go to their website at www.deltadentalins.com

Claims Address
P.O. Box 997330
Sacramento, CA 95899-7330

For more complete description of benefits refer to your Delta Dental Group Summary Plan Description. There are certain procedures not covered by Delta Dental. Thus, you should refer to the list of exclusions in the Delta Dental Booklet and above.

ARTICLE XII. VISION CARE BENEFITS

A. **General.** The Plan's Trustees have adopted a vision care benefits program through Vision Service Plan (VSP)(www.vsp.com) for eligible Participants and dependents who are not enrolled in the Kaiser Plan, which has its own vision coverage. VSP's phone number is 800-877-7195. Your VSP-participating optometrist can obtain eligibility and benefits information by phoning VSP directly and providing your 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)
101 California Street, Suite 975
San Francisco, CA 94111

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

Once you are eligible, you may create an account at www.vsp.com, which would permit you to review your benefit information.

VSP covers each eligible Participant and Dependent for a regular examination and lenses and frames when necessary for proper visual function or correction. You are entitled to care from a VSP network doctor, including a WellVision Exam—a comprehensive exam designated to detect eye and health conditions. Your decision of which eye care provider is yours to make—as VSP has the largest national network of private-practice eye doctors.

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. There are no claim forms to complete.**

VSP will pay the doctor directly. There is no ID card necessary but if you would like a card as a reference, you may print one at vsp.com. 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 contracts**.

If you use a doctor from the VSP network, this assures direct payment to the doctor and provides 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. **ALERT: Be aware of the smaller reimbursements if you obtain your vision care benefits at a non-network provider**.

Essential Medical Eye Care. Retinal Screening for members with diabetes. $0 per screening.

Additional exams beyond the Well Vision Exam (see below in the chart) and service beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma and more—cost is $20 per exam. Available as needed (no maximum). Coordination with your medical coverage may apply. Ask your VSP doctor for details.

B. SCHEDULE/SUMMARY OF VISION BENEFITS VSP Signature

Benefit	Description	Copay	Frequency
Your Coverage with a VSP Provider			
Well Vision Exam	Focuses on your eyes and overall wellness	$15 for exam & glasses	Every 12 months

Prescription Glasses			
Frame	$150 allowance for a wide selection of frames $170 allowance for featured frame brands 20% savings on the amount over your allowance	Combined with exam	Every 24 months
Lenses	Single vision, lined bifocal, and lined trifocal lenses Impact Resistant lenses for dependent children	Combined with exam	Every 12 months
Lens Enhancements	Progressive lenses Average savings of 35-40% on other lens	$0	Every 12 months

	enhancements		

Contacts (Instead of glasses)	$130 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months

Diabetic Eyecare Plus Program	Services related to diabetic eye disease, glaucoma, and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed

Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to www.vsp.com/offers for details. • 30% savings on additional glasses & sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam, or get 20% from any VSP provider within 12 months of your last WellVision Exam.
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam.
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price, discounts only available from contracted facilities. • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

Your Coverage with Out-of-Network Providers
Get the most out of your benefits & greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.
Coverage with a retail chain may be different or not apply. VSP guarantees coverage from VSP network providers only. Coverage Information is subject to change in the event of a conflict between this information and your organization's contract with VSP, the same terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc. is the legal name of the corporation through which VSP does business.

Total Copayment • **Exam Frequency** • **Lenses Frequency** • **Frame Frequency**	**$15** • Every 12 months • Every 12 months • Every 24 months
Out-of-Network Schedule • **Eye Exam** • **Single Vision** • **Lined Bifocal** • **Lined Trifocal** • **Lenticular** • **Progressive** • **Frame** • **Elective Contact Lenses** • **Necessary Contact Lenses**	 • $50 • $50 • $75 • $100 • $125 • $75 • $70 • $105 • $210

1. **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.

2. **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:

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

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

(b) Frames - Actives: **available once every 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 every 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.

From classic styles to the latest designer frames, you will find many frame options, choosing from featured frame brands like bebe, CALVIN KLEIN, Cole Haan, Flexon, Lacoste, Nike, Nine West and more. Not all eye doctor locations will carry these brands. Check out all available brands at VSP's online eyewear store at www.eyeconic.com.

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 www.vsp.com.

4. **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.

C. 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 7.

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. Hearing and speech impaired may use the California Relay Service's toll-free telephone number by dialing 711 in California. Health plan complaint forms and instructions are available 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.

ARTICLE XIII. DEATH AND ACCIDENTAL DEATH BENEFITS

The Plan provides a self-funded death benefits program for Employees and dependents, and accidental death and dismemberment benefits for Employees only. (See the exclusions/limitations in Section E on page 72.) The Plan also provides weekly disability benefits, which are also 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 Plan Office at (408) 288-4507. To file a claim for Weekly Disability Benefits, call the Plan Office at (408) 288-4507.

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 on a form available at the Plan 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 the 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 (For Employees Only)

The Plan self-funds an $8,000 accidental death and dismemberment benefit for any of the following losses occurring on or off the job through accidental means if the loss occurs within 120 days from the accident.

Life (paid to your beneficiary)	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 benefit or **$4,000** will be paid for the loss of one hand, one foot or the sight of one eye.

See the exclusions/limitations in Section E below.

E. Exclusions/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 death or accidental death and dismemberment 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).
2. War or any act of war, whether or not declared, or service in the armed forces of any country engaged in war or police duty.
3. Participation in a riot or insurrection.
4. Participation in, or in consequence of having participated in, the commission of an assault and/or a felony (no criminal charge or conviction is required for either).
5. Driving while intoxicated as defined by the application state law where the loss occurred (no conviction or charge is required).
6. Use of any drug, hallucinogen, controlled substance, or narcotic unless prescribed by a lawful physician

F. Weekly Disability Benefits of $100 for Certain Active Employees

The Plan will pay a weekly benefit of $100 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/she 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.

ARTICLE XIV. VACATION BENEFITS

A. 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. **During the July 1, 2023-June 30, 2024, period, your employer is required by the collective bargaining agreement to contribute $5.82 an hour to the Vacation Plan for non-residential employees.**

Vacation Savings Account Funds are distributed to Participants through Direct Deposit via electronic funds transfer into a checking or savings account that you choose.

Members who refuse to authorize direct deposit into a checking or savings account must request a check from the Benefits Office and pay a $50 processing fee. That fee could increase in the future.

B. EFFECTIVE DATE AND PLAN YEAR. The Vacation Plan became effective on January 1, 1985. The Plan year is from January 1 to December 31 of each year.

C. FUNDING AND ADMINISTRATION

1. The Fund consists of all contributions made or required to be made to it by any Individual Employer by reason of employment of any Employee under a Collective Bargaining Agreement with U.A. Local 467 (all Employee taxes having been deducted from the Employee's regular wages and fully prepaid).

2. The Fund is administered by the Board of Trustees of the U.A. Local 467 Health, Welfare and Vacation Trust Fund.

3. Contributions to the Fund are to be invested at the discretion of the Trustees.

4. The cost of administration of the Fund is paid out of earnings on investments, before allocation to the individual account of the Employee, and out of accounts forfeited in accordance with this Article.

D. EMPLOYEE ACCOUNTS

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 or her behalf, together with a share of the income profits and losses, less the proportional share of the expenses of administration.

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

E. WITHDRAWALS

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

2. Special withdrawals may be made at any time with the consent of the Trustees or the Trustees' delegate.

3. All requests for withdrawals shall be submitted to the Union on designated forms.

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 or her account and in accordance with the restrictions otherwise imposed in this Article.

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 and taken other steps to locate the individual. For purposes of this section, "inactive" means that no contributions or withdrawals have been made to or from the account.

F. DISTRIBUTION UPON DEATH OR INCOMPETENCE

1. In the event of the death of any Employee, monies credited to his or her 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 or her estate.

3. In the event of the adjudicated incompetence of any Employee, the monies in his or her account shall be paid over to his or her guardian or conservator upon presentation of certified copies of the Letters of Guardianship or Conservatorship of his estate or other appropriate legal documentation.

ARTICLE XV. GENERAL PROVISIONS

A. ESTABLISHMENT OF PLAN

1. **Restatement of Plan**. The Board of Trustees of the U.A. Local 467 Health and Welfare Trust

restates the U.A. Local 467 Health and Welfare Plan ("Plan") by this Plan Document effective as of May 1, 2024.

The Plan is intended to be maintained for the exclusive benefit of Participants and their beneficiaries. 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).

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 service. 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.

5. **May Offer Benefits Through Insurance Company**. The Board of Trustees offers certain Plan benefits through an insurance contract.

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

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 benefit or rule 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.

C. ADMINISTRATION 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 different Employer Associations that are signatory to a Collective Bargaining Agreement with U.A. Local. 467 and one-half of the Trustees, called "Union Trustees," are selected by U.A. Local 467. The current Trustees are listed on page ii of this booklet.

The Board of Trustees has many powers and functions including investing the Plan's assets, interpreting Plan provisions, amending the Plan, deciding policy questions, and contracting with advisors and consultants, such as an auditor, legal counsel, and benefit consultant.

Only the Board of Trustees, and its authorized representatives, is authorized to interpret the Plan schedule of 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) 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 Trustees.

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

2. **Standards of Interpretation**. The Board of Trustees, and/or persons designated by the Board, such as the Chair and Co-Chair of 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.

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 regarding 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. The Employer's hourly contribution rate is subject to change at any time if agreed to by the bargaining parties. The bargaining parties also may allocate additional or different contribution amounts to help fund the Plan. During the July 1, 2023-June 30, 2024, period, your employer is required by the collective bargaining agreement to contribute $16.00 an hour ($15.00 to the Group Plan and $1.00 to the HRA. (There are additional classifications which provide for greater contributions to the HRA.) There is an additional. $5.82 is contributed to the Vacation Plan. There are, however, no HRA contributions for residential employees. There may be different contributions for other categories too, such as apprentices and tradesmen.

Your Employer is required to make monthly contributions for your Covered Employment and mail (postmark) such payments by the 15th day of the month following the month in which your work was performed. By way of example, January hours generate employer contributions in February which are posted on the Plan's books in March. 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 <u>not</u> subject to withholding for FICA, FUTA, or state or federal taxes.

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

The amount of Employer Contributions made to the Plan for non-bargaining unit employees (such as employees of the Union, the Apprenticeship Program and others not working under a bargaining agreement) may 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 could lose eligibility with the Plan if the Employer contributions are not <u>timely received</u> by the Plan Office, depending upon your hour bank and how soon the Employer makes the late contributions. If the Employer contributions are eventually received, retroactive eligibility may be granted for a Participant. It is the Participant's responsibility to determine whether he or she has sufficient hours and Employer contributions for eligibility.

6. **Availability of Fund Resources**. It is recognized that the benefits provided through this Plan can be paid only to the extent that the Plan has available adequate resources for such payments. No Contributing Employer has any liability, directly or indirectly, to provide the benefits established hereunder, beyond the obligation of a Contributing Employer to make contributions as provided in the Collective Bargaining Agreement. In the event that at any time the Fund does not have sufficient assets to permit continued payments hereunder, nothing contained in this Plan shall be construed as obligating any Contributing Employer 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 by self-funding, insurance, an HMO, or by any other lawful means or methods. 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. **Special Exclusion for 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.

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.

9. **Plan Year**. The Plan Year commences January 1 of each year and ends on December 31 of the same year.

D. YOUR RESPONSIBILITIES

1. **Your Mailing Address**. Be sure to keep the Plan Office advised of changes in your address so that you can continue to receive Plan information because you may be entitled to benefits in the future.

2. **Enrollment Form**. You should keep your enrollment form up to date (add new spouse and dependent children with required proof). You are required to notify the Plan Office if a dependent no longer meets the Plan's requirements (i.e., divorce, death, and over-age dependents).

3. **Beneficiary Form**. You should keep your beneficiary form up to date so that family members or others you want to receive your benefits receive them without delay. If you are married, benefits are automatically paid to your legal spouse *unless* he or she consents in writing before a notary. You should submit a new form if there is a change in life circumstance (marriage or divorce).

E. NO ASSIGNMENT OF BENEFITS. The benefits payable hereunder shall not be subject to any manner of anticipation, alienation, sale, transfer, assignment, pledge, or garnishment. There is no assignment of benefits to providers and no benefit payments may be paid to providers.

F. TIME TO FILE CLAIMS. Benefits shall be paid by the Plan only if notice of a claim is made within 180 days from the date on which covered charges were incurred. The claimant must submit properly completed claim forms and itemized statements as required by the Board of Trustees. Any submission of claims later than 180 days are subject to the approval of the Board of Trustees, but in no event shall claims be considered for payment later than 12 months from the date on which the covered charges were incurred.

G. **INCOMPETENCE OR INCAPACITY**. If the Plan determines that the Covered Person is incompetent or incapable of executing a valid receipt with no appointed guardian, or in the event the Covered Person has not provided the Plan with a current address the Plan may pay any amounts otherwise payable to the Covered Person to the Covered Person's spouse, blood relative, or any other person or institution determined to be equitably entitled to payment. 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 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.

H. **NO RIGHT TO BENEFITS**. No Covered Person or other beneficiary shall have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to eligibility, type, amount, or duration of benefits under this Plan or any amendment or modification thereto shall be resolved by the Board of Trustees. No action may be brought for benefits provided by this Plan or any amendment or modification thereof, or to enforce any right thereunder, until after the claim has been submitted to and determined by the Board of Trustees. No such action may be brought unless brought within one year after the date of such decision. The decision of the Board of Trustees shall be final and binding on all parties.

I. **WORKERS' COMPENSATION INSURANCE.** The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

J. **CONTROL DOCUMENTS**. The provisions of this Plan are subject to and controlled by the provisions of the Trust Agreement, if applicable, and in the event of any conflict between the provisions of the Trust Agreement and the provisions of this Plan, the Trust Agreement shall prevail.

K. **AVAILABLE ASSETS FOR BENEFITS**. The benefits provided by this Plan can be paid only to the extent that the Fund has available adequate resources for such payments. No contributing Employer has any liability, directly or indirectly, to provide the benefits established hereunder beyond the obligation of the contributing Employer to make contributions as stipulated in the Collective Bargaining Agreement. In the event that the Fund does not have sufficient assets to permit continued payments hereunder, nothing contained in this Plan shall be construed as obligating any contributing Employer 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 such benefits. Likewise, there shall be no liability upon the Board of Trustees, individually or collectively, or upon any Employer, the Union, signatory association or any other person or entity of any kind to provide the benefits established hereunder if the Fund does not have sufficient assets to make such benefit payments.

L. **FUND PHYSICIAN**. The Fund, at its own expense, shall have the right and opportunity to have a physician of its choice examine the Covered Person when and as often as it may reasonably require resolving any claim at issue.

M. **TRUSTEE RIGHTS**. To carry out its obligation to maintain, within the limits of the funds available, a sound economic program dedicated to providing the benefits for Covered Persons, the Board of Trustees expressly reserves the right, in its sole discretion:

1. to terminate or amend either the amount or conditions with respect to any benefits or provisions of the Plan even though such termination or amendment affects the claims in process and/or expenses already incurred; or

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

3.to amend any provision of this Plan Document.

N. PARTICIPANT ON ACTIVE MILITARY SERVICE.

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

a. to have his/her 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 (and then be eligible to pay a premium for COBRA).

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 include the Army, Navy, Air Force, Marine Corp, Coast Guard, National Guard (full time duty), Commissioned Corps of Public Health Service, and anyone else designated as Covered by the President of the United States during time of war or National Emergency.

b. Employee Provide Prior Notice of Service. An employee leaving for uniformed service has to provide prior notice that his/her absence will be due to uniformed service. Written notice is not required. You are strongly urged to notify the Union Dispatch Office so that the uniformed service may be noted on the dispatch rolls, 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). You may assert USERRA benefits for military absence not to exceed five years. There are limited exceptions to the five-year rule so if you are close to that period, you may contact the Plan Office to determine if your situation may meet an exception to the five-year rule.

d. Employee Must be Honorably Discharged from Service. The employee must have been honorably discharged from the military service.

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

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

(2). Service of More than 30 and less than 181 Days. If your military service lasts

longer than 30 days but less than 181 days, you must be available for Covered Employment no later than 14 days after completion of military service.

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

3. Right to Certain Health Care Benefits Under the Plan.

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

b. Absent for More than 30 Days. If you are absent from Covered Employment as a result of military service for more than 30 days, you may elect to purchase COBRA-like coverage for up to 24 months (the first month of which is free). After that first 30 days, you will be required to pay a premium of 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 in January, you would 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. 24 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.

NOTE: Participants and their dependents may be eligible for coverage under CHAMPUS, a federal health care plan. Participants should review the coverage options before deciding to self-pay.

YOU MUST NOTIFY THE PLAN OFFICE OF YOUR RETURN FROM ACTIVE DUTY. Participants must notify the Plan Office of their return from active duty. The Plan Office will restore the Participant's frozen hours, and the Participant will once again be eligible for all benefits that he/she would normally have been eligible for had he/she not been called to active duty.

Right to Waive your Rights. However, you may elect to waive your rights under federal law. In that case, your Reserve Account may be applied to provide coverage for your dependents at the

applicable rate for active members. The months of coverage so applied.

O. FAMILY MEDICAL LEAVE ACT - EMPLOYEES OF LARGER EMPLOYERS

Certain large Employers (has at least 50 employees) may have to continue to pay for your health coverage during an approved leave under the federal or state Family and Medical Leave Act (FMLA). In general, you may qualify for up to 12 weeks of unpaid FMLA leave per year if:

a. Your Employer has at least 50 Employees.
b. You must be actively employed by a contributing employer at the time you take FMLA.
b. You worked for one or more contributing Employers for at least 12 months (not consecutive) and for a total of at least 1,250 hours during the most recent 12 months before the FMLA; and
c. You require leave for one of the following reasons:

i. birth (within one year of birth) or placement of a child for adoption or foster care (within one year of placement),
ii. to care for your child, spouse, or parent with a serious medical condition, or
iii. your own serious health condition,
iv. Military Caregiver Leave (up to 26 weeks during a 12-month period). 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.
v. if you are unable to work or telework due to the care of your child because of the closure of the child's school or place of care or the unavailability of a childcare provider due a public health emergency which is defined as an emergency with respect to COVID-19 declared by a Federal, State, or local authority (during the period of April 1, 2020 through December 31, 2020); or
vi. Any other purpose provided for by the FMLA as amended.

You must intend to return to work for your employer after the FMLA and you may use the FMLA benefit once per 12 consecutive months. Details concerning FMLA leave are available from your Employer. If you are requesting Emergency Expanded FMLA leave during April 1, 2020, through December 31, 2020, please contact your employer regarding taking Emergency Expanded FMLA leave.

Requests for FMLA leave must be directed to your Employer; the Plan Office cannot determine whether you qualify. If your Employer grants you an approved FMLA leave in accordance with FMLA, you may continue health coverage for you and your eligible dependents provided your Employer maintains the required contributions to the Plan on your behalf or you make any required contributions to the Plan. Your Employer is the one who will certify your eligibility for FMLA health care continuation. 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 to the Plan. 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. 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 contributions made for your coverage during the leave.

P. QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMSCO)/NATIONAL ORDER

The Plan will recognize a Qualified Medical Child Support Order (QMSCO) and enroll as directed by the Order any covered child of an Employee specified by the Order. A QMSCO is any judgment, decree, or

order (including approval of a domestic relations settlement agreement) issued by a court or by an administrative agency under applicable state law which:

1. provides the child of a Plan Participant with child support or directs the Participant to provide the child with coverage under a health benefits plan, or

2. enforces a state law relating to medical child support pursuant to Section 1908 of the Social Security Act which provides in part that if the Employee parent does not enroll the child, then the non-Employee parent or State agency may enroll the child.

A QMCSO may be either a National Medical Child Support Notice ("NMSN") issued by a state child support agency or an order or a judgment from a state court or administrative body directing the employer/plan to cover a child under the Plan. Federal law requires that a medical child support order meet certain form and content requirements to be qualified. You may request a copy of the written procedure for determining whether a medical child support order is qualified, free of charge, from the Plan Office. In general, the following steps will be followed to establish and determine whether a court order or NMSN will qualify as a QMCSO:

(a) The participant must provide the Plan Office with a copy of the court order or NMSN and/or QMCSO.
(b) Within 30 days of receipt of the QMCSO and/or NMSN, the Plan Office or the Plan's Legal Counsel will notify the Participant in writing if the order is acceptable to the Plan.
(c) If the Plan determines the court order or NMSN and/or QMCSO is not acceptable or if additional information is required, the Participant will be notified in writing by the Plan or the Plan's Legal Counsel.
(d) **If a QMCSO and/or NMSN is denied**. The notice will describe the reasons for denial and your right to appeal, along with a summary of the Plan's appeal procedures. In most instances however, you will simply be asked to revise the order in such a way that it is a QMCSO and/or qualified NMSN.
(e) **If additional information is required**. The notice will describe what is needed. There will be sixty (60) days to respond.
(f) To be Qualified, a Medical Child Support Order must clearly specify:
(g) The name and last known mailing address of the Participant and the name and mailing address of each child covered by the Order,
(h) A description of the type of coverage to be provided by the Plan to each such child,
(i) The period of coverage to which the Order applies, and
(j) The name of each Plan to which the Order applies.

A Medical Child Support Order will not qualify if it would require the Plan to provide any type or form of benefit or any option not otherwise provided under this Plan, except to the extent necessary to comply with Section 1908 of the Social Security Act.

Payment of Benefits by the Plan under a Medical Child Support Order to reimburse expenses claimed by a child or his custodial parent or legal guardian shall be made to the child or his/her custodial parent or legal guardian if so, required by the Medical Child Support Order.

No eligible Participant's child covered by a QMCSO will be denied enrollment on the grounds that the child is not claimed as a Dependent on the parent's Federal income tax return or does not reside with the parent.

A QMCSO recognizes an eligible Child(ren)'s right to receive Plan benefits as a beneficiary of an eligible Plan Participant. The Child(ren) must meet the Plan requirements of an eligible Dependent Child(ren) and will be covered through age 25. **Coverage may terminate earlier than age 26 if the QMCSO and/or NMSN states such.** The Plan and its delegates have the discretion to enroll the child(ren) using its best judgment in the interpretation of a QMCSO and/or NMSN.

Q. CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT

The Children's Health Insurance Program Reauthorization Act of 2009 created a new special enrollment period that applies to group health plans, like those currently in effect for the loss of eligibility for other group coverage or qualifying life status changes. Under this Act, group health plans must permit those eligible for group health plan coverage to enroll in the Plan if they:

- Lose eligibility for Medicaid or SCHIP coverage or
- Become eligible to participate in a premium assistance program under Medicaid or SCHIP

In both cases, you must request special enrollment within 60 days (of the loss of Medicaid/SHIP or the eligibility determination.

R. **CLAIM FORMS**. All claims for benefits shall be filed on forms provided by the Plan Office, which will be available from the Plan Office. The Plan, upon receipt of a written notice of claim, will furnish such forms to the claimants.

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

T. PAYMENT OF CLAIMS. Subject to any written direction of the Participant in an application or otherwise, all or a portion of any benefits provided by the Plan on account of hospital, medical or surgical services may, at the Plan's option, and unless the claimant requests otherwise in writing, no later than the time for filing proof of such loss, be paid directly to the Hospital or individual rendering such services.

Amounts payable for other than Death Benefits will be paid to the claimant subject to the provisions set forth in this section, or if the claimant is deceased, to the claimant's beneficiary.

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

V. CONSTRUCTION. The validity of the Plan or any of its provisions will be determined under and will be construed according to ERISA and other federal law and, to the extent permissible, according to the laws of the State of California. This Plan is intended to be construed as a whole, but in the event any

provision of this Plan is held illegal or invalid for any reason, such determination will not affect the remaining provisions of this Plan and the Plan will be construed and enforced as if said illegal or invalid provision had never been included.

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

X. GENDER AND NUMBER. Wherever applicable, the masculine pronoun as used herein shall include the feminine and the singular the plural.

Y. OVERPAYMENTS; DUTY OF COOPERATION. Whenever a payment or payments are made more than the allowable amount payable under the Plan, the Fund has the right to recover such excess payments from any person(s), service plan or any other organization to or for which the excess payments were made.

If an overpayment of benefits has been made to or on behalf of the employee or dependent, the Fund, at its option, may require immediate repayment in full, set-off the overpayment from current and future benefit payments, including benefit payments due on behalf of another covered family member, and/or institute legal action to collect the overpayment and related costs and attorney's fees and interest.

You and your covered dependents must provide the Fund with any information the Fund deems necessary to determine eligibility, process claims and/or implement Plan terms. Failure to provide any information requested by the Plan or its agents may result in the rejection of a claim for benefits.

If an overpayment results from misrepresentations made by or on the behalf of the recipient of the benefits, the Fund may also obtain reimbursement of interest, professional fees incurred, and other damages related to that over-payment.

A claim for benefits will be rejected and the Fund will be entitled to recover money that you, your dependents or a service provider have received if a false statement or omission of a material fact was purposely made by any person to receive benefits. The Fund may also obtain reimbursement of interest on this money as well as professional fees incurred and other damages.

Z. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA). The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that prevents large group health plans (such as this Plan) and health insurers that provide mental health or substance abuse benefits from imposing less favorable benefit limitations, including financial requirements (e.g., deductibles, copayments, coinsurance and out of pocket limitations) and treatment limitations (e.g., number of visits or days of coverage) on those benefits than on medical and surgical benefits offered. As such, the limitations applicable to mental health or substance abuse benefits can be no more restrictive than the predominant limitations applied to substantially all medical and surgical benefits. Pursuant to the Final MHPAEA rules, the Plan or Health Insurer will provide any current participants or potential participants, or contracting providers, upon request, the criteria for medical necessity determinations with respect to mental health/substance abuse benefits and the reason for any denial of reimbursement or payment for services with respect to mental health/substance abuse benefits will also be provided upon request.

It is the intention of the Board of Trustees and the contracted insurers that the Plan's benefits be provided in compliance with the requirements of MHPAEA and lawful regulations issued thereunder. For more

information on MHPAEA, please visit the Department of Labor website at *www.dol.gov/ebsa*.

AA. PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA)

1. **Grandfathered Plan.** The Board of Trustees believes this Plan is a "Grandfathered health plan" under the federal law known as the Patient Protection and Affordable Care Act of 2010 (ACA). As permitted by the ACA, a Grandfathered health plan can preserve certain basic health coverage that was already in effect when the ACA was enacted. Being a Grandfathered health plan means that the Plan is not required to include certain consumer protections of the ACA that apply to other plans, for example, requiring the provision of preventive health services without any cost sharing. Grandfathered health plans must comply, however, with certain other consumer protections in the ACA, such as the elimination of annual and lifetime limits on the Plan's Essential Health Benefits. (For a definition of what constitutes Essential Health Benefits please visit ***www. Healthcare.gov/glossary/essential-health-benefits.)***

   Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Manager. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor (DOL) at 1–866–444–3272 or ***www.dol.gov/ebsa/healthreform***. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

2. **No Pre-Existing Condition Exclusions for Any Individual.** The ACA prohibits insurance plans in the individual and group markets from imposing pre-existing condition exclusions on any individual for Plan Years beginning after January 1, 2014. This ban includes both benefit limitations (e.g., an insurer or employer health plan refusing to pay for chemotherapy for an individual with cancer because the individual had the cancer before getting insurance) and outright coverage denials (e.g., when the insurer refuses to offer a policy to the individual because of the individual's pre-existing medical condition). This Plan does not impose any pre-existing condition exclusions.

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

4. **Minimum Essential Coverage.** Under the ACA, Plan sponsors are required to provide minimum essential coverage. Minimum essential coverage includes jointly sponsored coverage such as this Plan. The ACA also establishes a minimum value standard of benefits for health plans. Minimum value means coverage under a health plan (such as this Plan) meets the minimum value standard if the plan's share of the total allowed costs of benefits provided is 60% or greater. The Board of Trustees believes this Plan provides minimum essential coverage and meets the minimum value standard for the benefits it provides.

5. **Availability of Summary of Benefits & Coverage ("SBC").** The ACA requires group health plans and health insurers to provide a Summary of Benefits and Coverage, also known as the "SBC," to Participants and their Dependents. The SBC is a standard format, written in easy-to-understand language, summary of what the Plan covers and what it costs. It is intended to help you understand and compare the different benefits and coverage options available to you under the Plan. Under the ACA, you also have a right to request and receive within 7 business days a copy of the Plan's SBC in

paper form, at any time and free of charge. If you want a copy of the Plan's self-funded Plan SBC, please call the Plan Office.

6. **Elimination of Lifetime and Annual Dollar Limits on Essential Health Benefits.** The ACA prohibits both grandfathered and non-grandfathered health plans from imposing lifetime and annual dollar limits on Essential Health Benefits. In accordance with the requirements of the ACA, this Plan does not impose any lifetime and annual dollar limits on its Essential Health Benefits. However, the Plan is permitted to impose annual limits on certain non-Essential Health Benefits consistent with the ACA and lawful regulations issued thereunder. Non-Essential Health Benefits means benefits that are not Essential Health Benefits as determined by the Plan and Claims Administrator in its sole discretion.

7. **Prohibition on Rescissions of Coverage.** Under the ACA, group health plans and insurers must not rescind coverage (meaning cancel or discontinue coverage retroactively) unless a covered individual commits fraud or makes an intentional misrepresentation of material fact. However, a retroactive cancellation or discontinuance of coverage is not a rescission if it: has only prospective effect; is initiated by the covered individual; due to delay in administrative record-keeping; termination of coverage retroactive to the divorce if a plan does not cover former spouses; or attributed to a failure to timely pay required premiums or contributions toward the cost of coverage. In accordance with the ACA, this Plan will not rescind coverage unless permitted by the ACA or your and/or your eligible dependent commits fraud or makes an intentional misrepresentation of material fact.

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

9. **CONSOLIDATED APPROPRIATIONS ACT OF 2021 ("CAA")**. The Plan's Insured Carriers (Kaiser and Anthem Blue Cross) are responsible for complying with certain provisions of Division BB of the Consolidated Appropriations Act under the No Surprise Act (Title I) and Transparency (Title II) provisions, including any subsequent implementing regulations as it relates to the CAA. More information on these federal requirements is also available directly with Kaiser and Anthem Blue Cross.

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

    2. Ensuring Continuity of Care (CAA Section 113).
    When a provider or contracted facility is removed from the self-funded Plan (if applicable) or Insurer's (Kaiser or Anthem Blue Cross) coverage, following termination of the provider/facility

contract between the Plan or Insurer and the Provider/Facility, the Plan (for self-funded plans) or Insurer (Kaiser and Anthem Blue Cross) should timely notify Participants or their eligible Dependents who are receiving continuing care for a serious and complex condition (serious and complex condition means an acute illness that is a condition that is serious enough to require specialized medical treatment to avoid reasonable possibility of death or permanent harm or in the case of chronic illness a condition that is life-threatening, degenerative, potentially disabling or congenital and requires specialized medical care over a prolonged period of time) from that provider or facility that:

a. The Provider/Facility is no longer part of the Insurer's network.

b. The Participant or eligible Dependent has the right to continue receiving transitional care for up to ninety (90) days at the in-network cost sharing and at the same terms that would have applied had termination not occurred.

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

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

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

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

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

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

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

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

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

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

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

b. **Cost-Sharing Limits.** In addition, for the three above-mentioned Surprise Act items and services (#1, #2 and #3) any cost-sharing (such as copayment, coinsurance, or deductible) must not be greater than the in-network cost sharing amount and must count towards the Insured Coverage's in-network deductible and out-of-pocket maximums, as of the items and services were provided by a participating provider. The Participant or Dependent's cost-sharing is based on the recognized amount. By statute, the recognized amount is (in order of priority) for only out-of-network emergency services and non-emergency services provided by an out-of-network provider at participating facilities:

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

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

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

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

d. Patient Protections Disclosure Requirements Against Balance Billing.

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

Contact Kaiser and Anthem Blue Cross directly for more information.

ARTICLE XVI. THIRD PARTY RECOVERY/SUBROGATION

A. THIRD PARTY RECOVERY/SUBROGATION/REIMBURSEMENT REQUIREMENTS - If the Covered Person is injured through the act or omission of another party, Plan benefits are available provided all of the following are met:

1. The Plan does not cover any illness, injury, disease or other condition for which a third party may be liable or legally responsible, by reason of negligence, an intentional act or breach of any legal obligation on the part of that third party.

You are required to notify the Plan Office if any claims you incur 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 responsible are not covered charges under any benefits provided in this Plan. However, payments will be advanced to an otherwise eligible participant or beneficiary, if the conditions of this section are met.

2. The Covered Person (Participant, Spouse, Child or Other dependent) agrees to pay to the Plan immediately any proceeds received by way of judgment, settlement or otherwise (including receipt of proceeds under any uninsured motorists coverage or other insurance including the Participant's own or family insurance coverage.) arising out of any claims for damages by the individual or his or her 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 or she is making a present assignment of his or her rights against such third party to the extent of the payments made by the Plan.

3. The Plan may require that any Covered Person complete an Accident Questionnaire Form and 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. An equitable lien attaches to any benefits advanced by the Plan on behalf of any Covered Person regardless of whether an Agreement to Reimburse and/or Assignment of Recovery is completed and returned to the Trust Fund. **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. The Participant is liable for any amounts not paid by a spouse or child**

or other covered person.

4. The Plan is entitled to a first priority and first-dollar basis recovery for the full amount of Covered Charge it has paid or may pay for the injury or illness of a Covered Person that are related to the Third Party Claim from any recovery whether by suit, settlement or otherwise, whether there is a partial or full recovery and regardless of whether the claimant is made whole and regardless of whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses.

5. As a condition of receiving benefits under the Plan, the Covered Person grants specific and first rights of subrogation, reimbursement and restitution to the Plan. Such rights shall come first and are not adversely impacted in any way by: (a) the extent to which the Covered Person recovers his/her full damages and/or attorneys' fees; or (b) how such recovery may be itemized, structured, allocated, denominated, or characterized; e.g., without regard to any characterization as a recovery for such matters as lost wages, damages, attorneys' fees, etc. rather than for medical expenses, the type of property or the source of the recovery, including any recovery from the payment or compromise of a claim (including an insurance claim), a judgment or settlement of a lawsuit, resolution through any alternative dispute resolution process (including arbitration), or any insurance (including insurance on the Covered Person, no-fault insurance, or uninsured and/or underinsured motorist coverage).

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

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

8. 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. A lien shall exist in favor of the Plan upon all sums of money recovered by the Covered Person against the third party. 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. The Plan's claim shall be a lien on said recovery and attach to the recovery or any tangible property that the recovery may be transmuted to. The Covered Person also agrees that until such lien is completely satisfied, the holder of any such property (whether the Covered Person, his/her attorney, an account or trust set up for the Covered Person's benefit, an insurer, or any other holder) shall hold such property as the Plan's constructive trustee. As such, the constructive trustee agrees to immediately pay over such property to or on behalf of the Plan pursuant to its direction to the extent necessary to satisfy the equitable lien.

a. If the Covered Person does not attempt to recover benefits paid by the Fund or for which the Fund may be obligated, the Plan shall, if in the Plan and Participants' best interest and at its sole discretion, be entitled to institute legal action or claim against the responsible parties, against any uninsured or underinsured

insurance coverage, or against any other first-party or third-party contract or claim in the name of the Fund or Trustees in order that the Fund may recover all amounts paid to the Covered Person or paid on their behalf.

b. The Covered Person shall immediately notify the Trust upon receiving a judgment, settlement offer, or other compromise offer and upon filing any petition to compromise a minor's claim. The Covered Person shall not settle or compromise any claims with the Trust's consent.

c. 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.

d. The Trust may cease advancing benefits if there is a possible basis to determine that the Covered Person will not honor the terms of this section. If the Covered Person does not reimburse the Plan or otherwise comply with the obligations under this section, the Plan may take all appropriate steps to recover money it paid on his/her behalf of for his/her dependents, including filing suit against the Covered Person and/o**r offsetting (including refusing to honor) any future claims incurred by the Participant and/or his or her family members against amounts owed to the Plan.**

ARTICLE XVII. HIPPA AND PRIVACY OF PROTECTED INFORMATION (NOTICE OF PRIVACY RIGHTS

A. PRIVACY OF PROTECTED HEALTH INFORMATION UNDER HIPAA

1. **INTRODUCTION.** The Plan is required by state and federal law, namely the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), to make sure that medical information, known as Protected Health Information ("PHI") that identifies you is kept private and secure to the extent required by law. We are also required to give you this Notice regarding the uses and disclosures of medical information that may be made by the Plan, and your rights and the Plan's legal duties with respect to such information. The Plan must also follow the duties and privacy practices described in this Notice. This Notice and its contents are intended to conform to the requirements of HIPAA, and it applies to all records containing your PHI that are created, transmitted or retained by the Plan or Business Associates (including their subcontractors) that help administer the Plan.

- **PHI Defined.** The term "PHI" or "medical information" in this Notice means individually identifiable medical and genetic information that relates to your physical or mental health condition, the provision of health care to you, or payment of such health care.
- **De-Identified PHI.** This Notice does not apply to information that has been de-identified. De-identified information neither identifies nor provides a reasonable basis to identify you.
- **Minimum Necessary.** When using or disclosing PHI, the Plan will make reasonable efforts not to use, disclose, or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological factors and limitations and any applicable law requiring greater disclosure.

The Plan office will also let you know promptly if a breach occurs that may have compromised the privacy or security of your information. The Plan will not use or share your information other than as permitted

by HIPAA and unless you tell the Plan Office it can in writing. If you tell the Plan office it can, you may change your mind at any time, but let the Plan Office know in writing.

The rights in this Notice apply to you, your Spouse, and your Dependents.

Please be advised that other vendors or entities that provide medical, dental and vision services to you related to your participation in the Plan have issued or may issue you a separate Notice regarding disclose of PHI that is maintained by those entities.

2. **For more information regarding POTENTIAL IMPACT OF STATE LAWS, please see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

The HIPAA Privacy Rule generally does not take precedence over state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule, might impose a privacy standard under which the Plan will be required to operate. For example, where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproduction rights, and so on.

3. **OBLIGATIONS Re: PROTECTED HEALTH INFORMATION.** The Board of Trustees will:

a. Prohibit Use and Disclosure of Protected Health Information. Not use or disclose your Protected Health Information except as permitted by the benefit booklet as amended from time to time or required by law.

b. Subcontractors and Agents. Ensure that any agent or subcontractor to whom the Board of Trustees provides your Protected Health Information agree to the restrictions and conditions in the benefit booklet including this
section, with respect to your Protected Health Information.

c. Permitted Purposes. Not use or disclose your Protected Health Information for employment-related actions or decisions in connection with any other benefit or employee benefit plan sponsored by the Board of Trustees.

d. Reporting. Report to the Plan's privacy officer any use or disclosure of your Protected Health Information that is
inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.

e. Access to Protected Health Information by Participants. Make your Protected Health Information available to you in accordance with 45 C.F.R. § 164.524.

f. Amendment of Protected Health Information. Make your Protected Health Information available for amendment and, upon request, amend your
Protected Health Information in accordance with 45 C.F.R. § 164.526.

g. Accounting of Protected Health Information Disclosures. Track disclosures made of your Protected Health Information so that an accounting of disclosures can be made available to you upon request in accordance with 45 C.F.R. § 164.528.

h. Disclosure to Governmental Agencies. Make available the Plan's internal practices, books and records relating to the use and disclosure of your Protected Health Information to the United States Department of Health and Human Services to determine compliance with 45 C.F.R. § 164.

i. Return or Destruction of Protected Health Information. When your Protected Health Information is no longer needed for the purpose for which use or disclosure was made, the Board of Trustees must, if feasible, return to the Plan, or destroy, all Protected Health Information that the Board of Trustees received from or on behalf of the Plan.

This includes all copies in any form, including any compilations derived from the Protected Health Information. If return or destruction is not feasible, the Board of Trustees agrees to restrict, and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

j. Minimum Necessary Requests. Use their best efforts to request only the minimum necessary type and amount of your Protected Health Information to carry out the functions for which the information is requested.

4. **ADEQUATE SEPARATION BETWEEN THE TRUSTEES AND THE PLAN.** The Board of Trustees represent that adequate separation exists between the Plan and the Board of Trustees so that Protected Health Information relating to the payment, health care operations or other matters pertaining to the Plan:

   - Employees of Plan Office; and
   - Business Associates of the Plan and their employees, officers, directors, agents and subcontractors provided the Business Associate has signed a Business Associate Agreement.

   The person and organizations identified above will have access to your Protected Health Information only to perform plan administration functions. The persons and organizations identified above will be subject to disciplinary action and sanctions, including termination of the contract for any use or disclosure or your Protected Health Information in breach or violation of the Business Associate Agreement.

5. **ADEQUATE SEPARATION CERTIFICATE.** The Board of Trustees represents that the employees and organizations identified above are the only employees and organizations who will access and use your Protected Health Information generated by the Plan. The employees and organizations identified above will only access and use your Protected Health Information for the purposes identified in the section titled *"DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE BOARD OF TRUSTEES."*

B. Privacy Practices of the U.A. Local 467 Health, Welfare and Vacation Plan

(This Privacy Notice is effective as of October 1, 2023.)

Our Uses and Disclosure

How the Plan typically uses or shares your medical information?

The following categories describe different ways that we use and disclose medical information. For each category of uses and disclosures, the Plan will explain what it means and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information may fall within one of the categories.

Treatment.	The Plan can use your PHI to tell you about or recommend possible treatment options or alternatives that may be of interest to you, including but not limited to consultations and referrals between your providers. For example, the Plan may disclose information to your physician. *Example: Doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
For Payment.	We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may share protected health

	information with other health plans for the purpose of determining which health plan is primarily responsible for payment of claims for benefits under the health plan. However, you may request that a Covered Entity not disclose protected health information to the plan for payment purposes if the disclosure is not otherwise required by law and the protected health information pertains solely to a health care item or service for which you (or any person other than the plan) have paid the Covered Entity in full. *Example: We share your eligibility for benefits information with Anthem Blue Cross to confirm whether payment will be made for a particular service.*
For Health Care Operations/Appeals.	The Plan can use and disclose health information about you for Plan operations that are necessary to run the Plan. The Plan may also release your PHI to the Board of Trustees or an Appeals Committee if it is needed to make a decision regarding an appeal. For example, we disclose protected health information for quality improvement, business planning, and cost management purposes. However, you may request that a Covered Entity not disclose protected health information to the plans for purposes of health care operations if the disclosure is not otherwise required by law and the protected health information pertains solely to a health care item or service for which you (or any person other than the plan) have paid the Covered Entity in full. *Example: We use health information in reviewing & responding to appeals, medical reviews, legal services, audit services, Plan administrative activities, premium rating, or conducting quality assessment and improvement activities.*
As Required by Law and to Prevent a Serious Threat to Health or Safety	The Plan can use and disclose your health information if required by state, federal or local laws. The Plan may use or disclosure your PHI when necessary to prevent a serious threat to your health or safety, or the health or safety of another person or the public. *Example: We share information with the Department of Health & Human Services for compliance with federal privacy laws.*
To Avert a Serious Threat to Health or Safety/Assist Public Health Issues. (including suspected abuse, neglect or domestic violence)	The Plan can use and disclose your health information when it believes, in good faith, that such disclosure is necessary to prevent a serious threat to the safety and health of you, another individual, or the public. This includes disclosing medical information for public health activities to a public authority. These disclosures will be made for the purpose of controlling disease, injury or disability. Such activities may include, for example, preventing or control disease, injury or disability; to report births or deaths,; or to report child abuse or neglect and/or domestic violence. *Example: We share health information to report suspected abuse, neglect or domestic violence if we have a reasonable belief, or to prevent disease, or to help with product recalls, or to prevent/reduce a serious threat to anyone's health or safety.*
To Inform You About Treatment Alternatives or Other Health Related Benefits.	The Plan may use PHI to identify whether you may benefit from communications from the Plan regarding (1) available provider networks or available products or services under the Plan, (2) your treatment, (3) case management or care coordination for you, or (4) recommended alternative treatments, therapies, health care providers, or settings of care for you. *Example: We may forward a communication to a participant who is a smoker regarding an effective smoking-cessation program.*
Disclosure to the Plan's Board of Trustees	Medical information may be disclosed to the Board of Trustees of the Plan in order for the Board to perform its plan administration functions such as determining issues related to eligibility and enrollment and performing its

	fiduciary obligations.
Organ and Tissue Donation.	The Plan can share health information about you with organizations involved in procuring, banking or transplanting organs, eyes or tissues, as necessary.
Military, Veterans, and Inmates.	The Plan may release health information about you as required by military command authorities, if you are a member of the armed forces, or to a correctional institute or law enforcement official, if you are an inmate or under custody of a law enforcement official.
Respond to Lawsuits and Disputes.	Th The Plan can use and disclose your health information to respond to a court order, administrative proceeding, arbitration, subpoena, other lawful process or similar proceeding. This includes assisting law enforcement officers with identifying or locating a suspect, fugitive, material witness, or missing person. It also includes informing law enforcement officers about the victim of a crime or if the Plan suspects a death resulted from criminal conduct, as well as if necessary to report a crime that occurred in or around the Plan's office. *Example: We receive a discovery request in which you are a party involved in a lawsuit.*
Government or Law Enforcement Requests.	To the extent permitted or required by local/state/federal law, the Plan may release your health information to law enforcement officials or for law enforcement purposes, to authorized government agencies, to health oversight agencies, or to comply with laws related to workers' compensation claims (and similar programs that provide benefits for work-related injuries or illness). This includes disclosure to government agencies authorized by law to conduct audits, investigations and inspections. These government agencies monitor the operation of the health care system, government benefit programs (such as Medicare and Medicaid) and compliance with government regulatory programs and civil rights laws. *Example: We release health information because there is suspicion that your death was the result of a criminal conduct, or because of civil administrative or criminal investigations, audits, inspections, licensure or disciplinary action, or other activities necessary for the government to monitor government programs (such as Medicare fraud review), or for special government functions such as military, national security and presidential protective services.*
Research.	The Plan can use and share your health information for health research subject to certain conditions, such as a waiver of authorization required by the HIPAA Privacy Rule has been approved by the Board of Trustees.
Child Immunization Proof to Schools.	The Plan may disclose proof of immunization of a student to the school, prior to admitting the student, where State or other law requires such information, upon obtaining the consent of the parent, guardian, or student of consenting age. Consent may be given by e-mail, in writing, over the phone, or in person.
Decedent's Health Information.	The Plan may disclose your PHI to your family members and others who were involved in your care or payment of your care, unless doing so is inconsistent with your prior written expressed wishes that was given to the Plan. However, PHI of persons who are deceased for more than 50 years is not protected under the HIPAA privacy and security rules. This includes disclosure of PHI to a coroner or medical examiner, as this may be necessary, for example, to determine the cause of death. The Plan may also disclose this information to funeral directors as is necessary to carry out their duties. *Example: We disclose health information to a coroner or medical examiner necessary to identify a deceased person or determine the cause of death.*
Business Associates & Subcontractors.	The Plan may also share your PHI with business associates, including its subcontractors or agents that perform certain administrative services for the Plan.

	As required by federal law, the Plan has a written contract with each of its business associates that contains provisions requiring them to protect the confidentiality of your PHI and to not use or disclose your PHI other than as permitted by the contract or as permitted by law.

Our Uses and Disclosures

For certain information, you can tell us your choices about what we Share.

Except as provided for in this Notice or as permitted by law, the Plan will not release your PHI without your written authorization. **If you have a clear preference for how the Plan shares your information in the situations described below, contact the Plan office and inform the Plan what you want the Plan to do. The Plan Office has an Authorization Form that you may sign to authorize the release of all or part of your PHI. In the situations below, you have both the right and choice to tell the Plan to:**

- ✓ Share information with your family, close friends, or others involved in your health care or payment for your case, if you do not object.
- ✓ Share information in a disaster relief situation.

If you are not able to tell the Plan your preference, for instance if you are unconscious or not around, the Plan may share your health information if the Plan believes it is in your best interest. The Plan may also share your health information when needed to lessen a serious and imminent threat to health or safety.

In these cases, the Plan will not share your information unless you give your written authorization subject to your right to revoke, amend, or limit your authorization in writing, at any time:

- ✓ **Psychotherapy Notes**. Psychotherapy notes are separately filed notes about your conversations with your mental health professional. Although this Plan does not routinely obtain psychotherapy notes, it must generally obtain your written authorization before the Plan will use or disclose psychotherapy notes about you.
- ✓ **Marketing Authorization**. The Plan cannot receive financial remuneration (direct or indirect payment) from third parties in exchange for the marketing of PHI unless permitted under HIPAA or with your prior written authorization. Marketing is any communication about a product or service that encourages recipients of the communication to purchase or use the product or service. This Plan never markets personal information.
- ✓ **Sale of PHI.** The Plan is prohibited from directly or indirectly receiving financial or non-financial remuneration in cash or in kind (including granting license rights) from a third party in exchange for your PHI unless permitted under HIPAA or with your prior written authorization. This Plan does not sell your PHI.
- ✓ **Fundraising Purposes**. Except as permitted under HIPAA or with your prior written authorization, the Plan cannot use or disclose your PHI for fundraising purposes. Although the Plan does not use nor does it intend to use your PHI for fundraising purposes, it must inform you of your right to opt out of receiving any fundraising communications (whether received in writing or over the phone) if it uses or discloses your PHI for fundraising purposes.
- ✓ **Genetic Information.** Your PHI includes genetic information. Regarding underwriting, which is premium rating, or similar activities, the Plan will not use or disclose genetic information about an

individual, as prohibited under the Genetic Information Nondiscrimination Act of 2008. Also, the Plan cannot use your genetic information to decide whether it will give you coverage and the price of that coverage.

- ✓ **Other Uses of Medical Information.** Other uses and disclosures of health information not covered by this Notice or the laws that apply to the Plan will be made only with your written permission. If you provide us with permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission.

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of your responsibilities to help you.

- ✓ **Right to Inspect and Copy Your Medical Information.** You have the right to request access to your PHI as well as have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy such medical information, you must submit your request in writing to the Plan Office. This includes the right to request a copy of your PHI in hard copy or electronic form contained in a designated record set for so long as the Plan maintains the PHI. The electronic form you request may be in the form of MS Word, Excel, text, or text-based PDF, among other formats. If the format you request is not readily producible, the Plan will provide you with a copy of your PHI in a readable format as agreed to by you and the Plan. Your requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the plan is unable to comply with the deadline. If you request a copy of this information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy your medical information in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Pursuant to government regulations, you do not have a right to copies of psychotherapy notes.

- ✓ **Right to Amend/Correct Your Medical Information.** If you feel that medical information, we have about you is incorrect or incomplete, you may ask us to amend or correct the information. You have the right to request an amendment or correction for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Plan Office. In addition, you must provide a reason that supports your request. The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or in part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your health information.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) is not part of the medical information kept by or for the Plan, (2) was not created by us, unless the person or entity -that created the information is no longer available to make the amendment, (3) is not part of the information which you would be permitted to inspect and copy, or (4) or is accurate and complete.

Right to an Accounting of Disclosures. You have a right to obtain an accounting of certain disclosures of your medical information. This right to an accounting extends to disclosures other than to individuals about their own medical information, incident to an otherwise permitted use or disclosure, pursuant to an authorization, or to persons involved in the patient's care or other notification purposes, as part of a limited data set, In addition, the accounting of disclosures will not include any of the following:

- Disclosures made before April 14, 2004; or
- Disclosures related to treatment, payment, or health care operations; or
- Disclosures we made to you; or
- Disclosures you authorized; or
- Disclosures made to federal officials for national security and intelligence activities; or
- Disclosures about inmates or detainees to correctional institutions or law enforcement officials; or
- Disclosures made more than six years ago (the amount of time we are required to maintain records under the HIPAA Privacy Rule); or
- Disclosures made incident to a use or disclosure permitted or required by the HIPAA Privacy Rule; or
- Disclosures for a facility's directory or to persons involved in your care or certain other notification purposes; or
- Disclosures that were made as part of a limited data set (*i.e.*, a disclosure of protected health information that excludes certain individual identifiers that is generally for the purpose of health care operations or public health issues).

We may temporarily suspend your right to receive an accounting of disclosures under certain circumstances, such as when we are requested to do so by a health oversight agency or law enforcement official.

To request an accounting of disclosures, you must submit your request in writing to the Plan Office. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the plan is unable to comply with the deadline. Your request must specify a time period, which may not be longer than six years. Your request should indicate in what form you want the accounting (for example, paper or electronic). The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- ✓ **Right to Request Restrictions/Additional Privacy Protections.** You have the right to request that we further restrict the way we use and disclose PHI for treatment, payment or health care operations. We are not, however, required to agree to your request and in some situations, the e restriction you request may not be permitted by law. You may also request that we limit how we disclose PHI about you to someone who is involved in your care or the payment for your care. To request restrictions, you must make your request in writing to the Plan Office. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply. If we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, the Plan will have the right to revoke the restriction too.

- ✓ **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Such requests shall be honored if, in the sole discretion of the Plan, the requests are reasonable and can be accommodated with minimal disruption to Plan administration. However, the Plan must say "yes" if you tell us, you would be in danger if the Plan office does not honor

your request. To request confidential communications, you must make your request in writing to the Plan Office. Your request must specify how or where you wish to be contacted.

- ✓ **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

- ✓ **Right to Provide an Authorization**. As noted above, the Plan may request your written authorization for uses and disclosures that are not identified by this Notice or permitted by law. Any authorization you provide regarding the use and disclosure of your PHI may be revoked at any time in writing.

- ✓ **Right to File a Complaint**. If you believe your privacy rights have been violated, you may file a complaint with the Plan Office by contacting the Privacy Officer listed on the last page or with the U.S. Department of Health and Human Services, Office for Civil Rights by sending a letter to 200 Independence Avenue S.W., Washington, D.C. 20201, calling (877) 696-6775, or **visiting www.hhs.gov/ocr/privacy/hipaa/complaints**/. You must file a complaint within 180 days after the occurrence of the event or violation. You may also contact the Privacy Officer if you have any questions or concerns regarding your Privacy rights or regarding the specifics of filing a complaint. All complaints must be submitted in writing. You will not be penalized for filing a complaint and the Plan will not retaliate against you for filing a complaint.

- ✓ **Right to Notice in Event of Breach of Unauthorized Disclosure (Breach Notice)**. You have the 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. There will be a presumption that any unauthorized acquisition, access, use, or disclosure of your PHI, in violation of the Privacy rule is a breach, *unless* the Plan demonstrates that there is a low probability that your PHI has been compromised based on the results of a risk assessment or an exception permitted by the Privacy Rule applies. This Plan has implemented a policy to require the performance of a risk assessment in all cases of impermissible uses or disclosures of PHI to ensure your PHI will not be compromised and intends on complying with any future guidance on risk assessments.

- ✓ **Right to Restrict Disclosure of PHI If Paying Out-of-pocket.** If you paid for services out-of-pocket, in full, for a specific item or service, you have the right to ask your Health Care Provider to not disclose your PHI related to that item or service to the Plan for purposes of payment of health care operations. The Health Care Provider must accommodate your request, except where the Health Care Provider is required by law to make a disclosure**.**

- ✓ **Right to Choose Someone to Act For You (Personal Representative).** You may exercise your rights through a Personal Representative, who will be required to produce evidence of his/her authority to act on your behalf before he/she is given access to your health information or be allowed to take any action for you. The Plan Office will verify that the person has this authority and can act for you before it takes any action. Proof of such authority may take one of the following forms: (a) notarized power of attorney for health care purposes or (b) court order of appointment of the individual as your conservator or guardian.

How To Obtain a Copy of This Notice or a Revised Notice. You may request a paper copy at any time, even if you have previously agreed to receive this Notice electronically. The revised Notice will apply to all of your protected health information, and we will be required by law to abide by its terms. To request a copy of the Notice, you may contact the Plan Office. **We may change our privacy practices at any time.**

The Plan's Responsibilities.

- ✓ We are required by law to maintain the privacy of protected information.
- ✓ Privacy of information is one of our highest priorities. We regularly review our security standards and practices to protect against unauthorized access or release of private information.
- ✓ We restrict access to non-public personal information about a member to those employees who need to know that information in order to provide our services.
- ✓ We maintain physical, electronic and procedural safeguards that comply with federal regulations to protect a member's personal information.
- ✓ We reserve the right to modify or change our privacy policies and related procedures at any time, in accordance with applicable federal and state laws. If we do so, we will communicate any material changes to the members as required by law.
- ✓ We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- ✓ We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- ✓ We must follow the duties and privacy practices described in this notice and give you a copy of it.
- ✓ **Retaliation and Waiver.** We will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against you (or any other individual) for the exercise of any right established under the HIPAA Privacy Rule, including filing a complaint with us or with the Secretary of Health and Human Services; testifying, assisting or participating in an investigation, compliance review, proceeding or hearing under the HIPAA Privacy Rule; or opposing any act or practice made unlawful by the HIPAA Privacy Rule, provided that you (or the individual) have a good faith belief that the practice opposed is unlawful and the manner of the opposition is reasonable and does not involve a disclosure of protected health information in violation of the HIPAA Privacy Rule. We will not require you to waive your privacy rights under the HIPAA Privacy Rule as a condition of treatment, payment, enrollment in a group health plan, or eligibility for benefits.

Changes to This Notice

We can change this Notice, and the changes will apply to all information we have about you. Any changes that may occur, we will mail the revised Notice to participants. The New Notice will be available upon request (at any time), on our website, and we will mail a copy to you. The Plan will comply with the terms of any such Notice currently in effect.

Requests for Information

Questions regarding this information (and requests for the right to inspect and copy, the right to correct or amend and the right to an accounting of PHI) should be addressed to the HIPAA Privacy Officer at:

U.A. Local 467 Health and Welfare Plan
c/o United Administrative Services
P.O. Box 5057
San Jose, CA 95150-5057
Telephone: (408) 288-4400

ARTICLE XVIII. COORDINATION OF BENEFITS (COB)

All benefits of this Plan are subject to Coordination of Benefits (COB) and benefits are coordinated when you and your spouse (and/or your dependent children) are eligible for benefits from both this Plan and another group health plan (usually your spouse's plan). Coordination allows benefits to be paid by two or more plans up to but **not to exceed 100% of the allowable expenses on the claim**. **COB payment amounts shall not exceed the contracted maximums of the contract providers. At no time will the Plan pay more than for what the Participant is financially responsible.**

A. PURPOSE - The intent of this Article is to guarantee that the amount of benefits paid under this Plan plus the amounts of benefits paid under all other plans shall not exceed the actual cost charged for a treatment or service.

1. COB Claims. Benefits are coordinated on all employee, retiree and dependent claims. COB applies only to medical, prescription drug and dental benefits—it does not apply to vision benefits, Life Insurance, AD&D Insurance or Weekly Disability Benefits.

2. Sharing of Information. The Fund Office may release or receive necessary information about your claim to or from other sources. You must furnish the Fund Office with any information it needs to process your claim.

3. Claim Filing Requirement. You must file a claim for any benefits you are entitled to from any other source. Regardless of whether you file a claim with these other sources, the benefits payable by this Plan will be calculated as though you have received any benefits you are entitled to from the other source(s).

4. Other Group Plans/Programs. Benefits are coordinated with other group plans, including group Blue Cross plans, motor vehicle insurance, blanket insurance plans or any program providing benefits. If you or your spouse are covered under another plan, you can contact the Plan Office to find out whether that plan fits the definition of a group plan.

5. Medicare. Benefits are also coordinated with Medicare. If a person is eligible for Medicare, this Plan's benefits will be calculated as though he is enrolled in both Part A and Part B of Medicare, even if he has not actually enrolled in both Parts.

6. File Claims with Other Plans Too. When anyone in your family is covered under another group health plan and has a claim, be sure that you file claims with all eligible plans and provide all required information about other coverage on all claim forms.

7. Failure to Take Action. If a person is covered under one or more other plans in addition to this Plan, this Plan will coordinate benefits on the assumption that the other plans' rules were followed, that required providers were used, and that the other plans' maximum benefits were paid. This Plan will not pay benefits for expenses which would have been covered by another plan, but which are not covered by the other plan because the person failed to take the action required under the other plan's rules. This could occur in a case where the person was required by the other plan to use certain doctors or hospitals under an HMO or PPO plan. Or it could occur in cases where the person failed to comply with the other plan's required utilization review or cost containment procedures, such as hospital preadmission review, second surgical opinions, certification of other types of treatment, or any other required notification or procedure of the other plan, including failing to file a claim on time.

8. Auto Insurance and Other Policies. In the event a covered person is eligible for benefits under this Plan as well as under other group or individual fault or no-fault automobile insurance policies, this Plan's benefits will coordinate with those under the automobile insurance policies, so that the total benefits be paid under all policies do not exceed 100% of the total allowable expenses actually incurred. In all cases where a covered person is eligible for receipt of benefits under a no-fault automobile insurance policy, the automobile insurance carrier will be primary.

B. DEFINITIONS

1. **COORDINATION** - shall mean benefits are paid so that no more than 100% of the Network Allowance shall be covered under the combined benefits from all of the plans shown in paragraph 2 below.

2. **PLAN** - shall mean any medical expense benefits provided under:

a. any insured or non-insured group, service, prepayment, or other program arranged through an Employer, Trustee, union, or association; or

b. any program required or established by state or federal law (including Medicare Parts A and B); or

c. any program sponsored by or arranged through a school or other educational agency; and the first party medical expense provisions of any automobile policy issued under a no-fault insurance statute including the self-insured equivalent or any minimum benefits required by law except that the term Plan shall not include benefits provided under a student accident policy or any individual policy, nor shall the term Plan include benefits provided under a state medical assistance program where eligibility is based on financial need.

The term Plan shall apply separately to those parts of any program that contain provisions for coordination of benefits with other plans and separately to those parts of any program that do not contain such provisions.

3. **ALLOWABLE EXPENSE** - shall mean all Prevailing Charges for treatment or service when at least a part of those charges is covered under at least one of the Plans then in force for the Covered Person for whom benefits are claimed.

4. **CLAIM DETERMINATION PERIOD** - shall mean the part of a calendar year during which a Covered Person would receive benefit payments under this Plan if this Article were not in force.

C. EFFECT ON BENEFITS - Benefits otherwise payable under this Plan for Allowable Expenses during a Claim Determination Period shall be reduced if:

1. benefits are payable under any other Plan for the same Allowable Expenses; and

2. the rules set forth below provide that benefits payable under the other Plan are to be determined before the benefits payable under this Plan.

The reduction shall be the amount needed to provide that the sum of payments under this plan plus benefits payable under the other Plan(s) is not more than the total of Allowable Expenses. Each benefit that would be payable in the absence of this Article shall be reduced proportionately; any such reduced amount shall be charged against any applicable benefit limit of this Plan.

For this purpose, benefits payable under other Plans shall include the benefits that would have been paid had the claim been made for them. Also, for any person covered by Medicare Part A, benefits payable shall include benefits provided by Medicare Part B, whether or not the person is covered under that Part B.

D. ORDER OF BENEFIT DETERMINATION - Benefits payable from a Plan that does not have a coordination of benefits provision substantially similar to the provision described in this Article are determined before the benefits payable of a Plan that does have such a provision. In all other instances, the order of determination shall be:

1. EMPLOYEE vs. DEPENDENT / PRIMARY vs. SECONDARY. The benefits of a Plan that covers the person for whom benefits are claimed as an Employee (other than as a Dependent) are determined before the benefits of a Plan that covers the person as a Dependent.

2. DEPENDENT CHILD - PARENTS NOT SEPARATED OR DIVORED (Birthday rule). Except as stated in Paragraph 3 below, when this Plan and another Plan cover the same child as a Dependent of different persons the benefits of the Plan of the parent whose birthday falls earlier in a calendar year are determined before those of the Plan of the parent whose birthday falls later in that year; but if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

If, however, another Plan does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall determine the order of benefits.

3. NATURAL DEPENDENT CHILD - SEPARATED OR DIVORCED PARENTS. If two or more Plans cover a Dependent child of divorced or separated parents or parents not living together, benefits for the child are determined in this order:

a. first, the Plan of the natural parent with custody of the child.
b. then, the Plan of the spouse (if any) of the parent with custody of the child.
c. the Plan of the natural parent not having custody of the child.
d. the Plan of the spouse (if any) of the non-custodial parent.

If there is joint physical custody of the children, without the Court stating that one parent must be "primary," but the Court uses words like "maintain or carry insurance," then the Plan that has been in effect longer is the primary plan.

If, however, the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or coverage, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. (Primary)

4. OTHER DEPENDENT CHILDREN. This Plan shall always pay secondary to any other group type coverage.

5. ACTIVE/INACTIVE EMPLOYEE. The benefits of a Plan which covers the person for whom benefits are claimed as an Employee who is neither laid off nor retired, or as that Employee's Dependent, are determined before the benefits of a Plan which covers that person as a laid off or Retired Employee or as that Employee's Dependent. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule shall not apply.

6. LONGER/SHORTER LENGTH OF COVERAGE. If none of the above rules determines the order of

benefits, the benefits of the Plan that covered the person (for whom the claim is filed) for the longest period will pay first.

7. DEPENDENTS OF DECEASED ACTIVE EMPLOYEES. This Plan shall always pay secondary to any other group type coverage.

E. COORDINATE WITH MEDICARE

1. EMPLOYEES CONTINUING TO WORK AFTER AGE 65. If you continue to work for a contributing employer after you become age 65 and eligible for Medicare, you are entitled to the same benefits as employees under age 65 as long as you meet the regular eligibility rules. This Plan will be your primary provider of health care benefits unless it is legally permitted to pay second. Medicare will pay secondary benefits only for expenses covered by it and which are not paid by the Plan.

If your dependent spouse is age 65 or older and eligible for Medicare while you are still working and eligible (regardless of your age), this Plan will usually pay its normal benefits for her before Medicare pays unless it is legally permitted to pay second. If she is covered under her own plan, her plan will pay first, this Plan will usually pay second, and Medicare will pay last.

2. RETIREES (AND THEIR SPOUSES) ELIGIBLE FOR MEDICARE. If you are an eligible retiree, and if you and/or your spouse are eligible for Medicare and have enrolled in both Medicare Part A and Part B, this Plan will coordinate benefits with Medicare on your claims. This means that Medicare will pay first, and this Plan will pay after Medicare pays, based on amounts not paid by Medicare. The Plan will determine its benefits as the secondary payor based on the amount of the charge allowed by Medicare—it will not pay any amount more than Medicare's allowable charge.

If you have not enrolled in Medicare Parts A and B, this Plan will calculate its benefits as if you had. This means that this Plan will only pay benefits equal to the benefits it would have paid if you were enrolled in both Parts unless a different payment is required by law. You will have to pay the amount normally paid by Medicare.

Medicare-eligible retirees (and Medicare-eligible spouses of retirees) have the option of dropping this Plan's prescription drug coverage and switching to a Medicare Part D plan.

3. MEDICARE-ELIGIBLE PERSONS UNDER 65. If any covered person is entitled to Medicare for reasons other than being 65 or older (for example, because of disability or being an End Stage Renal Disease beneficiary), this Plan will usually pay its benefits on that person's claims before Medicare pays its benefits unless it is legally permitted to pay second. This provision does not apply to retirees or their dependents.

4. ALL MEDICARE-ELIGIBLES AGE 65 OR OVER. Persons aged 65 or older are also entitled to select Medicare as their coverage. To do so, they must decline all coverage under this Plan. Contact your local Social Security Administration office if you have any questions about Medicare enrollment or eligibility.

F. EXCHANGE OF INFORMATION - Any Covered Person who claims benefits under this Plan shall, upon request, provide all information the Trust believes is needed to coordinate benefits as described in this Article. All information the Trust believes is needed to coordinate benefits shall be exchanged with other plans, companies, organizations, or persons.

G. FACILITY OF PAYMENT - The Trust may reimburse any other Plan if benefits were paid by that other Plan but should have been paid under this Plan in accordance with this Article.

In such an event, the reimbursement amounts shall be considered benefits paid under this Plan and, to the extent

of those payments, shall discharge the Trust from liability.

ARTICLE XIX. CLAIMS AND APPEAL PROCEDURE

The following procedures apply to the Eligibility Provisions and Indemnity Plan Benefits included in this booklet. They also apply to Dental, Vision & Life Insurance claims only after the Member has exhausted the appeal procedures that are available through the respective carriers. **The claims and appeals rules for insured benefits are governed by the rules (known as the Evidence of Coverage booklet) of the specific insurance companies and Health Maintenance Organizations (HMOs), which are available upon written request from the applicable insurance company or HMO (ex. Kaiser, Delta Dental VSP**). **These entities have their own claims review and appeals procedures, which are described in their materials and which you must follow. The Board of Trustees has established the claims and appeals procedures with the intent of comply with the regulations issued by the U.S. Department of Labor.**

A. **HOW TO FILE A CLAIM.** Claims are paid in accordance with bills and forms supplied by hospitals and attending physicians. A claim shall be considered to have been filed as soon as it is received by the Trust Fund Office at its principal office, provided it is substantially complete, with all necessary documentation. If the form is not substantially complete, or if required documentation has not been furnished, the claimant will be notified as soon as reasonably possible of what is necessary to complete the claim. **All claims for benefits must be filed within one year from the date of treatment or service.** Failure to do so will result in non-payment. Have your Physician forward claims directly to the Plan Office. It is your responsibility to ensure that proof of claims are timely filed with the Trust Fund Office.

Retiree members and their dependents that are eligible for Medicare should have the hospital and doctors submit claims to Medicare first. After Medicare has made a payment, a copy of the Medicare Explanation of Benefits Worksheet should then be submitted with a claim to the Trust Fund Office for processing.

B. **CLAIMS AND APPEALS PROCEDURES**

1. DEFINITIONS.

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

(1) a payment of less than 100% of a Claim for benefits (including coinsurance or co-payment amounts of less than 100% and amounts applied to the deductible);

(2) a denial, reduction, termination of or failure to provide or make payment for a benefit (in whole or in part) resulting from any utilization review decision.

(3) a failure to cover an item or service because the Plan considers it to be Experimental, Investigational, not Medically Necessary or not Medically Appropriate.

(4) a restriction on reimbursement for services because they are classified as related to a mental or nervous, rather than a physical, condition; and

(5) a decision that denies a benefit based on a determination that a claimant is not eligible to participate in the Plan.

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

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

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

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

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

Claims are categorized as Follows:

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

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

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

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

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

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

2. NOTICE OF CLAIM DENIAL. If a claim is wholly or partially denied, the claimant shall receive a written notice of denial as follows:

a) Contents of Notice: The notice of denial shall contain the following, written in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the denial.
(2) Specific reference to pertinent Plan provisions on which the denial is based.
(3) A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; and
(4) Appropriate information as to the steps to be taken if the claimant wishes to submit the claim for review.

b) Time of Notice: To assure that you are eligible for medical or hospital benefits, you should call or have your physician /hospital call the Plan Office to pre-certify your eligibility for benefits. If you do not obtain precertification and the Plan Office determines that a claim is not covered for any reason, you will be notified of a claim denial:

c) Urgent Care: In the event the claim involves "urgent care," which is defined as any claim for medical care or treatment which in your physician's opinion is required immediately to avoid jeopardizing your life, health or ability to regain maximum function, you will be notified within twenty-four (24) hours of the submission of the claim, if the information necessary to process the claim is incomplete, and/or within seventy-two (72) hours in the event coverage is denied.

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

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

f) Post-Service Claims. A Post-Service Claim must be submitted to the Plan Office in writing, using an appropriate claim form, as soon as possible after expenses have been incurred. A claim form may be obtained by contacting the Trust Fund Office. Failure to file a Post-Service Claim within the time required will not invalidate or reduce any Claim if it was not reasonably possible to file the Claim within such time;

however, in that case, the Claim must be submitted as soon as reasonably possible, but in no event later than one year from the date the charges were incurred.

The claim form must be completed in full, and an itemized bill(s) must be attached to the claim form in order for the request for benefits to be considered a Claim. The claim form and/or itemized bill(s) must include any information requested by the Trust Fund Office.

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

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

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

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

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

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

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

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

For an Adverse Benefit Determination on disability claims, the Content of the Notice will include (if applicable):

1. Reference to the specific Plan provision(s) on which the determination is based.
2. Explanation for: (a) disagreeing with the views of any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable), (b) disagreeing with the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable), and (c) disagreeing with the view of any disability determination made by the Social Security Administration (if applicable);
3. Statement that you have the right to receive, upon request and free of charge, reasonable access to and copies of all relevant documents, records and other information to your claim for benefits.
4. Statement that either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the denial or alternatively a statement that such rules, guidelines, protocols, standards or other similar criteria does not exist.
5. If the determination was based on the absence of Medical Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge.
6. Statement of your right to present evidence and testimony in support of your claim during the appeal/review process.
7. Statement that on appeal, you will have the right to respond to the denial if the Plan receives new or additional evidence and you will also be provided, free of charge, with any new or additional evidence considered as soon as it becomes available to the Plan and sufficiently in advance of the date on which the appeal determination notice is required to be provided to you under the Plan's rules. (This will usually be before the next regularly scheduled meeting of the Board of Trustees unless special circumstances require a further extension of time); and
8. If applicable, notice will be provided in a culturally and linguistically appropriate manner in the predominant non-English language spoken where you live.

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

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

3. APPEAL PROCEDURES.

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

receives the notice of Adverse Benefit Determination.

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

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

b. Faxing the request for the attention of the Utilization Review Representative.

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

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

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

a. the patient's name and address.
b. the Participant's name and address, if different.
c. a statement that this is an appeal of an Adverse Benefit Determination to the Board of Trustees.
d. the date of the Adverse Benefit Determination; and the basis of the appeal, i.e., the reason(s) why the Claim should not be denied.

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

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

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

c. Time Frames for Sending Notices of Appeal Determinations.

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

(2) Concurrent Claims. Notice of the appeal determination for a Concurrent Claim that involves an extension of an Urgent Care Claim will be sent by the Plan within 72 hours of receipt of an appeal by the Plan Office.

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

If the decision on review is not furnished to the Participant within the time specified in this Subsection (C), Participant's Claim shall be deemed denied upon review. Participant shall be free to bring an action upon his/her Claim in accordance with Subsection e, below.

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

(1) the specific reason(s) for the determination.

(2) reference to the specific Plan provision(s) on which the determination is based.

(3) a statement that the Participant is entitled to receive reasonable access to and copies of all documents relevant to the Claim, upon request and free of charge.

(4) a statement of the Participant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal.

(5) if an internal rule, guideline or protocol was relied upon, a statement that a copy is available upon request at no charge; and

(6) if the determination was based on Medical, Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge.

For Notice of denial of an appeal for Disability claims, the content of the Notice will include (if applicable):

1. Reference to the specific Plan provision(s) on which the determination is based.
2. Explanation for: (a) disagreeing with the views of any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable), (b) disagreeing with the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable), and (c) disagreeing with the view of

any disability determination made by the Social Security Administration (if applicable);

3. Statement that the Participant is entitled to receive reasonable access to and copies of all documents relevant to the Claim, upon request and free of charge.
4. Statement that either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the denial or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria does not exist.
5. If the determination was based on the absence of Medical Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge.
6. Any Plan imposed timeline for filing a lawsuit pursuant to your right under ERISA section 502(a) and the expiration date for suing; and
7. If applicable, notice will be provided in a culturally and linguistically appropriate manner in the predominant non-English language spoken where you live.

e. <u>Trustee Interpretation, Authority and Right</u>. The Board of Trustees has full authority to interpret the Plan, all Plan documents, rules and procedures. Their interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. Parties to whom the Trustees have delegated the right of decision-making may also have the discretion to interpret the Plan. If a decision of the Trustees, or a party to whom the Trustees have delegated decision-making authority, is challenged in court, it is the intention of the parties that such decision is to be upheld unless it is determined to be arbitrary or capricious.

Benefits under this Plan will be paid only when the Board of Trustees, or persons delegated by them to make such decisions, decide, in their sole discretion, that the participant or beneficiary is entitled to benefits under the terms of the Plan.

The Trustees have the authority to amend the Plan, which includes the authority to change eligibility rules and other provisions of the Plan, and to increase, decrease or eliminate benefits. In addition, the Trustees may terminate the Trust and this Plan of Benefits at any time. All benefits of the Plan are conditional and subject to the Trustees' authority to change or terminate them. The Trustees may adopt such rules as they feel are necessary, desirable or appropriate, and they may change these rules and procedures at any time.

The Trustees specifically have the right and the authority to change the provisions relating to coverage for retirees and their dependent at any time and in their sole discretion, since the Retiree Benefits are not "accrued" or "vested" benefits. Any such change made by the Trustees will be effective even though employee has already become a covered retiree.

The Trustees intend that the Plan terms, including those relating to coverage and benefits, are legally enforceable and that the Plan is maintained for the exclusive benefit of the participant and beneficiaries.

f. <u>When a Lawsuit may be Started – One Year</u>.

e. **<u>Statute of Limitations For Lawsuits</u>**. No Employee, Dependent, Beneficiary or other person shall have any right or claim to benefits under these Rules and Regulations or any right or claim to payments from the Fund, other than as specified herein. If an appeal has been denied or there has been a different form of adverse action taken, such person (Participant, Beneficiary or any other person or entity) has **one** year from the date of such denied appeal or adverse action to file a lawsuit against the Plan, an individual

Trustee, the Board of Trustees and/or any other person or entity involved with the denied appeal or adverse action. If the person fails to do so, no lawsuit is permitted. In addition, a Participant may not start a lawsuit to obtain benefits until after either: (1) the Participant has submitted a Claim pursuant to these Rules and Regulations, requested a review after an Adverse Benefit Determination, and a final decision has been reached on review; or (2) the appropriate time frame described above has elapsed since Participant filed a request for review and Participant has not received a final decision or notice that an extension will be necessary to reach a final decision.

This one-year limitation period covers all claims for benefits referenced in this Plan and is intended to supersede any language in this Plan document to the contrary.

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

No lawsuit may be started more than one year after the date on which services were provided, or, if the Claim is for short term disability benefits, more than one year after the onset of the disability. The provisions of this Section shall apply to and include 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 or not the claimant is a Plan "Participant" or "beneficiary" within the meaning of those terms as defined in ERISA.

g. Venue Restrictions. Any claim that you, your authorized representative, or your eligible dependent(s) may have related to or arising under the Plan may only be brought in the U.S. District Court for the Northern District of California. No other court is a proper venue or forum for you, your authorized representative or eligible dependent's claim. The U.S. District Court for the Northern District of California will have personal jurisdiction over you and any other participant or beneficiary named in the action.

h. Class Action Waiver. The Plan and the Participants and Dependents agree that all Claims pursued against each other will be on an individual basis. To that end, the Participants and Dependents hereby waive their right to commence, to become a party to, or to remain a participant in, any group, representative, class, collective, or hybrid class/collective action in any court, arbitration proceeding, or any other forum, against the other.

ARTICLE XVIII. POTENTIAL LOSS OF COVERAGE AND/OR BENEFITS

You or your beneficiary could lose your benefits or have payments delayed in at least the following circumstances:

A. Exclusions/Co-Payments. The Plan, HMO (Kaiser) and insurance policies contain exclusions that may preclude you from having coverage. You are also responsible for co-payments in most situations. You should be aware of the Plan's limitations, exclusions, co-payments and other facets of the Plan for which you

may not receive full reimbursement or for which there is a co-payment.

B. **Ineligible**. The person on whose behalf the claim was filed was not eligible for benefits on the date the expenses were incurred.

C. **Not Timely—One Year Time Period**. The claim was not filed within the Plan time limits. By way of example, claims must be submitted within one year.

D. **Not Covered or Not Incurred**. The expenses that were denied are not covered under the Plan or were not actually incurred.

E. **Full Benefit Provided**. The person for whom the claim was filed had already received the maximum benefit allowed for that type of expense during a stated period.

F. **Plan Change**. The Trustees amended the Plan's eligibility rules or decreased Plan benefits.

G. **Employer's Failure to Timely Make Required Contributions**. If your Employer fails to timely make a required contribution on your behalf and you do not have any hours in your hour bank, you will lose coverage under the Plan.

H. **Fail to File Complete Application** Benefits may not be payable until a completed application and other required forms and information is received by the Plan Office.

I. **Incomplete Information/False Statements**. If you fail to provide requested information or give false information to verify disability, age, beneficiary information, marital status or other vital information, coverage under the plan or benefits provided may be postponed or cancelled.

If you make a false statement to the Plan or other officials regarding the payment of benefits or other issues related to the Plan, you will be liable to the Plan for any benefits paid in reliance on such false statements or information, and any attorney 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 Plan 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.

J. **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 Plan Office any information, proof, or coverage reasonably required to administer the Plan.

K. **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 for the rules on third party claims and liability.

L. **Coordination of Benefits**. If Dependents are covered by more than one Plan, this Plan may not be responsible for many claims.

M. **Work-Related Injuries**. The Plan is not responsible for paying any claims incurred because 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 person has workers compensation insurance. This is so even though you have not filed a claim with workers compensation.

N. **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.

O. **Right to Recover Claims Paid or Offset of Future Claims**. The Plan has the right to recover any amounts improperly paid. The Plan may offset any amounts owed to the Plan against any claims that you and/or a Dependent incur in the future.

P. **Prohibited Employment in the Plumbing and Pipefitting Industry**. 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 contribution to a U.A. Local Union health care plan, or you go into business in the plumbing or pipefitting industry without being signatory to an agreement with a U.A. Local Union. If you engage in certain kinds of work in the Plumbing and Pipefitting Industry, known as Prohibited Employment, you will no longer be entitled to Retiree Health and Welfare benefits.

Q. **Plan Termination**. If the Plan terminates, benefits may no longer be provided.

The above list is not an all-inclusive listing of the circumstances that may result in denial or loss or delayed payment of benefits. It is only representative of the types of circumstances, in addition to failure to meet the regular eligibility requirements, that might cause denial of a claim for benefits. If you have any questions about a claim denial, contact the Fund Manager.

ARTICLE XIX. AMENDMENT/MERGER/TERMINATION OF PLAN

A. **AMENDMENT OF PLAN**. The Board of Trustees has the discretion to amend the Plan at any time. Moreover, if the Collective Bargaining Agreement is amended by the insertion or deletion of provisions relating to the Plan, the Board of Trustees will amend the Plan to effectuate the intent of the amendment to the Collective Bargaining Agreement, unless such amendment conflicts with applicable law or is actuarially unsound.

Any amendment may apply to all groups and/or Participants covered by the Plan or only to certain groups of Participants. Retroactive amendments may be made to the extent permissible under ERISA. Except as is permitted or required by applicable law, no amendment may divest any accrued benefits which have previously been vested.

B. **MERGER OR CONSOLIDATION OF THE PLAN WITH ANOTHER PLAN.** In the event of a merger or consolidation of the Plan with, or transfer in whole or in part, of the assets or liabilities of the Plan to any other Pension Plan, each Participant is entitled to a benefit immediately after the merger, consolidation or transfer which is at least equal to the benefit such Participant would be entitled to receive before such merger, consolidation or transfer.

C. **TERMINATION OF PLAN.** It is anticipated that the Plan is permanent and will continually be in operation. It is, however, legally necessary to consider the possibility of termination of the Plan and to state the rights of the Participants in such an unlikely event.

The parties to the Collective Bargaining Agreements between U.A. Local 467 and the Employer associations may terminate the Plan in whole or in part. Although there is no intent to terminate the

Plan, there is no guarantee that the Plan will last forever.

ARTICLE XX. ADDITIONAL INFORMATION REQUIRED BY ERISA

A. **NAME AND TYPE OF PLAN.** The name of the Plan is the U.A. Local 467 Health and Welfare Plan. The Plan is tax-exempt under Section 501(c)(9) of the Internal Revenue Code.

B. **PLAN ADMINISTRATOR.** The Board of Trustees is the designated Plan Administrator of the Plan under ERISA. The Board is responsible for the operation and administration of the Plan, including ensuring that information regarding the Plan is reported to governmental agencies and disclosed to Plan Participants and beneficiaries in accordance with ERISA. The Board has contracted with Benefit Plan Administrators Inc. to be the Fund Manager for the Plan. You may contact the Plan as follows:

Sandy Stephenson, Fund Manager
U.A. Local 467 Health & Welfare Plan
P.O. Box 5057, San Jose, CA 95150-5057
(408) 288-4400/800-541-8059

C. **PLAN SPONSOR.** The Plan is sponsored by a joint labor-management Board of Trustees, the name and address of which is set forth in Section B above.

D. **AGENT FOR THE SERVICE OF LEGAL PROCESS**. The person designated as agent for service of legal process is:

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

Service of legal process may also be made upon the Fund Manager, any Plan Trustee, or the Board of Trustees, at the addresses listed on page ii of this booklet.

E. **PLAN YEAR.** The Plan Year commences on January 1 and ends December 31.

F. **EMPLOYER IDENTIFICATION NUMBER.** The Internal Revenue Service Employer Identification Number (EIN) for the Health and Welfare Plan is 94-6415220. The Plan Number is 516.

G. **FUNDING CONTRIBUTIONS AND COLLECTIVE BARGAINING AGREEMENTS**. The Plan is maintained in accordance with Collective Bargaining Agreements (CBA) between U.A. Local 467 and certain Employer associations (and some individual Employers), which require Employers to contribute to the Plan. The hourly contribution rate is specified in the applicable CBA. Copies of the CBA can be obtained from the U.A. Local 467 office.

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

H. **MEDIUM AND SOURCE OF CONTRIBUTIONS.** Assets of the Plan are held in Trust. The Board of Trustees has retained Steve Callow as the Plan's Investment Consultants. The Board of Trustees may

select other Investment Consultants in the future. The Board of Trustees makes the investment decisions to the Plan Assets. The Plan is funded through employer contributions, the amount of which is specified in the applicable Collection Bargaining Agreement, or the amount specified by the Board of Trustees for non-bargaining unit employees. Also, self-payments by employees or dependents are permitted as outlined in this booklet. The number of self-payments is established from time to time by the Board of Trustees.

STATEMENT OF ERISA RIGHTS

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

(1) RIGHT TO RECEIVE INFORMATION ABOUT THE PLAN AND YOUR BENEFITS

a. Examine without charge at the Plan Office and at other specified locations such as worksites and the Union office, documents governing the Plan, including Collective Bargaining Agreements, insurance contracts (if applicable), and a copy of the latest annual report (Form 5500 series) filed with the Department of Labor (and which is also available at the Public Disclosure room of the Department of Labor's Employee Benefits Security Administration ("EBSA") office.

b. Obtain copies of Plan documents governing the operation of the Plan (ex. Updated Summary Plan Description, Collective Bargaining Agreements, Copies of the latest annual report, insurance contracts) upon written request to the Plan. Pursuant to ERISA, the Plan Office may require that you pay a reasonable charge for the copies.

c. Receive a summary of the Plan's annual financial report, known as a Summary Annual Report ("SAR"). The Plan is required by law to furnish each Participant with a copy of this SAR.

d. Continue health coverage for yourself, eligible spouse or dependent child(ren) if there is a loss of coverage under the Plan because of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this booklet for the rules governing COBRA continuation coverage rights.

(2) PRUDENT ACTIONS BY PLAN FIDUCIARIES. In addition to creating rights for Plan Participants, ERISA imposes duties upon the people responsible for operating the Plan. The people who operate your Plan, called "fiduciaries," have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your Union, or any other person or entity, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

(3) ENFORCING YOUR RIGHTS UNDER ERISA. If your claim for a benefit is denied in whole or in part, you will receive a written explanation of the reason for the denial. You have the right to know why this was done, to obtain copies of applicable documents relating to the decision, and to have the Plan review and reconsider your claim, without charge and all with certain time limits.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan such as certain Plan documents or the latest annual report (Form 5500) and do not receive them within 30 days, you may file a suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $112 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator or the Plan’s delegate’s control.

If you have a claim for benefits which is denied or ignored in whole or in part, and which is upheld on appeal (or ignored), you may also 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, you may file a suit in federal court. **Under the Plan, you are required to file a lawsuit within one year after your appeal has been denied or other action, omission or decision which adversely affected you or your dependent.**
Venue Restriction. Any claim that you, your authorized representative, or your eligible dependent(s) may have related to or arising under the Plan may only be brought in the U.S. District Court for the Northern District of California. No other court is a proper venue or forum for you, your authorized representative or eligible dependent's claim. The U.S. District Court for the Northern District of California will have personal jurisdiction over you and any other person named in the action.
Class Action Waiver. The Plan and the Participants and Dependents agree that all Claims pursued against each other will be on an individual basis. To that end, the Participants and Dependents hereby waive their right to commence, to become a party to, or to remain a participant in, any group, representative, class, collective, or hybrid class/collective action in any court, arbitration proceeding, or any other forum, against the other.

If Plan fiduciaries misuse the Plan's money or other assets, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. If you file a lawsuit, the court will decide who should pay court costs and legal fees to. If you are successful, the court may order the person(s) you have sued to pay your costs and fees to the prevailing party. If you lose, the court may order you to pay the Trust's or other defendants' costs and fees (e.g., your claim was frivolous). **Again, no lawsuit may be filed more than one year after services were provided or benefits were partially or totally denied, or an otherwise adverse benefit determination was made against you.**

If you have any questions about your Plan, you should contact the Plan Office.

If you have any questions about this statement or about your rights under ERISA, of if you need assistance in obtaining documents from the Plan Administrator, you should contact Employee Benefits Security Administration (EBSA), U.S. Department of Labor at EBSA's toll free number at 866-444-3272 or electronically at www.askebsa.dol.gov. or write to the Department's national office at the following address:

Division of Technical Assistance and Inquires
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 1-800-998-7542 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**.

U.A. LOCAL 467 HEALTH AND WELFARE PLAN

ADOPTION RESOLUTION

RESOLVE, effective May 1, 2024, the Trustees of the U.A. Local 467 Health and Welfare Plan adopt this Restated Summary Plan Description and Plan Document.

The benefits provided by the Plan can be paid only to the extent that the Plan has available resources for such payments. No contributing employer has any liability, directly or indirectly to provide the benefits established hereunder, beyond the obligation of the contributing employer to make contributions as stipulated in the applicable collective bargaining agreement. Likewise, there shall be no liability imposed upon the Board of Trustees, individually or collectively, or upon the Union, signatory association or any other person or entity of any kind to provide the benefits established hereunder if the Plan does not have sufficient assets to make such benefit payments.

APPROVED:

_____	_____
Mark Burri, Chairman	**Alex Hall, Co-Chairman**
_____	_____
Date	**Date**