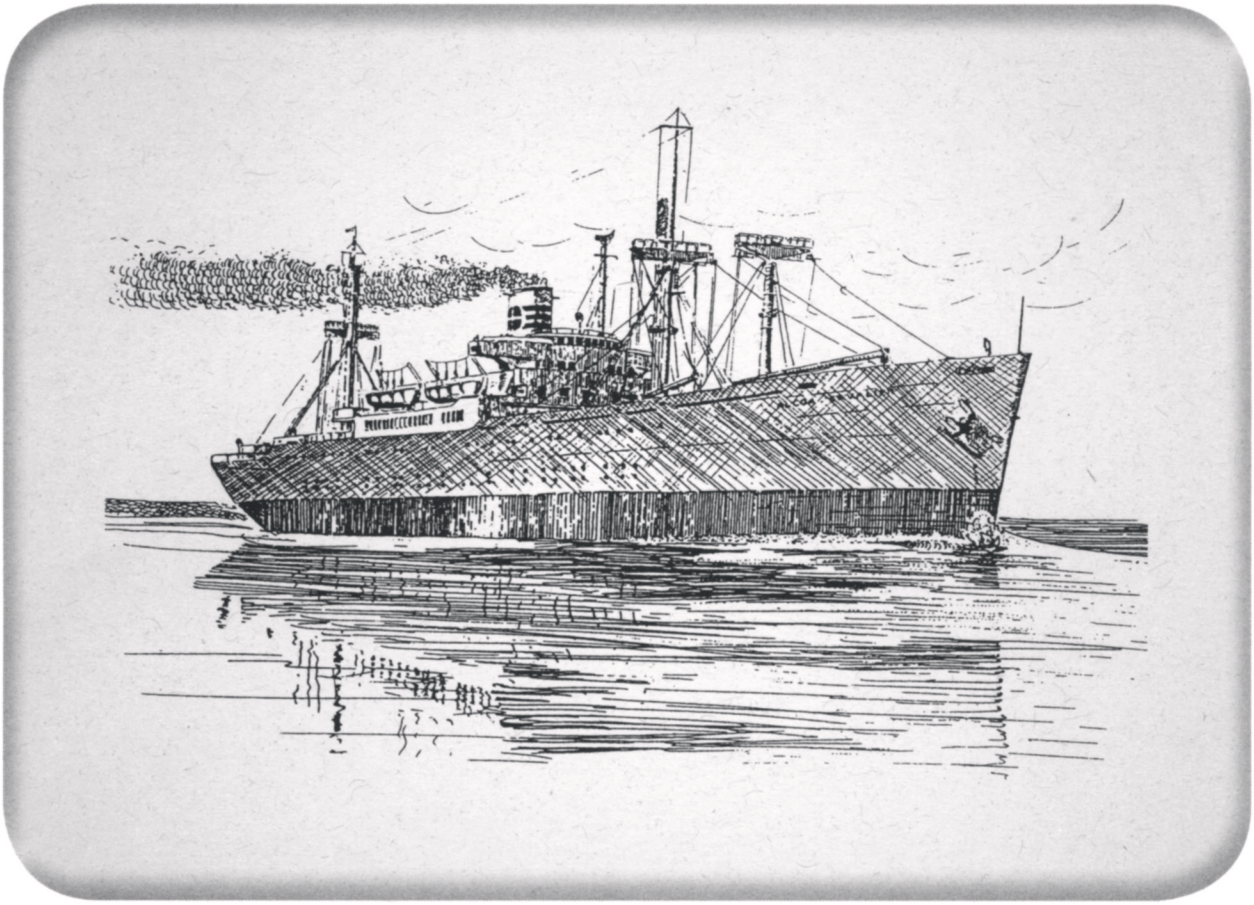
HEALTH AND WELFARE PLAN OF THE

PACIFIC COAST SHIPYARDS METAL TRADES TRUST FUND



WRAP SUMMARY PLAN
DESCRIPTION (SPD)/PLAN
DOCUMENT FOR THE INSURED PLAN BENEFITS

Effective May 1, 2016

HEALTH
AND
WELFARE PLAN
OF THE

PACIFIC COAST SHIPYARDS METAL TRADES TRUST FUND

This document together with the separate Evidence of Coverage (EOC) documents issued by each of the insurance companies for the Medical, Dental, Vision and Life and Accidental Death and Dismemberment plans constitute this Fund's Wrap Summary Plan Description/Plan Document.

Contact the Fund Office at the telephone number listed on the Quick Reference Chart for assistance obtaining EOC documents if such documents are not provided with this Wrap Plan Document. You may also contact the HMO for assistance.

WRAP SUMMARY PLAN
DESCRIPTION (SPD)/PLAN
DOCUMENT FOR THE INSURED PLAN BENEFITS

Effective May 1, 2016

PACIFIC COAST SHIPYARDS
METAL TRADES TRUST FUND

7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566
(925) 398-7056 or (844) 403-0032

To Active and Retired Metal Trades Shipyard Workers:

We are pleased to provide you with this updated booklet describing your benefits under the Health and Welfare Plan of the Pacific Coast Shipyards Metal Trades Trust Fund.

There have been several eligibility and coverage changes since the last booklet was printed. Please read this booklet carefully in order to become familiar with the Plan's current eligibility requirements and the financial protection the Trust Fund provides for you and your family.

This booklet replaces all other documents previously provided to you by the Trust Fund Office except for the current ***Evidence of Coverage*** brochures for the benefit plans in which you are enrolled.

In addition to the eligibility provisions, this booklet provides you with information about your federally protected rights, including COBRA and USERRA Continuation of Coverage rights and information required by the Employee Retirement Income and Security Act of 1974 (ERISA).

All benefits are provided under the terms of insurance contracts entered into between the Board of Trustees and various insurance companies and HMOs. You will receive an ***Evidence of Coverage*** from each insurance company for the medical and dental plans which you select. Brochures are also available from Vision Service Plan for your vision benefits and Standard Life Insurance Company for your life insurance and (for Washington State participants) short term disability benefits. The terms of those ***Evidence of Coverage*** documents and the contracts between the Board of Trustees and the insurance companies and/or HMOs are determinative.

This booklet is only a summary of your benefits. If this summary is incomplete, or if there is any inconsistency between what is written in this summary and the official Plan documents, including insurance and HMO contracts, the provisions of the official Plan documents will rule.

Any questions you may have concerning your health and welfare benefits should be directed to the Trust Fund Office, where the staff will be happy to assist you.

Sincerely,

BOARD OF TRUSTEES

GENERAL INFORMATION

This Summary Plan Description (SPD)/Plan Document is a wrap document that highlights some of the fully insured benefits available through the various insurance companies that contract Pacific Coast Shipyards Metal Trades Trust Fund. The Plan described in this document is effective January 1, 2016, and replaces all other summary plan descriptions and applicable amendments to those documents previously provided to Plan participants.

It is important to note that you are not covered for these benefits unless you meet the eligibility requirements listed in this booklet and you complete an enrollment form.

The Trust Fund has contracted with Group Health Cooperative, Kaiser Foundation Health Plan and United Healthcare to provide your medical benefits. If you are an **Active Employee**, the Trust Fund has also contracted with Standard Insurance Company, Assurant Dental Care, Dental Health Services and Vision Service Plan to provide additional health and welfare benefits to you.

For a complete description of your medical benefits, life, accidental death and dismemberment, short-term disability, dental and vision coverage, you should read the ***Evidence of Coverage*** booklets supplied by the Insurance Company. Please refer to the Quick Reference Chart beginning on page 1 for complete contact information for each insurance company. Those booklets are available from the Trust Fund Office or your Local Union Office.

VERY IMPORTANT NOTE: The only benefit that you will have until you have completed an enrollment form for one of the medical HMO options available to you is life insurance. However, your dollar bank account will be charged as if you were enrolled in the most costly plan of benefits available to you.

If you have questions about the plan, you should contact the Fund Office.

Si usted no entiende la información en este documento, favor de ponerse en contacto con personal de la Oficina Administrativa.

The Board of Trustees reserves the right to amend or modify any or all of the Plan benefits at any time, or terminate all Plan Benefits at any time. The benefits provided by the Trust Fund are not vested.

The Board of Trustees has sole discretionary authority to determine all questions of eligibility for benefits. Any determination adopted by the Trustees will be binding on everyone who participates in this Trust Fund. If a decision of the Board of Trustees is challenged in court, it is the intention that such decision be upheld unless it is determined to arbitrary or capricious.

All benefits are provided on a fully insured basis by HMOs or insurance companies. The Evidence of Coverage document from the Plans will be provided in your enrollment packet. These documents will provide definitive information about your benefits.

No employer or local union, nor their representatives or agents are authorized to interpret this Plan on behalf of the Board of Trustees. Only information that is provided to you in writing, signed by the Board of Trustees or an authorized designee of the Board of Trustees acting on behalf of the Board, is binding on the Board.

DEPENDENT SOCIAL SECURITY NUMBERS NEEDED

To comply with federal Medicare coordination of benefit regulations and certain IRS reporting rules, you must promptly furnish to the Plan Administrator, or its designee, the Social Security Number (SSN) of your Eligible Dependents for whom you have elected, or are electing, Plan coverage, and information on whether you or any of such dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE.

Failure to provide the SSN or complete the CMS model form (form is available from the Claims Administrator or http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Downloads/New-Downloads/RevisedHICNSSNForm081809.pdf) means that claims for eligible individuals may not be considered a payable claim for the affected individuals.

QUICK REFERENCE CHART
WHERE TO CALL FOR INFORMATION

Information Needed	Whom to Contact
Trust Fund Office • Health and Welfare Eligibility and Pension Information • COBRA Administrator • Cost of COBRA Continuation Coverage • COBRA Premium payments • COBRA Second Qualifying Event and Disability Notification • Life Insurance and Accidental Death and Dismemberment questions • Medicare Part D Notice of Creditable Coverage • Summary of Benefits and Coverage (SBC)	**Pacific Coast Shipyards Metal Trades Trust Fund** 7180 Koll Center Parkway, Suite 200 Pleasanton, CA 94566 (925) 398-7056 (844) 403-0032
HMO Medical Plan (for California Employees, Early Retirees and Medicare Retirees who live in the Service Area) • Medical Network Provider Directory (free of charge) • Evidence of Coverage (EOC) • Medical Claims and Appeals • Plan Benefit Information • Physician Referrals • HIPAA Privacy Notice	**Kaiser Foundation Health Plan** **Northern California Region** 1950 Franklin Street Oakland, CA 94612 **Northwest Region** 500 NE Multnomah Street, Suite 100 Portland, OR 97232 Phone: (800) 464-4000
HMO Medical Plan (for Washington Employees, Early Retirees and Medicare Retirees who live in the Service Area) • Medical Network Provider Directory (free of charge) • Evidence of Coverage (EOC) • Medical Claims and Appeals • Plan Benefit Information • Physician Referrals • HIPAA Privacy Notice	**Group Health Cooperative (GHC)** 320 Westlake Ave. North, Suite 100 Seattle, WA 98109 Phone (800) 901-4636

Information Needed	Whom to Contact
HMO Medical Plan (for Early Retirees and Medicare Retirees who do not live in the service area of one of the HMOs offered) • Medical Network Provider Directory (free of charge) • Evidence of Coverage (EOC) • Prior authorization for all non-emergency inpatient admissions, all surgical procedures and certain outpatient procedures. • Medical Claims and Appeals • Plan Benefit Information • Physician Referrals • HIPAA Privacy Notice	**United Healthcare (UHC)** P. O. Box 6035 Cypress, CA 90630-6035 1-866-316-9776 **To obtain authorization, call 1-866-863-9776.**
Prepaid Dental Plan • Dental Network and Provider Directory • Dental Claims and Appeals • HIPAA Privacy Notice	**Assurant Dental** 2185 N California Boulevard, Suite 250 Walnut Creek, CA 94596 Phone: (800) 443-2995
Dental Plan • Dental Network and Provider Directory • Dental Claims and Appeals • HIPAA Privacy Notice	**Standard Insurance Company** P.O. Box 209 Portland, OR 97207-0209 1-800-547-9515 https://www.standard.com
Dental Plan • Dental Network and Provider Directory • Dental Claims and Appeals • HIPAA Privacy Notice	**Dental Health Services (DHS)** 3833 Atlantic Avenue Long Beach, CA 90807 https://www.dentalhealthservices.com/ Phone: (877) 490-9991
Vision Plan • Vision Network and Provider Directory • Vision Claims and Appeals • HIPAA Privacy Notice	**Vision Service Plan (VSP)** One Market Street, Ste. 2625 Stuart Tower San Francisco, CA 94105 Customer Service: 800-877-7195 www.vsp.com
Short Term Disability Plan (for Washington Employees only) • Short term disability Claims and Appeals	**Standard Insurance Company** P.O. Box 2800 Portland, OR 97208-2800 1-800-368-2859 https://www.standard.com

Information Needed	Whom to Contact
Life Insurance and Accidental Death and Dismemberment • Life Insurance and Accidental Death and Dismemberment Claims and Appeals	**Standard Insurance Company** https://www.standard.com/individual/insurance/group-life

HIGHLIGHTS OF MEDICAL OPTIONS

The benefit chart below is a summary of the medical options available to you in each state. It does not describe your benefit coverage. For details on your benefit coverage, please refer to the ***Evidence of Coverage*** issued by the HMO in which you enroll. The ***Evidence of Coverage*** is the binding document between the Health Plan (HMO) and its members.

Your physician must determine that services and supplies are medically necessary to prevent, diagnose, or treat your medical condition. The services and supplies must be provided, prescribed, authorized, or directed by your physician. You must receive the services and supplies at a contracted facility or skilled nursing facility inside the Service Area of the Health Plan you are enrolled in, except where specifically noted to the contrary in the ***Evidence of Coverage***.

For details on the benefit and claims review and adjudication procedures, please refer to the Health Plan's ***Evidence of Coverage***.

Pacific Coast Shipyards Metal Trades Trust Fund 7180 Koll Center Parkway, Suite 200 Pleasanton, CA 94566 (925) 398-7056 or (844) 403-0032	
California	
• Active Employees and Dependents who live or work in the Kaiser Service area	Kaiser HMO
• Early Retirees and Dependents who live inside the Kaiser service area	Kaiser HMO
• Early Retirees and Dependents who do NOT live in the Kaiser service area.	Coverage is not available
Oregon	
• Early Retirees and Dependents who live inside the Kaiser service area.	Kaiser HMO
• Early Retirees and Dependents who do NOT live in the Kaiser service area.	Coverage is not available
Washington	
• Active Employees and Dependents who live or work inside the GHC service area	Group Health Cooperative HMO
• Early Retirees and Dependents who live inside the GHC service area	Group Health Cooperative HMO
• Early Retirees and Dependents who do NOT live in the GHC service area.	Coverage is not available

Pacific Coast Shipyards Metal Trades Trust Fund 7180 Koll Center Parkway, Suite 200 Pleasanton, CA 94566 (925) 398-7056 or (844) 403-0032	
Medicare Eligible Retirees • Medicare Eligible Retirees who <u>live</u> in the service area of one of the HMOs that are offered by the Plan and that HMO offers a Medicare Advantage Plan. • Medicare Eligible Retirees who <u>do NOT live</u> inside the service area of any Medicare Advantage HMO Plan that the Plan offers	California Kaiser Senior Advantage[1] Group Health Cooperative Medicare Plan (Clear Care)[1] United Healthcare Secure Horizons[1] United Healthcare Medicare Supplement[1]

[1]If you and/or your dependents are Medicare eligible, you must enroll in an HMO if you live in the service area of one of the HMOs that are offered by the Plan. If the HMO offers a Medicare Advantage Plan, you must enroll in that option. You will be required to assign your Medicare benefits to the HMO and to receive treatment **only** from the HMO. If you obtain services outside of the HMO, you will **not** receive reimbursement from Medicare or the Trust Fund for those services. If you reside outside the service area of a Medicare Advantage HMO Plan, you may enroll in the Medicare Supplement Plan. **Remember, if you are a Medicare eligible participant, you MUST elect both Parts A & B.**

The Board of Trustees reserves the right to modify the benefits, change HMOs or terminate the Plan entirely at any time. In addition, retiree benefits are not guaranteed.

ELIGIBILITY AND PARTICIPATION

It is important to note that you are covered for the benefits described in this booklet only when you meet the eligibility requirements stated below and you complete the required enrollment procedures for the benefits you elect.

Active Employees

Eligible employees include all employees in the states of California and Washington for whom contributions are made to the Trust Fund for the maintenance of the Health and Welfare Plan. You are eligible for coverage when the required amount of contributions are made in your name. See **"How to Qualify for Coverage"** below.

How to Qualify for Coverage – The Cost of Benefits

The hourly contribution rate made by Contributing Employers to this Trust Fund varies according to the differing Collective Bargaining Agreements. The actual cost of the benefit options offered by the Trust also varies greatly between States and among the medical and dental plans offered. It is the policy of the Board of Trustees to maintain equity among Plan participants and also to keep the Trust Fund on a sound financial basis. To achieve these goals, the contributions required on your behalf must be sufficient to cover the cost of your benefits. The contributions to your account are the product of your Employer's health and welfare contribution rate and the number of hours you work. Currently the Trust Fund provides some subsidy for coverage, but the subsidy is the same for all Plan participants. This means that the amount you are charged each month is determined by the cost of the benefits you elect less any current subsidy determined by the Trustees. Any contributions received in excess of that amount are credited to your dollar bank.

Plan Subsidy: At their sole discretion, the Trustees may provide a subsidy for a portion of the actual cost of benefits. No such subsidy is guaranteed. At any time that a subsidy is in effect, it may be changed or eliminated by action of the Board of Trustees.

How to Qualify for Coverage – Initial Eligibility

Your coverage starts on the first day of the second month after sufficient contributions are **received** by the Trust Fund on your behalf. For example, if you work sufficient hours in January *(the work month)* to meet the initial contribution requirement, your Employer should make the appropriate contributions to the Trust Fund in February *(the contribution month)*. You will then be eligible for benefits in April (*the eligibility month*) ***if you have completed enrollment forms for your HMO and dental providers*** (see Enrolling for Benefits, pg. 10). The two-month lag allows the Fund Office to make certain all contributions have been properly credited.

Required Amount of Initial Contributions

The amount of contributions required for initial eligibility is sufficient funds to equal or exceed the lowest then current charge-off in your state for HMO coverage, indemnity dental coverage, vision coverage and life coverage. This means that should you wish to participate in a more costly benefit program, your initial eligibility will be delayed until

such time as your Dollar Bank has a sufficient balance to meet the charge-off for that combination of benefits. The Fund Office will notify you when your Dollar Bank reaches a stage to permit initial eligibility.

There is a rolling six-consecutive month period for you to meet the initial eligibility requirement. If, after that six-month period you have not accumulated a sufficient Dollar Bank balance to earn eligibility, those dollars that were contributed prior to the most recent six-month period will be forfeited.

How to Qualify for Coverage – Maintaining Eligibility

After you become eligible for the first time, you need to have sufficient contributions during each month to pay for the cost of the benefits in which you are enrolled. You will be eligible for coverage two months later. Any contributions over the actual cost of your benefits are credited to a "dollar bank" in your name to use in any month that contributions are less than the cost of your benefits. For any month that you have less than the required current contributions, the plan will deduct enough dollars from your dollar bank to make up the difference so you will be eligible for coverage two months later.

Example: You have elected benefits that cost $1,000 and your Employer makes contributions based on $6.50 for every hour you work. In May (the work month), you work 100 hours, which generates $650 in contributions in June (the contribution month) for August (the eligibility month) eligibility. Since $650 is not adequate to provide coverage for August, the plan will withdraw $350 from your dollar bank. You will then have the $1,000 in contributions required to be eligible for coverage in August. At the same time, your dollar bank will be reduced by $650.

DOLLAR BANKS ARE FOR ELIGIBILITY ONLY. The dollar bank is not pre-funded and presumes that ongoing bargaining units will continue participation in the Trust. The Trustees retain the right to change the monthly deduction for coverage at any time. Further, no participant has a vested right to any amount credited to his or her dollar bank.

How to Retain Coverage - Self-Payments

After meeting the initial eligibility requirement, you may make self-payments up to $7,000 (amount subject to change by the Board of Trustees) per calendar year (January-December eligibility), so long as you are not working for a non-contributing employer in the shipyard repair industry. This self-pay provision may allow you to retain eligibility. Any remaining dollar bank balance may be applied to partially offset the charge for COBRA or other self-payment plan coverage after your eligibility runs out.

If you do not re-earn eligibility based on hours worked (i.e., hour accumulating in your dollar bank) within twelve months, any unused dollar bank balance will be forfeited.

Example of How Eligibility Works for a New Employee

Note: Contributions should be paid by your Employer to the Fund Office in the month after you work. The Coverage Month is the second month after the month in which the contributions are received.

Assumptions used in this example (*illustrative only*):

Employer contribution rate: $6.50 per hour

Highest cost coverage in state: $1,500 per month

Cost of coverage elected: $1,000 per month

Work month	Hours worked	Contributions (paid the following month)	Amount in Dollar Bank	Eligibility month	Eligible
January	100	$650	$650	April	no
February	70	$455	($1,105 - $1,000) = $105	May	yes
March	85	$553	$658	June	no
April	50	$325	$983	July	no
May	60	$390	($1,373-$1,000)=$373	August	yes
June	120	$780	($1,153-$1,000) = $153	September	yes

You may make a maximum of $7,000 (amount subject to change by the Board of Trustees) in self-pay contributions per calendar year (January-December). Once you gain eligibility, you generally do not lose the dollars in your bank. If your coverage terminates, any remaining dollars in your bank may be applied to your first month of COBRA coverage. (You **cannot** receive this as a cash payout.)

Electing Coverage

Once you earn eligibility, you must enroll in one of the Trust Fund's medical HMO plans. You may also elect dental and vision benefits. Please review the Highlights section of this booklet and the plan information that will be sent to you by the Fund Office when you become eligible if you have not already completed your enrollment process. You will not be allowed to change plans until the next open enrollment period, as determined by the Board of Trustees.

Declining dental and vision benefits

If you decline to enroll for dental and vision benefits when you are first eligible, or if you drop those benefits during any subsequent open enrollment period, you will be required to enroll in the dental HMO option for the first two years after you re-enroll for those

benefits. You will not be allowed to enroll in the indemnity dental plan immediately after a voluntary break in dental coverage.

VERY IMPORTANT NOTICE: Should you fail to enroll in a medical plan, or fail to advise the Fund Offices that you are delaying enrollment until your dollar bank reaches the amount necessary for coverage more expensive than that available for the required amount of initial contributions as set forth on page 6, your dollar bank will be charged as if you had enrolled in the option for your state that includes the lowest price HMO coverage, indemnity dental coverage, vision coverage and life coverage. But you will have no actual coverage (except for life insurance) until after you do enroll for benefits in an appropriate Plan. Your failure to take appropriate action in enrolling for benefits will cause a reduction in your dollar bank balance without providing you with the benefits of coverage which would exist if you enrolled in one of the benefit plans available to you.

Trust Fund Receipt of Employer Contributions

Remember that your employer must pay the required contributions for the hours you work to the Trust Fund. If your employer fails to make the required contributions for those hours on a timely basis, your Health and Welfare Plan coverage will be suspended for the month of coverage, if contributions actually received for your hours worked **and** any existing dollar bank credits are **not** sufficient to establish eligibility.

Special Eligibility Rules During Disability

If you establish eligibility for coverage and then become disabled, you may be considered employed for purposes of qualifying for coverage during the period of your disability. Those months during which you are considered employed for this purpose are referred to as ***"disability months."*** However, your coverage under this special rule can **only** be extended for up to six months while you remain disabled. A ***"disability month"*** is the ***work month*** during which an employee is unable, due to illness or injury, to work enough hours to receive the required amount of employer contributions remitted to the Trust Fund on his behalf.

Generally, in order to qualify for disability extension of coverage, you should have worked sufficient hours in the month ***before*** you became disabled such that, combined with any hours in your dollar bank you will be eligible based on the regular provisions in the second month after the disability month. Your disability extension under this provision will start the third month after the disability month.

For example: If you have been continuously covered and then become disabled in January, your disability extension begins in April (January, February and March coverage are based on your hours worked during October, November and December). In this case, your disability extension will be up to 6 months, from April through September.

Exception: If you do not have enough contributions credited to your dollar bank to meet the requirement above, you may begin the disability extension one month earlier.

For example: You have been continuously covered and then become disabled in January. If you do not have enough contributions credited to your dollar bank for March

coverage, your disability extension can begin in March. In this case, your disability extension will be up to 6 months, from March through August.

In either case above, your disability extension will end at the earlier of 6 months or when you are no longer disabled. You must meet the following requirement:

(1) receive temporary or permanent disability benefits pursuant to a State or Federal Workers' Compensation Law, or

(2) receive State disability benefits pursuant to a State Law (California participants), or

(3) receive benefits from the Trust Fund's short term disability benefit insurer (Washington participants), and

(4) mail a copy of the disability extension application and disability award or first disability check to the Trust Fund Office no later than the later of three months following the end of the qualifying month in which you initially became disabled or within thirty days of the Trust Fund Offices mailing of a COBRA notice to you, and

(5) mail a copy of each succeeding disability check or award to the Trust Fund Office within twenty-one days of your receipt of the check or award.

For example: Should you become disabled due to an illness or injury during January, a copy of the disability extension application and disability award or check reflecting disability benefits must reach the Trust Fund Office by April 30.

Please note: If the information above does not reach the Trust Fund Office within the required time period, your request for an extension of coverage under this special rule will be denied, unless you can prove that circumstances beyond your control prevented you from filing the form in a timely manner. If you are unable to submit the form yourself, a relative or other person caring for you may submit it on your behalf.

Enrolling for Benefits

In order to be eligible to receive medical and dental services, you need to be properly enrolled in the Health and Welfare Plan. To do this, obtain an ***enrollment form*** and medical and dental plan applications from the Trust Fund Office or from your Local Union Office; complete the forms and mail them to the Trust Fund Office. You may do this at any time after you start working for a contributing Employer but in no case later than 30 days after you have worked sufficient hours to qualify for eligibility. If you do not complete an enrollment form for a dental plan at the same time as you enroll for medical benefits, you will lose the option of enrolling in the indemnity dental plan when you elect dental and vision benefits at a later date. Lastly, you will be required to enroll in the dental HMO option for the first two years of coverage.

The medical and dental enrollment forms are the only way the Trust Fund Office can keep your personal records on file, providing such information as:

- Your choice of medical and dental plan.
- Your eligible Dependents.
- Your designated beneficiary (or beneficiaries) for Life Insurance and Accidental Death and Dismemberment Insurance benefits.
- Your current address.

Note: You will not have medical or dental coverage unless you complete the appropriate enrollment forms for the plans you select.

If, at any time, you want to add or drop a Dependent or change your beneficiary, complete a new enrollment form and medical and dental change forms. Be sure to notify the Trust Fund Office if you change your address. **You must keep your personal records information up to date at all times.**

Family & Medical Leave Act of 1993 (FMLA)

The Family & Medical Leave Act (FMLA) allows some employees to take up to twelve weeks of unpaid leave during any twelve-month period due to (1) the birth of a child or placement of a child with you for foster care or adoption, (2) the care of a seriously ill spouse, parent or child, or (3) your serious illness. If the leave is for the care of a family member who became seriously injured or ill while in military service, the leave may extend to 26 weeks during any 12-month period. The federal legislation provides that when an employer is required to grant leave the employer is required to continue medical coverage for the employee on leave. The federal legislation provides that in determining which employees are entitled to leave more liberal provisions of state law are permitted and also provides that more liberal provisions contained within collective bargaining agreements be permitted. It is not the role of the Trustees or the Trust Fund to determine whether or not an individual employee is entitled to leave with continuing medical care under the federal statute, any state statute or the provisions of a collective bargaining agreement. Disputes as to the entitlement to leave with continuing medical benefits must be resolved by the employer, employee and, where applicable, the Local Union. To the extent that an employee is entitled to leave with continuing medical coverage the Trust Fund will provide that coverage so long as required monthly contributions are received from the contributing employer.

If you believe you will be required to take leave for one of the reasons described above you should contact the Local Union and notify your employer.

Military Service

The plan complies with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Unless terms of a collectively bargained agreement require otherwise, the following governs benefits required under USERRA. "Uniformed Services" means the United States Armed Forces, National Guard or Public Health Service, and any other category of persons designated by the President in time of war or emergency.

If you (or your eligible Dependent) were eligible under this plan as of the date of entry into service in the Uniformed Services of the United States, and your absence was due to a Uniformed Service leave, you (or your eligible Dependent) may elect to continue coverage under USERRA. A premium for continued coverage under USERRA will be charged in amounts established by the Board of Trustees. Such premium shall be payable in monthly installments. This benefit is an alternative option to COBRA continuation (refer to page 19). If you do not elect USERRA continuation coverage for yourself and

your dependents, your dependents may elect COBRA continuation coverage to continue their own benefits.

If the duration of your absence due to service in the Uniformed Services is 30 days or less, your employer will be required to pay the premium. If the duration exceeds 30 days, you will be responsible for paying the premium. The maximum length of continued coverage is the lesser of:

- 24 months beginning the day that the Uniformed Services leave commences; or
- A period ending on the day after you fail to return to employment within the time allowed by the USERRA.

If you were eligible for benefits as of the date of entry into service in the uniformed services of the United States, and upon completion of the period of service you notify your employer of your intent to return to employment as specified under USERRA, your eligibility shall be reinstated. You will be credited with the amount held in your dollar bank at the time you entered active duty.

If you are re-employed with a Contributing Employer in accordance with the provisions of USERRA, you shall be entitled to coverage under the plan and all rights and benefits under the plan that you would have attained if you had remained continuously employed with a Contributing Employer.

If you have questions related to your reemployment rights you should contact the Department of Veteran Affairs. If you have questions related to continuing your medical coverage at your own expense during periods of military service or believe that your employer has failed to remit required contributions for coverage during a period of military service you should contact the Trust Fund Office.

Termination of Coverage

Your coverage will automatically terminate on the earliest of the following:

- The last day of the month in which you do not have sufficient current contributions, combined with your dollar bank, to continue coverage (see How to Qualify for Coverage – Maintaining Eligibility, page 7);
- The last day of the month in which your employer discontinues participation to the Trust Fund in regard to its employees in your trade or craft, but continues the operations for which contributions on behalf of its employees of that trade or craft were previously required, you may continue coverage under this plan using your dollar bank **only** if all of the conditions listed below are met. The Trustees reserve the right to modify these rules.
- Your union must inform this Trust of the identity of the new Trust that will receive future contributions for you and other employees of the withdrawing trade or craft.
- Before you can use your dollar bank to continue any coverage under this plan, this Trust must receive the eligibility rules of the plan sponsored by the Trust that will receive future contributions for you.

- You can use your dollar bank to continue coverage under this plan only for the time period that you are not eligible for benefits under the new plan, as specified by the new Trust to this Trust.
- To be eligible to continue coverage under this plan using your dollar bank, your employer or bargaining unit must have contributed to this Trust for at least three years.
- As soon as you gain coverage under the other plan, your dollar bank under this plan will be permanently cancelled and you will receive no further coverage under this plan based on your previously existing dollar bank
- During any month, you may be required to have your employer or bargaining unit provide this Trust with reports of hours worked before you can receive any continuing coverage under this plan using your dollar bank.
- The date you enter full-time duty in the Uniformed Services of any country (subject to the provisions of federal law described above under "Military Service");
- The date the Health and Welfare Plan is terminated or amended to eliminate or reduce coverage.

Rescission of Coverage

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage (a rescission) except when contributions and self-payments are not timely paid, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan.

Continuation of Active Employee Coverage

If, at the time you terminate active employment, you have established eligibility under the active employees' medical plan, you may be eligible to qualify for one or more extensions of coverage under this plan if: (a) you are disabled; and/or (b) you have accumulated sufficient credit in your dollar bank; and/or (c) you are eligible under the COBRA continuation coverage rules. The following explains the order in which such extensions will be applied, when applicable.

Disabled Employees

- The disability extension may be applied under "Special Eligibility Rules During Disability" for up to six months;
- Accumulated credit in your dollar bank may be used to continue coverage (see How to Qualify for Coverage – Maintaining Eligibility, pg. 6);
- Coverage continuation is available under COBRA if you qualify (see COBRA Continuation Coverage through Self-Payments, pg. 19).

Non-disabled Employees

- Accumulated credit in your dollar bank may be used to continue coverage (see How to Qualify for Coverage – Maintaining Eligibility, pg. 6);

- Self-payments up to $7,000 (amount subject to change by the Board of Trustees) per calendar year (January-December eligibility), so long as you are not working for a non-contributing employer in the shipyard repair industry;
- Coverage continuation is available under COBRA if you qualify (see COBRA Continuation Coverage through Self-Payments, pg. 19).

Retired Employees

You are an eligible retiree if you were employed in the state of California, Oregon or Washington **and**

- you had at least 36 months of active coverage in the 60-month period before you retired and three of those months of coverage were immediately prior to the date of your retirement; **and**
- you are receiving a pension from a pension fund established under a collective bargaining agreement with one of the Unions whose members participate in the Pacific Coast Shipyards Metal Trades Trust Fund; **and**
- if eligible, you must apply for and pay for Part B of Medicare; **and**
- you have attained age 55; **or**
- you are receiving a disability pension under the terms of one of the funds mentioned in the second item above.

Participation

Upon retirement, to establish your eligibility for retiree medical coverage, you must:

- File a completed ***Application for Retiree Medical Benefits*** no later than 30 days after exhaustion of your Active Employee Coverage. You should protect your Retiree participation rights by filing an Application for Retiree Benefits with this Plan at the same time you file a Pension Application with your Pension Plan.
- Forward to the Trust Fund Office a ***Letter from the Pension Fund Office*** from which you are receiving a pension. The letter must confirm that you are receiving a pension and must state the effective date of that pension.

Please note: As a Retired Employee, you may exhaust your Active Employee dollar bank and continue active coverage so long as your dollar bank has the equivalent of one month's coverage. Should a Retired Employee prefer, their dollar banks may be utilized for required charges for the Fund's Retiree Health and Welfare coverage. A Participant may choose to continue active coverage pursuant to COBRA Continuation Coverage prior to enrollment as a Retired Employee. COBRA Continuation Coverage may serve as a bridge to enrollment in Retiree Health and Welfare coverage.

Electing Coverage

When you retire, if you meet the applicable residency requirement, you will be given the opportunity to enroll in one of the Fund's medical plans. Once you elect your medical plan, you will not be allowed to change plans until the next annual open enrollment period, as determined by the Board of Trustees. The only exception is if you move out of

the service area of the plan you select or you have a Special Enrollment event. Dental, vision and life insurance benefits are not available to retirees.

When Your Coverage Begins

Upon receipt of the completed application and/or a confirmation letter from the Pension Fund Office, the Trust Fund Office will verify whether you will qualify for Retiree Medical Plan coverage. The Trust Fund will then notify you of the contribution you will have to pay for yourself and, if applicable, your spouse and dependent children. Contributions for Retiree Medical Plan coverage are payable in advance on a monthly basis. A statement will be sent to you by the Trust Fund Office in advance of the monthly due date.

The Trustees will determine the amount of your contribution on a yearly basis. You must pay the full cost of the benefits you and your Dependents elect. The cost of your coverage will change each year after the Trustees complete negotiations with the medical plans.

Coverage in the Retiree Medical Plan is effective on the first day of the month after the Trust Fund Office has

- received your application for retiree medical benefits, and
- verified your eligibility, and
- received your first monthly contribution payment in advance.

Please Note: Coverage will continue in effect during each month in which you remain eligible and the monthly contribution is paid in advance. The Trust Fund does not allow pro-rata contribution payments or retroactive contribution payments. Therefore, to avoid an unnecessary delay or termination of your coverage because of non-payment of your contribution, be sure to make your contribution payments prior to the due dates.

When Your Coverage Terminates

Your coverage will automatically terminate at the earliest of the following:

- the last day of the month in which you cease to be an eligible retiree and /or you fail to pay the required contribution to the Trust Fund for the next month.
- the date the Health and Welfare Plan of the Pacific Coast Shipyards Metal Trades Trust Fund is terminated or amended to eliminate or reduce retiree medical coverage.
- the date pension benefits are no longer payable to you.

If your employer discontinues participating in the Trust Fund in regard to employees in your trade or craft, and continues operations for which contributions on behalf of that trade or craft were previously required, the retiree medical benefits for those employees will be canceled.

Dependents of Active and Retired Employees

Your eligible Dependents include:

- Your lawful spouse. Please note that a spouse who is in the full time military service of any country is not eligible.

- Children up until the last day of the month in which they turn age 26. In accord with Internal Revenue Code Section 152 (f) (1), children include:
  - Natural children;
  - Legally adopted children and children placed with you for adoption. "Placed for adoption" means the date on which the Employee first becomes legally obligated to provide full or partial support for the child whom the Employee plans to adopt. To qualify, children must be placed in your home before age 18 with an expectation that they will live with you and that you will have legal responsibility for total or partial support;
  - Stepchildren who live in your home and are chiefly dependent on you for support;
  - Foster children who live in your home, are being raised by you as your own, depend on you for support and for whom you are the legal guardian and have full parental responsibility. Foster children are not eligible if they are living with you temporarily or if their parents or a social service agency exercises or shares control;
  - Any other child who lives with you in a regular parent-child relationship;
  - Children for whom you may be responsible for providing coverage as a result of a Qualified Medical Child Support Order (QMCSO), including a National Medical Support Order. You should contact the Trust Fund Office Eligibility department for a copy (free of charge) of the Plan's procedures for determining if the Medical Child Support Order is qualified; and
  - An unmarried child who is physically or mentally handicapped and chiefly depends on you for support and maintenance. You must provide proof of incapacity when requested.
  - Unmarried grandchildren who prior to attainment of age 19 resided in your house for more than half of the year and who were dependent upon you for support as reflected upon your federal income tax return for the year.

Each of your eligible Dependents will be covered on the date your coverage becomes effective or if later, on the date that you acquire an eligible Dependent while your coverage is in effect, provided, however, that you have enrolled and made any required payment for coverage for your Dependents within 30 days of the Dependent becoming eligible for coverage.

Your Dependent's coverage will automatically terminate on the earliest of the date of your coverage termination (upon the death of an active employee, dependent coverage will terminate upon exhaustion of the Participant's dollar bank) or the date he or she no longer qualifies as a Dependent as defined above.

Domestic Partner Benefits

Certain Collective Bargaining Agreements have instructed the Trustees to establish a same and/or opposite sex Domestic Partner Benefit. The Trust Fund will provide imputed income information to any such employer and such employer shall make any and all tax filings and payments, including withholdings from wages, when an employee working under the employer's Collective Bargaining Agreement enrolls a Domestic Partner. To enroll a Domestic Partner, the employee must provide proof of lawful Domestic Partner

status under state or local law to the Fund Office at the time of enrollment. The Domestic Partner's coverage will terminate upon the earlier of; the loss of the employee's employment with an employer whose Collective Bargaining Agreement provides the benefit, the employee's loss of eligibility or the dissolution of the Domestic Partner relationship. Any coverage continuation rights of a Domestic Partner losing coverage shall be governed solely by the medical, dental and vision carriers with whom the Domestic Partner is enrolled at the time of the loss of coverage under the Plan.

Natural Children of a Covered Domestic Partner

A natural child of a covered domestic partner is also eligible for coverage under the Fund so long as such child satisfies all other requirements for dependent status under the Plan document, including age, support and residency requirements. However, please note that such child's coverage as a dependent will terminate upon receipt by the Fund Administrator of a "Statement of Termination of Domestic Partner Status" by either of the eligible employee or the domestic partner.

In most cases, coverage for the natural children of a domestic partner will not be provided on a tax-advantaged basis unless those children are legally adopted by the employee. This means that the employer is required to include the fair market value of the children's coverage in the employee's taxable income for purposes of income tax withholding, FICA and FUTA taxes. Also, any employee contributions for this coverage would have to be made with after-tax dollars.

Termination of Coverage

Your Dependent's coverage will automatically terminate on the earliest of the following:

- the end of the month following the date your coverage terminates (upon the death of an active employee, dependent coverage will terminate upon exhaustion of the participants dollar bank); or
- the end of the month following the date he or she no longer qualifies as a Dependent, as defined above.

Please note: there are additional termination rules for Domestic Partners and children of Domestic Partners outlined in the sections above titled "Domestic Partner Benefits" and "Natural Children of a Covered Domestic Partner".

Extended Benefits After Coverage Terminates

Medical Plan Benefits

Refer to your ***Evidence of Coverage*** for the plan in which you are enrolled for a description of any extended coverage.

Dental Plan Benefits

Dental benefits may be provided for covered services or supplies furnished to you or your covered dependents within 30 days after coverage terminates if the charges were incurred while coverage was in effect.

Short Term Disability Benefits

If you are totally disabled due to illness or injury not related to your occupation, the Plan will pay weekly benefits as long as you are disabled, for up to the 39-week maximum even though your coverage may have terminated during the 39 weeks. Contact the Trust Fund Office for more information. **Please note this benefit is not applicable to California employees,** who are eligible for weekly disability benefits under state-mandated disability insurance laws.

Life Insurance

If you should die within 31 days after your coverage terminates the full amount of your life insurance benefit will be paid to your beneficiary.

Accidental Death and Dismemberment Insurance

If you are injured in an accident while insured for AD&D under the Plan, and then die or suffer a covered loss within 365 days after that accident, AD&D benefits will be payable, even though your coverage may have terminated during that 365-day period.

Surviving Family Coverage (For Retirees)

In the event of your death, your **Retiree Medical Plan** coverage may be continued for your surviving eligible dependents. Your surviving eligible dependents must be participants in the Plan at the time of your death and must continue to pay the required monthly contribution. Surviving ***family*** coverage will be continued while this Plan is in effect, but not beyond the earliest of:

- the death of your spouse or, if there is no surviving spouse, the date your last surviving child ceases to be an eligible dependent; or
- the date the surviving dependent fails to pay the required contribution to the Trust Fund for the next month; or
- the date your spouse becomes eligible under another group health plan; or
- the date your spouse remarries.

Surviving Spouse Coverage (For Retirees)

A surviving **spouse** may continue coverage under the Plan for their lifetime, provided they do not remarry, whether the surviving spouse is eligible for Medicare benefits or not. Your surviving spouse must be a participant in the Plan at the time of your death and must continue to pay the required monthly contribution.

If your eligible dependents elect surviving family coverage, such coverage continuation may satisfy COBRA's maximum 36-month coverage continuation requirement (see "COBRA Continuation Coverage" in the following section). ***The maximum coverage period which could apply under this Surviving Family Coverage is greater than the maximum coverage period which could apply under COBRA.*** Therefore, if a surviving dependent becomes ineligible under this coverage **during** the initial 36-month COBRA maximum period, the dependent may elect COBRA coverage for the remaining COBRA period. However, if a dependent becomes ineligible for surviving family coverage **after** the initial 36-month COBRA period expires, no additional COBRA coverage will be offered.

COBRA Continuation Coverage through Self-Payments

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended, requires that Trust Fund participants (covered employees and eligible dependents) be allowed to continue their medical and dental coverage under the Trust Fund at their own expense following certain "qualifying events" which result in a loss of coverage. If your employment terminates, or for any reason your hours or employer contributions are reduced so that you become ineligible for coverage, you and your eligible dependents may elect COBRA continuation coverage lasting for up to eighteen months from the date your coverage otherwise would have ended.

Your self-payment for COBRA continuation coverage is payable on a monthly basis. It is your responsibility to pay the self-payment directly to the Trust Fund in a timely fashion. You must make your first payment within 45 days after the date that COBRA continuation coverage is elected (you and/or your covered Dependents have 60 days from the date of receipt of the notice to elect COBRA Continuation Coverage). Your date of election is considered to be the date your Election Notice is postmarked, if mailed, and the date received by the Trust Fund if your Election Notice is hand delivered. If your first payment for continuation coverage is not received within the 45-day period after the date of your election, you will lose all continuation rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the Trust Fund Offices to confirm the correct amount of your first payment.

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage month. Periodic payments must be made on a monthly basis. Under the Plan, each of these monthly payments for continuation coverage is due on or before the first day of the month for which coverage will be provided. If you make period payment on or before the first day of the monthly period to which it applies, your coverage under the Plan will continue for that month without any break. The plan will send periodic notices of payments due for each coverage month.

Although periodic payments are due on a monthly basis, you will be given a grace period of 30 days after the first day of the monthly coverage period to make each periodic payment. Should you fail to make your payment on or before the first day of the month your coverage will be suspended during the 30-day grace period until payment is received. If you pay the periodic payments before the end of the applicable 30-day grace period, your coverage will be retroactively reinstated to the first day of the monthly coverage period. The failure to make payments on a timely basis means that any claims you submit for benefits while coverage is suspended will be denied and will have to be resubmitted if your coverage is reinstated due to a timely payment during the grace period. If you fail to make a periodic payment before the end of the applicable grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

If you, or an eligible dependent, are determined by Social Security to be disabled within sixty days of the date on which COBRA coverage commenced, the disabled individual is entitled to extend the regular eighteen-month COBRA continuation coverage to twenty-nine months. Eligible dependents of the individual electing this coverage may also

receive additional coverage during this special eleven-month extension. The premium for the additional eleven months of extended coverage is 150% of the normal cost of coverage. To be eligible for this special eleven month extension the disabled individual must notify the Trust Fund within sixty days following the later of the date on which the individual receives the initial COBRA notice following the loss of eligibility or the date Social Security determines that the individual is disabled and in all events before the end of the initial eighteen month COBRA continuation coverage.

Children born to you or placed with you for adoption during your COBRA continuation coverage are eligible to participate in your COBRA coverage, but there may be an additional premium required for their participation. Should you desire this additional coverage you must promptly notify the Trust Fund Office at the time of birth or placement for purposes of adoption. If you first become entitled to Medicare while on COBRA continuation coverage which was elected following a loss of employment or reduction in hours, your eligible dependents may elect to extend their initial eighteen month COBRA continuation coverage period to a thirty-six month maximum continuation coverage period measured from the date you initially became covered due to a COBRA election.

If your dependents lose coverage due to your death, your surviving spouse and other covered dependents may elect COBRA continuation coverage lasting for up to thirty-six months from the date their coverage otherwise would have ended. This coverage is in lieu of and not in addition to the surviving spouse coverage discussed at page 18.

If a child ceases to be eligible for benefits due to a loss of dependent status, that former dependent may elect COBRA continuation coverage lasting up to thirty-six months from the date his or her coverage would otherwise have ended.

If your spouse ceases to be an eligible dependent because of a divorce (or legal separation), your former spouse may elect COBRA continuation coverage lasting for up to thirty-six months from the date your spouse's coverage would otherwise have ended.

A parent electing COBRA continuation coverage may elect coverage which will include coverage for dependent children. An employee electing COBRA continuation coverage may elect continuing coverage which will include the employee's lawful spouse.

All individuals who elect COBRA continuation coverage must pay the costs of that coverage. The COBRA continuation coverage premiums are adjusted annually by the Board of Trustees and reflect 102% of the cost of coverage as of the date the premiums are set for the coverage. As noted above, if an individual is disabled and entitled to the eleven months of extended coverage the premium for those additional eleven months will be 150% of the cost of the coverage.

COBRA continuation coverage terminates on the earliest of the following events.

- The last day of the period for which COBRA continuation may be elected.
- The date a required COBRA payment premium due and payable is not received by the Trust Fund Office.
- The date all Trust Fund sponsored medical plans are terminated.

- The date the individual receiving coverage pursuant to COBRA first becomes covered under another group medical plan which does not contain an exclusion or limitation with respect to any pre-existing condition of such person. This date may vary for different members of the same family.
- The date the person on COBRA continuation coverage first becomes entitled to Medicare coverage. The right to COBRA continuation coverage terminates only for the person who becomes entitled to Medicare coverage.
- For individuals who are receiving the special eleven month extended coverage period due to disability, the first date of the month that begins not more than thirty days after such person is no longer disabled.
- The expiration of the applicable eighteen month, twenty-nine month or thirty-six month COBRA continuation period.

If your coverage under the active Plan ends because of the termination of employment or reduction in hours, or because of your death, you or your dependents will receive information from the Trust Fund Office explaining the right to elect COBRA continuation coverage, an explanation of the coverage and an application for coverage.

When coverage terminates because of divorce, legal separation or because a dependent is no longer eligible, it is the responsibility of you or the former dependent to notify the Trust Fund Office in writing within sixty days of the date of loss of coverage. The Trust Fund Office will then transmit information related to COBRA and an application for coverage.

In every instance, the materials transmitted by the Trust Fund Office will explain all options available in terms of electing core benefits or core and non-core benefits, the application process and the premium rates applicable to the coverage elected. Election of COBRA continuation coverage may serve as a bridge in creating eligibility for retiree coverage.

At the end of any COBRA continuation period elected, you will be allowed to enroll in an individual conversion health plan provided by the medical benefit plan in which you are enrolled. The benefits of these individual plans may not be the same as the benefits provided under the Trust Fund. Information related to individual conversion health plans may be obtained directly from your medical benefit plan or through the Trust Fund Office. If at the commencement of COBRA continuation coverage you are covered by a region specific HMO and you subsequently relocate to another area where that HMO is not available you may be entitled to transfer your coverage to other programs offered by the Trust. During the annual open enrollment period you will also be able to have the same open enrollment rights as are enjoyed by all other Plan participants. Under no circumstances will such a transfer change during open enrollment prolong the period of your COBRA continuation coverage.

In order to assure receipt of all COBRA materials and other announcements describing changes in the Plan, you and your dependents should advise the Trust Fund Office of all changes in address.

Your self-payment for COBRA continuation coverage is payable on a monthly basis. It is your responsibility to pay the self-payment directly to the Trust Fund Office in a timely

fashion. Following election your first payment must be made within forty-five days after the date the COBRA continuation coverage is elected.

Other Health Coverage Alternatives to COBRA

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the **Health Insurance Marketplace**. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

MEDICAL BENEFITS

About the Medical Plans Offered To You

The medical plans offered to you by the Trust Fund are designed to provide you and your family with comprehensive medical coverage for illness or accidental injury.

Newborns' & Mothers' Health Protection Act of 1996

Pursuant to the Newborns' & Mothers' Health Protection Act of 1996, a Plan may not require a health care practitioner to obtain authorization to prescribe a length of stay in connection with childbirth to less than 48 hours following a normal delivery, or less than 96 hours following a caesarian section delivery. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or her newborn earlier than 48 hours (96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998

Pursuant to the Women's Health and Cancer Rights Act of 1998, group health plans, insurers and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. In the case of a participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, the law requires coverage in a manner determined in consultation with the attending physician and the patient, for: 1) reconstruction of the breast on which the mastectomy was performed, 2) surgery on the other breast to produce symmetrical appearance, and 3) prosthesis and physical complications of all stages of mastectomy, including lymphedemas.

This coverage is subject to the Plan's annual deductibles and coinsurance provision. Benefits provided under this Plan will be covered in accordance with the provisions of the law.

HMO Plans

Active Employees

The Trust Fund has contracted with Kaiser to provide medical benefits for California residents. In addition, the Trust Fund has contracted with Group Health Cooperative for Washington residents.

Early Retirees not Eligible for Medicare

The Trust Fund has contracted with Kaiser and Group Health Cooperative (GHC) to provide medical benefits for early Retirees and Dependents who live inside the service area of one of the HMOs. Coverage is not available for early Retirees and Dependents who do not live in the Kaiser or GHC service areas.

HMO Benefits

HMOs provide a wide range of health care services to you. Your primary care physician will manage your care and refer you to a specialist when you need one. Except in certain emergency situations (or in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology), treatment must be provided by, or authorized by, your HMO physician or it will not be covered by the HMO or the Trust Fund.

Specific HMO benefits vary by state. In general, office visits are covered subject to a copayment for each visit and most hospital and surgical expenses are covered at no charge. Each plan has limitations and exclusions that are described in detail in the ***Evidence of Coverage***. Please be sure to read your ***Evidence of Coverage*** carefully. Benefit coverage under the HMOs may change from year to year. Be sure to read all material sent to you from your HMO and the Trust Fund Office to ensure that you have current information about your plan.

If you enroll in an HMO plan, the HMO will send you:

- an ID card;
- a HMO directory of doctors, hospitals and other service providers; and
- a ***Certificate of Coverage*** or ***Evidence of Coverage.***

Special Medicare HMO Programs – for Retirees Eligible for Medicare

The federal Medicare program is administered by the Centers for Medicare and Medical Services (CMS). In 1985 Congress passed a law allowing CMS to contract directly with federally qualified health maintenance organizations (HMOs) to provide all Medicare benefits. HMOs who offer this type of Medicare plan do so under their own plan name.

The plans offered by the Trust Fund to eligible retirees are generally called Medicare Advantage Plans. This Trust Fund offers the following Medicare Advantage plans: Group Health Cooperative, United Healthcare's Secure Horizons and Kaiser's Senior Advantage. These plans and some others are also available on an individual basis to the general public. However, these individual plans may not cover the same benefits offered through the Trust Fund. Under the arrangement with CMS, Medicare pays the HMO a monthly payment to provide all of your Medicare covered services.

To enroll in one of these plans, you and your dependents must:

- have Medicare Parts A and B, except that you may not enroll if you have end-stage renal disease or have elected hospice benefits through a Medicare certified hospice;
- live in the Plan's service area;
- agree to receive your health care from plan providers and facilities. All of your Medicare covered treatment will be provided by the HMO. Any care you receive from non-HMO providers or hospitals, except for emergency care, urgently needed care outside the service area and plan approved referrals, will not be covered by Medicare, the HMO or the Trust Fund.

- have your enrollment approved. The HMO must submit your enrollment request to CMS for approval. Upon receipt of approval, the HMO will provide you with an identification card to use instead of your Medicare card to obtain medical services.

Note: If you move out of the service area for a period that exceeds 90 consecutive days, you must notify the HMO prior to your move. Your coverage under a risk plan may be terminated if you spend more than 90 consecutive days out of the service area, as this is considered a permanent move. You should not enroll in a risk plan if you intend to travel or live out of area for more than 90 consecutive days a year. Your option, in this case, is the Medicare Supplement Plan.

United Healthcare Medicare Supplement

If you are a Medicare Eligible Retiree who does NOT live inside the service area of any Medicare Advantage HMO Plan that the Plan offers, you may enroll in United Healthcare's Medicare Supplement Plan. This Plan allows you to use any licensed physician or hospital you choose. However, your out of pocket costs are higher than they would be if you were in one of the HMO options. The plan benefits and all exclusions and limitations are described in the ***United Healthcare Membership Certificate***. Please be sure to read this membership certificate carefully.

The Indemnity Plan requires you to obtain authorization for:

- **all non-emergency hospital admissions;**
- **all surgical procedures; and**
- **certain outpatient procedures.**

To obtain authorization, call the telephone number on your ID card. If prior authorization is not obtained, your benefits will be reduced by 20%.

If you enroll in the Indemnity Plan you will receive:

- An ID card;
- A Medical Management brochure which explains when you need to obtain prior authorization for medical care; and
- A Membership Certificate (booklet).

Open Enrollment

Each year, you may elect to change coverage for yourself and your dependent(s) from the plan in which you are currently enrolled to another plan offered in your state. This open enrollment period is determined by the Trust Fund. Once an open enrollment period closes, you are not allowed to make changes until the next open enrollment period, unless you move out of the service area of your HMO or you have a Special Enrollment event.

Special Enrollment

This Plan complies with the Federal law regarding Special Enrollment by virtue of the fact that all eligible employees and their eligible dependents are eligible to enroll in this Plan whenever the eligibility requirements of the Plan are met. **There is no option to**

decline coverage. However, should any factual situation arise covered by these Special Enrollment rights, the Trust Fund will provide enrollment in compliance with the law.

Medicare

Once you reach age 65, you are typically eligible for Medicare hospital (Part A), supplemental medical (Part B), and prescription drug coverage (Part D). **If eligible, you must purchase Part B in order to participate in this Plan.** You may also qualify for Medicare coverage after two years of Social Security disability benefits, or if you have a chronic kidney disease. As a result, your benefits payable under the Retiree Medical Plan change in a way designed to supplement your Medicare coverage. For information about how your Retiree Medical Plan benefits coordinate with Medicare refer to your ***Evidence of Coverage***.

Signing Up for Medicare

Since eligibility for Medicare benefits is tied to eligibility for Social Security benefits at age 65, the Plan will assume that persons age 65 and older are enrolled in Medicare. If you are entitled to and are receiving Social Security benefits, you will automatically be enrolled in Part A of Medicare when you turn 65. If you do not decline Part B when you receive the Medicare card, you will be enrolled in Part B too. The monthly premium for Part B will be deducted from your Social Security benefits. If you are eligible for, but not receiving a Social Security check, you ***must apply*** for Medicare coverage. It is up to you to make sure you are enrolled in Medicare Parts A and B and D. You can contact your local Social Security Administration office for information.

Coordination of Benefits

Most group health plans, including HMOs, contain a "coordination of benefits" provision. Coordination of benefits applies when you or a dependent are eligible for medical benefits from more than one health plan, including Medicare.

If you or your dependents are covered under Medicare or any other group health plan, one plan will be determined as the "primary" plan. The primary plan is the one that pays benefits **first**. The other ("secondary") plan then adjusts its benefits so that the total benefits available will not be more than the covered expenses. For retirees who are eligible for Medicare, Medicare will be your primary plan. You should refer to your ***Evidence of Coverage*** for specific details.

Medical Plan Conversion Privilege

Participants Not Eligible for Medicare

If you are not eligible for Medicare and you or your dependent's Medical Plan coverage terminates under the Trust Fund, you may obtain an individual policy. Please refer to the Evidence of Coverage from the insurance company for a complete description of your conversion rights.

Note: Under some circumstances, conversion may not be offered. Please refer to your Evidence of Coverage for a description of your conversion rights or call the Trust Fund Office.

DENTAL BENEFITS

(Active Employees and their Eligible Dependents Only)

Dental Plan benefits are treated as a standalone (or excepted) benefit under HIPAA and Health Reform. Even though not required to do so, the Fund allows coverage of dependent children up to age 26.

Choice of Dental Coverage

Your Trust Fund Health and Welfare Plan offers you a choice of dental care plans:

- The primary dental coverage that is insured by Standard Insurance Company.
- A prepaid dental program is offered through Assurant Dental for California participants and through Dental Health Services for California and Washington participants.

An Evidence of Coverage/booklet describing one of the dental plans (along with the appropriate enrollment form) may be obtained from the Trust Fund Office or your Local Union Office. You may also contact the insurance company at the telephone number listed on the Quick Reference Chart.

Reinstatement of Coverage

Enrollment for dental benefits is optional. If you decline to enroll when you are first eligible, or if you drop your dental coverage during any subsequent open enrollment period, you will be required to enroll in the dental HMO option for the first two years upon re-enrollment. However, if your eligibility for coverage terminates and is later reinstated, the plan in which you were enrolled before eligibility terminated will automatically be reinstated unless you have not been eligible for benefits for one year or longer. You may not change coverage until the next open enrollment period.

VISION BENEFITS

(Active Employees and their Eligible Dependents Only)

Vision Plan benefits are treated as a standalone (or excepted) benefit under HIPAA and Health Reform. Even though not required to do so, the Fund allows coverage of dependent children up to age 26.

The Trust Fund Health and Welfare Plan provides vision benefits to all eligible active employees and Dependents through Vision Service Plan (VSP). Vision coverage is only available if dental coverage is also elected. For a copy of the Evidence of Coverage/booklet, please contact the Trust Fund Office or VSP at the telephone number listed on the Quick Reference Chart.

SHORT TERM DISABILITY BENEFITS

(Active Employees in the State of Washington Only)

About Your Short Term Disability Benefits

This is an insured "employee only" benefit for those active employees in the state of Washington. California workers are covered for non-occupational temporary disability benefits under the State's mandated disability insurance law. This benefit is insured by Standard Insurance Company.

If you become totally disabled as a result of a covered disability that occurs while you are covered under the Trust Fund, you will be paid the weekly benefit for up to the Maximum Benefit Period (defined below). "Totally disabled," for purposes of this benefit, means that you are unable to perform with reasonable continuity the material duties of your own occupation.

Covered Disabilities

- A disability due to sickness;
- A disability due to an accidental injury;
- A disability due to pregnancy, childbirth or a related medical condition.

Temporary Recovery

You may temporarily recover from your disability during the maximum benefit period and then become disabled again from the same cause or causes, without having to serve a new benefit waiting period. "Temporary recovery" means you cease to be disabled for no longer than 14 days.

If your temporary recovery does not exceed 14 days:

- The period of temporary recovery will not count toward your maximum benefit period; and
- No benefits will be payable for the period of temporary recovery.

Effect of a New Disability

If a period of disability is extended by a new disability while you are receiving a disability benefit, a benefit will continue to be paid while you remain disabled but not beyond the original 39-week period.

Plan Benefits

The benefit will begin on the ***first day*** of disability due to an accidental injury or the ***eighth day*** of disability due to illness, pregnancy, childbirth or a related medical condition. Benefits will be paid while you remain totally disabled, but not longer than the maximum benefit period (stated below) during any one period of disability. You must be under the care of a duly qualified physician while you are disabled. Benefits are as follows:

- $300 Weekly Benefit (subject to Social Security and Medicare withholding tax)

- Maximum Benefit Period: 39 Weeks.
- If you are disabled for less than one full week, Standard will pay 1/7 of the weekly benefit for each day of disability.
- The short-term disability benefit is limited to 70% of pre-disability earnings.
- Your pre-disability earnings will be based on your earnings in effect on your last full day of active work. Any subsequent changes in your earnings will not affect the pre-disability earnings.

Pre-disability earnings means your weekly rate of earnings from your Employer. Your weekly rate of earnings is based on your hourly pay rate multiplied by the average number of hours you worked per week during the preceding 52 calendar weeks (or during the period of employment if less than 52 weeks), but not more than 40 hours.

Excluded Disabilities

The plan does not cover disabilities incurred in the following situations:

- **Work-Related:** you are not covered for a disability arising out of or in the course of any employment for wage or profit.
- **Intentionally Self-inflicted Injury:** you are not covered for a disability caused or contributed to by an intentionally self-inflicted injury, while sane or insane.
- **War:** you are not covered for a disability caused or contributed to by war or any act of war. "War" means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.

When Benefits End

Your Short Term Disability benefits end automatically on the earliest of the following events:

- The date you are no longer disabled;
- The date your maximum benefit period ends;
- The date you die;
- The date you begin working for any employer.

Please note: No Short Term Disability benefits will be paid for any period when you are receiving paid sick leave from your employer.

Benefits After Insurance Ends or Is Changed

Your right to receive Short Term Disability benefits for a period of disability which begins while you are insured will not be affected by:

- Termination of the Group Policy after you become disabled;
- Termination of your coverage while the Group Policy remains in force; or
- Any amendment to the Group Policy approved after the date you become disabled.

LIFE INSURANCE BENEFITS

(Active Employees Only)

About Your Life Insurance Benefits

This is an "employee only" benefit. If you should die while you are an active employee eligible for Plan benefits, your beneficiary(ies) will be paid the amount of your life insurance coverage.

Life Insurance Amount……$10,000

For complete information regarding the life insurance benefit, please refer to the insurance policy provided by Standard on file at the Trust Fund Office.

Accelerated Life Insurance Benefit for Qualifying Medical Conditions

The Standard Insurance Company Policy allows you to receive an advance payment of up to 75% of your life insurance benefit if, while you are insured:

- You qualify for waiver of premium and
- You are terminally ill with a life expectancy of less than 12 months

This advance payment is called an "accelerated benefit."

Standard may have you examined at its expense in connection with your claim for an accelerated benefit. Any such examination will be conducted by one or more physicians of Standard's choice.

You may elect an accelerated benefit once in your lifetime. This benefit will be paid to you in a lump sum. If you recover from your qualifying medical condition after receiving an accelerated benefit, you will not have to refund the payment to the insurance company.

The amount of your insurance after payment of the accelerated benefit will be reduced by the amount of the accelerated benefit and an interest charge.

Example:	Life benefit	$10,000
	Accelerated benefit	($5,000)
	Interest on accelerated benefit	($200)
	Remaining life benefit	$4,800

No accelerated benefit will be paid if:

- All or part of your insurance must be paid to your child(ren), or your spouse or former spouse as part of a court approved divorce decree, separate maintenance agreement, or property settlement agreement.
- You are married and live in a community property state unless you give Standard a signed, written consent from your spouse.

- You have filed for bankruptcy, unless you give Standard written approval from the Bankruptcy Court for payment of the accelerated benefit.
- You are required by a government agency to use the accelerated benefit to apply for, receive, or continue a government benefit or entitlement.
- You have previously received an accelerated benefit under this Standard policy.

NOTE: The receipt of an accelerated benefit may be taxable and may affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax and/or legal advisor before you apply for an accelerated benefit.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) BENEFITS

(Active Employees Only)

About Your AD&D Benefits

This is an "employee only" benefit. The full amount of your accidental death benefit is payable, in addition to your life insurance benefit under the Plan, if you should die as a result of an accidental injury while you are eligible for Plan benefits. If you lose a limb or your eyesight, as a result of an accidental injury, the accidental dismemberment benefit is payable.

For a copy of the booklet explaining the accidental death and dismemberment benefits available, please contact the Trust Fund Office or the insurance company listed on the Quick Reference Chart at the beginning of this SPD.

AD&D Insurance Amount

Accidental Death Benefit	$10,000
Accidental Dismemberment Benefit	
Loss of one hand, one foot, or sight of one eye	$5,000
Loss of any two of the above	$10,000

Please Note: The maximum benefit for all losses resulting from the same accident is $10,000. Standard may pay an additional benefit of $10,000 for loss of life in an automobile accident if certain conditions are met as outlined in the Booklet from the insurance company.

CLAIMS

How to File a Claim

HMO

Be sure to carry your medical plan identification card with you at all times. Before you receive treatment, you will be asked to show your ID card.

If you enroll in an HMO, you do not have to file a claim form when receiving care from an HMO provider. Remember that the only care provided by non-HMO providers is for out-of-area emergencies.

Out-of-Area Plan (United Healthcare)

For any claims or customer service questions, contact United Healthcare.

United Healthcare

P. O. Box 6035

Cypress, CA 90630-6035

For questions about your claim, call: 1-866-316-9776

Dental Claims

For any claims or customer service questions, contact Standard Insurance Company.

Standard Insurance Company

P.O. Box 209

Portland, OR 97207-0209

1-800-547-9515

Vision Claims

Vision Service Plan

3333 Quality Drive

Rancho Cordova, CA 95670

For questions about your claim call: 1-800-877-7195

Short Term Disability Claims

For Washington Employees only: Claim forms for short term disability benefits are available from Standard, your Local Union Office or the Trust Fund Office. The claim form has two parts and must be completed as follows:

- **Employee's Statement** – you must complete this part.
- **Physician's Statement** – have your doctor complete this part.

Short term disability claim forms should be sent to:

Standard Insurance Company

P.O. Box 2800

Portland, OR 97208-2800

For questions about your claim call: 1-800-368-2859

Life and Accidental Death Claims

Life and accidental death claims will be paid by Standard upon receipt of *a certified copy of the employee's death certificate*. Your beneficiary(ies) must send that certificate to the ***Trust Fund Office within 90 days*** after your death, or as soon as possible thereafter. The Trust Fund will file the claim on your beneficiary's behalf.

Accidental Dismemberment Claims

If you suffer a loss that qualifies for accidental dismemberment benefits, you must file a statement with the Trust Fund Office from your physician giving a full description of the loss you suffered, including when, where and how the loss occurred. The Trust Fund Office will notify you if any further information is required before your claim can be processed.

Third Party Liability

If you or a dependent incur medical expenses as a result of an illness or injury caused by or contributed to by some other person or persons, a "third party" (for example, an automobile accident), your medical plan may require you to sign a subrogation agreement. This agreement authorizes the plan to be reimbursed from any settlement or judgment you may receive that is payment for the medical expenses incurred.

Notify your medical plan promptly if you or a dependent incur medical expenses as the result of the actions of a third party. You should keep that plan informed of the progress of all legal action, formal or informal, that is undertaken to obtain a judgment or settlement from the third party and/or an insurance company.

If Your Claim is Denied

If a claim for any benefits under a plan in which you are enrolled is denied, the claimant (you, your dependent or a beneficiary) will receive a written notice from the plan in which you are enrolled. The Notice of Denial received from that plan should set forth the detailed basis on which the claim has been denied. That plan will advise you of your appeal rights under that plan. If you encounter difficulties with an HMO or insurance company you should bring those difficulties to the attention of the Board of Trustees. For this purpose you should not hesitate to contact the Trust Fund Office.

The following rules apply when the Trust Fund Office denies a claim as to basic eligibility under the Plan due to a determination of lack of eligibility. As examples the Trust Fund Office determines (1) if your dollar bank contains sufficient credits for eligibility; (2) if your COBRA premium has been received within the required time period; (3) if your disability extension application is timely and supported by required evidence, (4) if you are entitled to change your HMO enrollment.

Within 30 days of receipt of an eligibility claim, the Trust Fund Office will grant or deny your basic eligibility claim. If the Trust Fund Office require additional information, they will within 30 days, advise you what additional information is required, why it is required and issue a decision within 30 days of receipt of the requested information.

If your claim for basic eligibility is denied, the Trust Fund Office's notice of denial will include: (1) the specific reason for the denial; (2) specific reference to the provisions of this plan on which the denial is based; (3) any additional information that might change the decision of the Trust Fund Offices; (4) the procedures you must follow to have your claim of basic eligibility reviewed by the Board of Trustees.

Should the Trust Fund Office fail to take any action on your claim of basic eligibility within 30 days of the Trust Fund Office's receipt of your claim of basic eligibility, you may treat your claim as denied and seek review by the Board of Trustees under the following Review Procedures.

Review Procedure

You may appeal a denial of initial eligibility, continuing eligibility, a change of enrollment or eligibility for a disability extension within 180 days of the date you received the denial notice. To appeal, write to the Trust Fund Office and state the reasons why you believe you were incorrectly determined to be ineligible, including any additional documentation to support your claim. You also may submit questions or comments you think are appropriate and you may review all relevant documents including those related to how the Trustees dealt with comparable eligibility issues in the past.

The Trustees typically meet quarterly. If your appeal is received by the Trust Fund Offices at least 30 days in advance of a regularly scheduled meeting, your appeal will be considered by the Trustees at the next regularly scheduled meeting. To the extent permitted by federal regulations, consideration of your appeal may be put over to the next meeting of the Board if additional information is required. You will be notified in writing of any need for additional information.

To assure timely consideration of appeals, the Board has established an Appeals Committee of one Union and one Employer Trustee. This Committee is empowered to make final decisions, if required, in order to deal with appeals in a timely fashion, for example, when a regular Board meeting is canceled.

When the Committee or Board makes a final determination on your appeal, you will be advised in writing of the determination by the Trust Fund Office within five days of the decision.

Under a Federal Law known as ERISA, a participant or beneficiary whose claims for benefits has been denied, may file suit against the Plan pursuant to ERISA Section 502(a). However, prior to filing such a suit, the appeal process described above must be pursued and exhausted. Thus, following any denial of eligibility, if you disagree it is important you file a timely appeal. In all cases, your appeal must be filed no later than 180 days after you receive the initial eligibility denial. If you do not file an appeal within the required time frame, you will have failed to exhaust your appeal rights. If is important to understand that all benefits provided under this Plan are provided through HMO

contracts and contracts of insurance. Thus, even if the Trustees eventually agree with your eligibility claim, benefits can be paid for a retroactive period only if the HMO and/or insurer aggress to accept retroactive premiums for retroactive coverage. HMOs and insurers typically will not accept more than one or two month's worth of retroactive premiums. Accordingly, it is in your best interest to promptly file all appeals related to eligibility.

The foregoing rules related to eligibility in no fashion replace the claims and appeal rules set forth in the ***Evidence of Coverage*** you receive from the HMO in which you enroll and those set forth in the insurance policies described in the ***Evidences of Coverage*** you received related to those policies. The Board of Trustees only deals with basic eligibility issues (i.e., does your dollar bank contain sufficient amounts for coverage, have you paid a COBRA premium in a timely fashion, have you filed a timely disability extension request with a required proof of eligibility for a disability extension).

Should you have any questions related to these rules, do not hesitate to contact the Trust Fund Office.

The Privacy of Your Health Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted by Congress to streamline the operation of health benefit plans and to protect the privacy interests of Plan participants. Pursuant to the legislation, the Department of Health & Human Services promulgated various regulations in the area of privacy. Those regulations were effective April 14, 2003.

The Pacific Coast Shipyards Metal Trades Trust Fund is a hands-off Protected Health Information entity that only provides benefits through fully insured HMO contracts and insured policies. Those HMO providers and insurers are called "covered entities" under the regulations. Those covered entities are required by the regulations to provide you with detailed notices as to your privacy rights under the regulations as to your Protected Health Information (PHI).

The Trust has no access whatsoever to such PHI other than the information necessary to establish your eligibility for benefits and to enroll you in those benefit programs you select in the enrollment process. That enrollment information is shared by the Trust solely with the benefit programs in which you enroll and any necessary business associates to assure your timely enrollment. For example, absent your prior written authorization, the Trust Fund does not advise your Local Union or your employer as to the benefit program in which you have enrolled.

The Trust Fund does receive from the HMOs and insurers so-called summary health information. Summary health information is limited and does not identify specific Plan participants. By way of example, the Trustees will receive such information as the total amount of claims paid under an insurance policy or the Trust Fund's experience rating with a particular HMO but will never receive information from an HMO or insurer as to claims paid or costs incurred on an identified Plan participant.

The Trust Fund receives this summary health information from HMOs and insurers for the limited purpose of obtaining premium bids or considering modifications or amendments to existing policies and contracts.

The Trustees wish to stress that no waiver of your HIPAA rights is required to participate in the Pacific Coast Shipyards Metal Trades Trust Fund. The Trustees also wish to assure that you are informed that no one, including the Trust, an HMO, an insurer, your Employer or your Union can discriminate against you for your exercising your rights to privacy as set forth in the privacy regulations.

The HIPAA notices included in the Evidence of Coverage brochures you receive from the HMO or insurer provides your benefits and explain to you your right to complain to the provider and/or the Secretary of the Department of Health & Human Services if you believe the provider (covered entity) is violating your rights as set forth in the privacy regulations.

YOUR ERISA RIGHTS

As a participant in the Pacific Coast Shipyards Metal Trades Trust Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and subsequent amendments. ERISA provides that all Plan Participants are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents, including insurance contracts, Collective Bargaining Agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself and dependent(s) if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependent(s) may have to pay for such coverage. Refer to the COBRA Continuation Coverage section of this booklet.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your Plan when you lose coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and the interest of other Plan participants and beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request certain materials required to be furnished by the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the

materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents for the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone book. Alternatively, you may obtain assistance by calling EBSA too free at 866-444-EBSA (3272) or writing to the following address:

Division of Technical Assistance and Inquires
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210.

You may obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of EBSA at 800-998-7542 or contacting the EBSA field office nearest you.

You may also find answers to your plan questions and a list of EBSA field offices the website www.dol.gov/ebsa.

Health Plan Addresses

In accordance with disclosure requirements of ERISA, listed below are the name and address of the Health Providers for this Plan:

Kaiser Foundation Health Plan
Northern California Region
1950 Franklin Street
Oakland, CA 94612
Provides prepaid medical plans.

Kaiser Foundation Health Plan
Northwest Region
500 NE Multnomah Street, Suite 100
Portland, OR 97232

United Healthcare
P.O. Box 6098
Cypress, CA 90630
Provides out-of-area medical plan

Group Health Cooperative 320
Westlake Ave. North, Suite 100
Seattle, WA 98109
Provides prepaid medical plan.

Standard Insurance Company
1600 Riviera Avenue, Suite 385
P.O. Box 8185
Walnut Creek, CA 94596
Provides life, AD&D, weekly disability, and dental benefits.

Assurant Dental
2185 N California Boulevard, Suite 250
Walnut Creek, CA 94596
Provides prepaid dental plan.

Dental Health Services
3833 Atlantic Avenue
Long Beach, CA 90807
Provides prepaid dental plan.

Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670
Provides fully insured vision plan.

ERISA PLAN INFORMATION

Name of Plan:

Health and Welfare Plan of the Pacific Coast Shipyards Metal Trades Trust Fund

Plan Sponsor:

Participating local unions, various employers and employer associations

Plan Administrator:

Board of Trustees, Pacific Coast Shipyards Metal Trades Trust Fund
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566

Taxpayer Identification Number:

94-1248513

Plan Number:

501

Type of Plan:

This is an employee welfare plan providing life, weekly disability, medical, dental and vision care benefits.

Type of Administration:

The Plan is funded by payment of premiums required by the insurance policies. The following organizations receive premiums and other funds from the Trust Fund to provide the benefits indicated:

Kaiser Foundation Health Plan
Prepaid medical benefits.

United Healthcare Health Plan
Indemnity medical Plan Medicare eligible retirees who do NOT live inside the service area of any Medicare Advantage HMO Plan that the Plan offers

Group Health Cooperative
Prepaid medical benefits.

Standard Insurance Company
Life, AD&D, weekly disability, and dental benefits.

Assurant Dental
Prepaid dental benefits.

Dental Health Services
Prepaid dental benefits.

Vision Service Plan
Fully insured vision benefits.

Agent for Services of Legal Process:

Charles P. Scully II, Esq.
Law Offices of Carroll & Scully, Inc.
300 Montgomery Street, Suite 735
San Francisco, CA 94104-1909

Legal process may also be served on the Board of Trustees or the Administrator.

Availability of Collective Bargaining Agreement:

The Plan is maintained pursuant to various collective bargaining agreements. Copies of the collective bargaining agreements are available for inspection at the Trust Fund Office during regular business hours, and upon written request, will be furnished by mail.

Source of Contributions:

Contributions to provide Plan benefits are paid by the sponsoring employers in accordance with their bargaining agreements on a cents-per-hour basis. The Administrator will provide the names of the sponsoring employers upon written request.

Plan Effective Date:

July 1, 1976

Plan Year:

April 1 through March 31

Date of SPD Issue:

May 1, 2016

Plan Amendment or Termination

The provisions of the Plan may be amended or terminated at any time by a vote of the Board of Trustees.

If the Plan terminates, any and all monies and assets remaining in the Trust Fund, after payment of expenses, will be used for the continuance of Plan benefits in a manner permitted by ERISA so long as Trust assets permit.

Plan Trustees:

Trustees serving at the time this booklet is printed are:

Employer Trustees

Peter J. Blake
General Engineering
222 Napoleon Street
San Francisco, CA 94124
(415) 740-2993

Union Trustees

Michael Grabowski
Pacific Coast Metal Trades District Council
4437 James Avenue
Castro Valley, CA 94546
(510) 504-2094

Employer Trustees

D. Carl Hanson
822 Castle Rock Road
Walnut Creek, CA 94598
(415) 385-9494

Warner Nelson
15000 Village Green Drive, Unit 23
Mill Creek, WA 98012
(425) 316-6973

Michael D. Parmelee
24135 W. Greystone Lane
Woodway, WA 98020
(206) 910-9901

Ellen Vinck
BAE Systems Ship Repair
2205 East Belt Street
Foot of Sampson Street
San Diego, CA 92113
(619) 990-2585

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Union Trustees

Jeffery J. Owen
Plumbers & Pipefitters UA Local 32
595 Monster Road SW #213
Renton, WA 98057
(425) 277-6680

Gary Powers
Boilermakers, Local #104
2800 1st Avenue, Room 220
Seattle, WA 98121
(206) 623-2876

Kal Rohde
Sheet Metal Workers Local #66
11831 Beverly Park Road, B-2
Everett, WA 98204
(425) 493-5928

Jose Santana
Painters Union Local 1176
2020 Williams Street, Suite A-1
San Leandro, CA 94577
(510) 454-8150

Robert M. Scott
10449 34th Avenue SW
Seattle, WA 98146
(206) 550-4260

Grant Zadow
P.O. Box 684
Tualatin, OR 97062
(503) 317-2166