

**U. A. LOCAL NO. 393
HEALTH AND WELFARE PLAN**

SUMMARY PLAN DESCRIPTION

January 1, 2026

Preamble

This Summary Plan Description covers three Plans:

- The U.A. Local No. 393 Health and Welfare Plan (“Plan”), established on September 1, 1952, is a welfare benefit plan that provides medical, pharmacy, dental, vision, death, disability, wage replacement benefits, and a health reimbursement account.
- The Supplemental Unemployment Plan (“SUB Plan”) was established on July 1, 1993 and provides supplemental unemployment benefits.
- The Dependent Care Assistance Flexible Spending Account (“DCA FSA”) is a qualified flexible spending account pursuant to IRC Sections 106, 125, and 129 and was established on January 1, 2019.

How to Use This Document

This document serves as the updated and combined Summary Plan Description (“SPD”) for the U.A. Local No. 393 Health and Welfare Plan, the Supplemental Unemployment Plan and the Dependent Care Assistance Flexible Spending Account. The SPD uses understandable language to explain some of the more complex features of the Plans. The SPD and its text boxes and exhibits are not meant to interpret, extend or change these provisions in any way. Where there is a conflict between the SPD and the Formal Plan Rules, the Formal Plan Rules shall govern.

Only the full Board of Trustees is authorized to interpret the Plans. The Board has discretion to decide all questions about the Plans. No individual trustee, employer, union representative or other person has authority to interpret the Plans on behalf of the Board or to act as an agent of the Board.

The Plans shall not be bound by the representations of any person, other than the Board of Trustees, regarding participation in the Plans, eligibility for benefits under the Plans, the status of Participants or employers under the Plans, or any other matters relating to the Plans. If you have a question about your benefits, you should contact the Administration Office, BeneSys Administrators. To obtain an accurate answer, you will need to provide complete and accurate information about your situation. As a courtesy to you, BeneSys may also respond informally to oral questions. Oral information and answers provided by BeneSys is not binding upon the Board and cannot be relied on in any dispute concerning your benefits. BeneSys’ contact information can be found at the back of this document.

Este resumen describe el Plan para ayudarlo a comprender los beneficios y la seguridad de jubilación que le brinda el Plan. Si desea recibir esta información en español, llame a la Oficina de Administración al (408) 588-3751.

Dear Plan Participant:

We are pleased to provide you with this revised document. The Plan has over 70 years of history providing meaningful benefits to members and we hope that this document will help you understand how the Plan works. Some of the key features explained include:

*Eligibility
Hour Bank
Medical and Pharmacy
Dental and Vision
Short- and Long-Term Disability
Death Benefits
Health Reimbursement Account (Bennycard)
Supplemental Unemployment Benefits*

You can find more information about the Plan on the member portal at www.ualocal393benefits.org. The portal is updated frequently with all of the forms, FAQs, and additional information you may need.

If you have any questions about your benefits or eligibility, please call the Administration Office at (408) 588-3751.

*Sincerely,
The Board of Trustees*

U.A. LOCAL NO. 393 HEALTH AND WELFARE PLAN SUMMARY PLAN DESCRIPTION

Formal Eligibility Rules

Definitions

Aetna Medicare Advantage PPO - One of two plans in which eligible Local 393 Retirees may enroll after they reach age 65 while also enrolling in Medicare Part A and Medicare Part B.

Annual Deductible - The amount of expenses which a Covered Individual or family must pay each year toward covered charges before benefits are payable under the Plan for that individual or family.

Balance Bill - The amount a Covered Individual could be responsible for (in addition to any Copayments, deductibles or Coinsurance) if he or she use an out-of-network provider and the fee for the particular service exceeds the allowable charge.

Basic Monthly Charge – The number of hours needed to “pay” for one month of eligibility for coverage under the Plan.

Building Trades Employee - Employees and former Employees of employers signatory to U.A. Local No. 393 Master Agreement.

COBRA (Consolidated Omnibus Reconciliation Act) - The federal law that permits you to purchase extended medical coverage for a period of months after it would ordinarily end (such as upon termination). Your eligible dependents also may purchase COBRA coverage on their own if their Plan coverage ends (such as a child reaching age 26, a Spouse becoming divorced or separated from you, or, for a child or Spouse, on account of your death). To find out if COBRA coverage applies to you, your Spouse, or child, call the Administration Office at (408) 588-3751. To read more about COBRA, see Appendix C.

Coinsurance - An arrangement under which the Covered Individual pays a fixed percentage of the cost of medical care after the deductible has been paid. For example, a plan might pay 90% of the allowable charge, with the Covered Individual responsible for the remaining 10%, which is then referred to as the coinsurance amount or percentage.

Collective Bargaining Agreement (CBA) - A collective bargaining agreement, also known as a labor contract, is a legally binding contract between an employer and a labor union that represents a group of Employees. It outlines the terms and conditions of employment for union-represented Employees, including wages, working hours, benefits, and other employment-related matters. This Plan covers Employees under the U.A. Local 393 Master Agreement, the UA National Plumbing Service Agreement and the Northern California & Northern Nevada Refrigeration and Air Conditioning and Food Store Addendum.

Coordination of Benefits - This is the process by which the Plan determines if it should be the primary or secondary payer of medical claims for a patient who has coverage from more than one health plan.

Copayment – A specific charge that a health plan may require a member to pay for a specific medical service or supply, after which the health plan pays the remainder of the charge.

FAQ: What's HIPAA?

Answer: Health Insurance Portability and Accountability Act (HIPAA) - A federal health benefits law passed in 1996, effective July 1, 1997, which among other things, protects the privacy rights of health plan Participants.

Covered Individual or Covered Person - is someone who meets the eligibility requirements for coverage under the terms of the Plan. You are no longer a Covered Individual or Covered Person if your coverage terminates or you lose eligibility.

Employee Assistance Program (EAP) - A program that is designed to provide Employees and their dependents with access to resources to support various life situations. It also provides confidential, short-term counseling by qualified practitioners, in person or virtually.

Employee - means any person on whose account an Employer is required to make contributions to the Plan, or for whom an Employer did make such contributions and who qualified for benefits to be provided by the Plan. Employee may include non-bargained Employees, travelers or Employers who were formerly Employees.

Essential Benefits - Coverage for ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. This Plan uses the Utah Benchmark for determining what constitutes an essential benefit.

HMO Plan (Health Maintenance Organization) - One of the two medical plans you may select for yourself and your eligible dependents when you become eligible for coverage under the U.A. Local No. 393 Health and Welfare Plan. An HMO Plan offers a wide range of health care services through a network of providers who agree to provide services at a pre-negotiated rate. You will choose a primary care physician who manages all healthcare and refers you to specialists as needed. If you decide to enroll in the HMO Plan, all of your medical care (except emergency) must be provided by the doctors, hospitals, and laboratories affiliated with the HMO, currently Kaiser Permanente. You will rely on a separate booklet from Kaiser Permanente to learn about HMO enrollment, coverages, and benefits.

Hour Bank – The Plan’s system that allows Employees to accumulate hours worked during peak periods and use them during slower times or when there are work stoppages. The hours in the Hour Bank are used to “pay” for Plan eligibility.

Hour Bank Maximum or Basic Reserve Account Maximum - This is the maximum number of hours that can be banked for the Initial Eligibility Amount.

Initial Eligibility Amount – The amount of hours Employees must accumulate into their Hour Bank in order to become initially eligible for benefits under the Plan.

Kaiser Permanente Senior Advantage - One of two plans in which eligible Local 393 Retirees may enroll after they reach age 65 while also enrolling in Medicare Part A and Medicare Part B. For details, consult the KPSA booklet.

Medically Necessary or Medical Necessity - procedures, services, supplies, or equipment which are determined by the PPO Plan to be:

- Appropriate and necessary for the diagnosis or treatment of the medical condition.
- Clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for the patient’s illness, injury, or disease.
- Provided for the diagnosis or direct care and treatment of the medical condition.
- Within standards of good medical practice within the organized medical community.
- Not primarily for the convenience of the patient, doctor, or another provider.
- Not more costly than alternative services that are medically appropriate and likely to produce equivalent therapeutic or diagnostic results.

- The most appropriate procedure, supply, equipment, or service that can safely be provided, supported by valid scientific evidence demonstrating expected health benefits.

The fact that the Covered Person's physician prescribes services or supplies does not automatically mean such services or supplies are Medically Necessary or covered by the PPO Plan. The Administration Office will make available the criteria for Medical Necessity or Medically Necessary determinations upon request.

Non-PPO Providers - Any doctors, hospitals, and laboratories who are not in the Prudent Buyer Network. PPO members are free to seek services from non-PPO providers (also known as “non-preferred providers”). However, you will pay more than if you had stayed in-network with a preferred provider.

Participant - is an Employee or former Employee who meets the eligibility requirements for coverage under the terms of the Plan. You are no longer an eligible Participant if your coverage terminates or you lose eligibility.

PPO Plan (Preferred Provider Organization) - One of the two medical plans you may select for yourself and your eligible dependents when you become eligible for coverage under the U.A. Local No. 393 Health and Welfare Plan. The PPO Plan is a type of managed care organization that has a panel of “preferred providers” who are paid according to a discounted fee schedule. If you decide to enroll in the PPO Plan, you have a choice of doctors, hospitals, and laboratories – the “preferred providers” or the “non-preferred providers.” Substantially greater benefits are available from the Plan when you choose “preferred providers.”

PPO Providers - The network of doctors, hospitals, and laboratories who have contracted to provide care for PPO members (also known as “preferred providers”). They are listed in the Prudent Buyer Network (www.anthem.com/ca). When you select a PPO Provider, your health care will cost you and the Plan less because these preferred providers have agreed to lower contract rates to serve PPO enrollees.

Public Safety Officer - An individual serving a public agency in an official capacity, with or without compensation, as a law enforcement officer, firefighter, or member of a rescue squad or ambulance crew.

Retiree - an Employee who is retired under either the U.A. Local No. 393 Defined Benefit Pension Plan or the U.A. Local No. 393 Defined Contribution Plan.

Residential Employees or Residential Plumber - Residential Building Tradesmen and Residential Provisional Journeypersons Levels I and II working under the Residential Market Recovery Agreement.

Service Plumber - Service Plumbers and Levels I through III working under the UA National Plumbing Service Agreement.

Spouse - means the person to whom the Participant is legally married. Notwithstanding any other Plan provision to the contrary, effective as of June 26, 2013, a Spouse shall include the same-sex spouse of a Participant, provided the marriage was validly entered into in a state whose laws authorize the marriage of two individuals of the same sex and regardless of whether the individuals are domiciled in a state that does not recognize the validity of same-sex marriages.

Trust Agreement - means the agreement and declaration of trust providing for the establishment and continuance of the U.A. Local No. 393 Health and Welfare Plan, and any modification, amendment, extension or renewal thereof.

Usual, Customary and Reasonable (“UCR”) - This refers to the standard or most common charge for a particular medical service when rendered in a particular geographic area.

Rule 1: Active Employee Eligibility

Rule 1 defines which Employees are eligible under the Plan, how to become eligible by working, and how to maintain eligibility for coverage through the Employee's Hour Bank.

- (a) **Bargained Employees:** Each Employee working under a Collective Bargaining Agreement with U.A. Local No. 393, in a position for which contributions are required to be made to this Plan, or on whose behalf contributions are made, will accrue an hour into his or her Hour Bank for each hour of covered employment. Hours will be added to each Employee's Hour Bank and become available to be applied to eligibility, effective on the first day of the second month following the month in which the hours are worked. The Basic Monthly Charge will then be deducted, effective on the first day of each month, for eligibility for coverage for that month. The Hour Bank Maximum is set by the Board of Trustees and Employees may not bank more than the Hour Bank Maximum.

Group A: Bargained Employees include the following classifications:

- Construction Tradesmen Levels 2-5 ("Construction Tradesmen")
- Building Trades Apprentice and Journeyman working under the U.A. Local 393 Master Agreement. ("Building Trades Employee")
- Building Trades Plumbing Service Journeyman and Apprentices working under the Northern California Refrigeration and Air Conditioning or the National Service and Maintenance Agreements

Group B: Bargained Employees who have earned eligibility from hours worked in residential plumbing or as service tradesmen working under the Northern California & Northern Nevada Refrigeration and Air Conditioning and Food Store Addendum:

- Mechanical Electrical Service Tradesman ("MEST")
- Residential Building Tradesmen and Residential Provisional Journeypersons Levels I and II ("Residential Employees")

The Board of Trustees have authority to determine whether work performed under a Collective Bargaining Agreement constitutes residential plumbing, service tradesman, or provisional journeymen service work.

- (b) **Non-Bargained Employees:** The Hour Bank rules shall also apply to any Employee who is working as a non-collectively bargained Employee for a participating employer, the Union, the training program, or other related entity approved by the Board of Trustees, if the employer has executed a Participation Agreement with the Board of Trustees which allows contributions on behalf of the Employee.

Employer Who Was Formerly a Bargained Employee:

(1) The Hour Bank rules **apply** if the person is an officer/shareholder of an Employer and all of the following requirements for active Employees are met:

- (A) The Employer is incorporated; and
- (B) The Employer is signatory to a Collective Bargaining Agreement with U.A. Local No. 393; and
- (C) The officer/shareholder Employee must be a working Employee. A working Employee is one that is actively engaged in providing services to the Employer.
- (D) The Employer signs a Participation Agreement requiring the Employer to make a set 150 hours per month contribution on behalf of the officer/shareholder at the Journeyman rate; and
- (E) The officer/shareholder's participation is approved by the Board of Trustees or a designated committee of the Board of Trustees; and
- (F) The officer/shareholder has at least 10 Vesting Credits in the U.A. Local No. 393 Defined Benefit Plan; and

(G) The participation is otherwise in accordance with the law.

(2) The Hour Bank rules **do not apply** to persons who are working in the trade as employers or in self-employment, who may be eligible for benefits only under Rule 14, Eligibility Rules for Individual Employers.

(c) **Travelers:** The Hour Bank rules apply to any Employee who is working outside the jurisdiction of U.A. Local No. 393, and who elects to have his or her health and welfare plan contributions reciprocated back to this Plan. Such contributions shall be deemed available for a month's coverage only if received by the 25th day of the prior month. Such contributions shall be prorated to the current commercial journeyman rate. For example, 160 hours worked at a contribution rate of \$1/hour where the requirement is \$10/hour would be calculated down to 16 hours.

***FAQ:** I'm traveling to work in a UA in the Midwest. Where's my Hour Bank?*

***Answer:** Your Hour Bank and coverage remains with the U.A. Local No. 393 Health and Welfare Plan. If you have contributions transferred here from another U.A. Trust Fund, your work in the other U.A. is treated as covered hours, except that they are adjusted proportionally to reflect the difference in hourly contribution rates. Likewise, if you are a member from another U.A. Trust Fund and are working for a U.A. Local 393 employer, the contributions made on your behalf are transferred to your home U.A. Trust Fund. Your hours are counted only under the plan of your home Trust Fund.*

(d) **Coverage when contributions are late:** Upon the failure or refusal of any employer to make the required contributions, the Trustees and/or a designated committee of Trustees shall have authority to pay or provide for the payment from the Trust for the cost of providing the benefits hereunder for a maximum of 60 days to the eligible Employees of such delinquent employer, but the Trustees shall not be obligated either to the Employees or the employer to make or provide such payments and they shall incur no liability whatsoever, either individually or collectively, for their failure or refusal to do so. In the event such payments are made by the Trustees from the Plan on behalf of a delinquent employer, the Plan shall be reimbursed by the employer for such payments and the Trustees shall have the authority to enforce such right of reimbursement.

Rule 2: Hour Bank Accrual Rates

An Hour Bank will be opened for each eligible Employee once the work hours are paid to the Plan. The following rates and amounts are set by the Board of Trustees from time to time:

- (a) **Hours:** Each Employee's Hour Bank will be credited with hours based on the actual contribution rate. If an Employee is working under a CBA with a lesser contribution rate than the Journeyman Building Trades rate, then that Employee's Hour Bank will be credited with hours that are pro-rated.
- (b) **Initial Eligibility Amount:**
- (1) Group A Employees must have 440 hours contributed into their Hour Bank to become initially eligible for benefits under the Plan.
 - (2) Group B Employees must have 480 hours contributed into their Hour Bank to become initially eligible for benefits under the Plan.
- (c) **Maximum Hour Bank:**
- (1) The Maximum Hour Bank a Group A Employee may accrue is 660 hours of contributions.
 - (2) The Maximum Hour Bank a Group B Employee may accrue is 720 hours of contributions.

- (d) **Basic Monthly Charge:** The Basic Monthly Charge for one month of eligibility for coverage under the Plan for Group A is 110 hours and for Group B is 120 hours, which is subject to change from time to time by the Board of Trustees.
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A Typical New Hire Example

A new member in Group A who starts work on January 1st and works 20 hours per week of covered work, will accumulate 440 hours 22 weeks later, on May 31st. In June, the employer reports the hours to the Administration Office. The new member's enrollment will be processed, and at the start of the next month, on July 1st, Plan eligibility and coverage begins.

If the member does not complete the required number of hours by December 31st (the end of the initial 12-month eligibility period), the eligibility period would continue. The member would become eligible to enroll as soon as he or she has completed the required hours of work within 12 consecutive months. In the above example, if the new member worked 10 hours in January and a total of 439 hours by the end of the year, he would be short one hour. His or her eligibility period would shift forward to be from February through January 31 of the following year. The 10 hours from the first January would no longer count for Initial Eligibility and he/she would need to work additional hours to meet the 440 hour requirement in the next January.

Default Enrollment Option: *Once you become eligible for coverage, you will automatically be placed in the PPO Plan. However, no dependents will be enrolled. If you prefer HMO or want to add your dependents, you have 90 days to submit an enrollment form and other required documentation to switch to HMO.*

Your Hour Bank Helps You Stay Enrolled Month-to-Month

1. *Once you become enrolled, you need to work enough hours to meet the Basic Monthly Charge (either 110 or 120 hours per month) to stay enrolled each month. You can satisfy this requirement by:
 - a. *Working at least 110 or 120 hours per month at the current base contribution rate,*
 - b. *Drawing on reserves, if any, in your Hour Bank, or,*
 - c. *If eligible, paying the monthly cost via the Self-Payment Provisions (See Rule 8).**
 2. *Your Hour Bank is available to you in months when you have low or no work hours – should your hours dip below the Basic Monthly Charge, you can draw on your Hour Bank to fill in the gap.*
 3. *Your Hour Bank is made up of work hours in excess of the Basic Monthly Charge that is deducted for a month of continuing enrollment. For example, if you save an extra 20 hours a month into your Hour Bank, after 33 months you will have accumulated 660 reserve hours (20 hours \times 33 months = 660 hours). A maximum of 660 hours may be reserved.*
 4. *When your Hour Bank is full (660 hours), it will provide six months' continuing enrollment during times when you are out-of-work.*
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FAQ: *If I work overtime or double time, do I get more hours in my Hour Bank?*

Answer: *No, one hour is contributed for every hour you work, regardless of how much you are paid for that hour of work.*

What's My Hour Bank Balance?

To inquire about your Hour Bank balance, you can contact the Administration Office, log onto your member portal at www.ualocal393benefits.org or check your most recent Monthly Benefit Statement which is mailed to you. Also, please retain your pay stubs. They provide evidence of hours worked.

Rule 3: Initial Eligibility

- (a) **Initial Eligibility:** Each Employee now eligible for benefits (and his or her eligible dependents) may maintain eligibility for coverage subject to these eligibility rules. Each Employee not currently eligible will become eligible for Employee and dependent benefits as of the first day of the month following any period of **12 consecutive months** or less in which the Employee's Hour Bank has been credited with the Initial Eligibility Amount. However, no benefits will be paid until a properly completed enrollment form with all supporting documents is on file with the Administration Office.

Example: Initial Eligibility for Group A (Working 440 Hours Within 12 Months)

- Employee A has more than 440 hours by the end of Month 6. Month 7 is the “skip” month. On the first day of Month 8, Employee A’s enrollment starts.
- Employee B doesn’t finish 440 hours within a period of 12 months in a row until the end of Month 13. Month 14 is the “skip” month. On the first day of Month 15, Employee B’s enrollment starts.

Month	Employee A Hours Worked	Employee A Cumulative Hours	Employee B Hours Worked	Employee B Cumulative Hours
1	40	40	40	40
2	80	120	40	80
3	80	200	40	120
4	80	280	40	160
5	90	370	40	200
6	80	450	40	240
7	Skip*		30	270
8	Enrollment Start		30	300
9			30	330
10			30	360
11			30	390
12			40	430 (still not eligible)
13			53	443 (430 minus 40 from Month 1, plus 53 from Month 13)
14			Skip*	
15			Enrollment Start	

***Skip Month Accounting** - Hours accumulated for eligibility are reported by the employer the month following the date of accumulation. They do not enter the employee’s Hour Bank until the first day of the second month after they were accumulated. For example, the 440 hours accumulated by the end of June are reported by the employer in July, then are used for coverage beginning August 1st. July is the “skip” month for June’s hours.

- (b) **Newly Organized:**
- (1) Notwithstanding the above, a new Employee who becomes enrolled in the Plan because of organizing by the Union shall be granted an Hour Bank advance equal to the Initial Eligibility Amount, in accordance with the following rules. An Employee shall be eligible for an Hour Bank

advance upon notice to the Administration Office by the Union that, as a part of an organizing effort by the Union:

- (A) The Employee left employment with a non-contributing employer for employment by a contributing employer, or the Employee's employer is newly contributing; and
 - (B) The Employee is employed by a contributing employer.
- (2) An Employee who qualifies for an advance shall be covered under the Plan and such advance shall be applied effective the first of the month of the month the Employee is employed by a contributing employer.
- (3) An Employee may use an advanced Hour Bank on the same basis as a regular Hour Bank, except as follows:
- (A) Any hours that an Employee works in covered employment for which contributions are actually received that are in excess of 110 hours per month, shall be applied toward repaying the amount advanced to the Employee's Hour Bank. An Employee has 24 consecutive calendar months from the date he or she first receives the Hour Bank advance to repay the amount advanced to the Employee's Hour Bank through such excess hours of covered work; thereafter he or she shall be required to self-pay the entire remaining balance at a rate set from time-to-time by the Trustees; and
 - (B) The advanced Hour Bank amount shall be revoked immediately if the Employee ceases to work in, or to be available for, covered employment before contributions equal to the advanced Hour Bank amount are received.

Rule 4: Dependents and Enrollment Requirements

- (a) **Dependents:** Dependents of eligible Employees will qualify as eligible dependents under the following conditions, subject to the Plan's enrollment requirements:
- (1) A lawful Spouse (if not legally separated from the employee) is covered whenever the Employee is covered.
 - (2) A registered Domestic Partner is covered whenever the Employee is covered. Domestic Partner shall be defined pursuant to section 297 of the California Family Code and shall include only Domestic Partners who are registered with the California Secretary of State. Domestic Partners and their children are eligible for benefits under the Plan on the same basis as other qualified dependents.
 - (3) Children are covered, until the end of the calendar month in which the child attains age 26. The term "children" includes the employee's natural children, legally adopted children (including children placed with the Employee for legal adoption), an Employee's legal ward, stepchildren, foster children and children of an eligible Domestic Partner.
 - (4) Unmarried children, age 26 or older, who are incapable of self-support because of a total and permanent disability that commenced prior to reaching age 26 are covered whenever the employee is covered. Evidence of the child's total and permanent disability must be provided in the form of a Social Security Disability Award and must be submitted within 6 months following an eligible child's 26th birthday.
- (b) **Enrollment Requirements:**
- (1) If a Participant is enrolled in PPO Plan: No person (other than a newborn child) who is otherwise qualified to be an eligible dependent of a Participant enrolled in the PPO Plan shall receive any coverage or benefits from the PPO Plan unless and until a Plan enrollment form has been completed and documents proving eligible dependent status are on file at the Administration Office. Claims for newborn children will be held and will not be paid until such time as an enrollment form and birth certificate are received by the Administration Office. Continued eligibility of a dependent is conditioned on confirmation, on request of the Administration Office, of eligible dependent status, in a manner satisfactory to the Board of Trustees.
 - (2) If a Participant is enrolled in a Plan HMO: No person who is an eligible dependent of a Participant covered under a Plan HMO shall receive medical and related benefits from the PPO Plan. No person

who is an eligible dependent of a Participant covered under a Plan HMO shall receive any benefits from the HMO, unless that person is enrolled in the HMO by the Participant, in accordance with procedures acceptable to the HMO, at one of the following times, unless the HMO consents or unless otherwise required by law:

- (A) Upon the Participant's initial enrollment in the HMO;
- (B) Within 31 days of the person's becoming qualified as an eligible dependent if an enrollment form and supporting documentation are submitted within 31 days of eligibility; or
- (C) The first day of the calendar month following the month the dependent's enrollment form (and supporting documentation) is received by the Administration Office.

(c) **Surviving Dependents:** Surviving dependents of a deceased eligible Employee and surviving dependents of a deceased eligible Retiree are eligible for 6 months of coverage at no charge starting the 1st of the month following the date of death of the Employee or Retiree. If a deceased eligible Employee or a deceased eligible Retiree has an Hour Bank remaining upon his or her death, then the surviving dependents may first use any hours remaining in the Hour Bank for coverage before using the 6 months of coverage at no charge. Thereafter, surviving dependents may continue to maintain eligibility for coverage as follows:

- (1) The surviving Spouse and/or surviving eligible dependent children of an eligible Retiree may continue to maintain eligibility for coverage indefinitely, by paying the monthly charge determined from time to time by the Board of Trustees.
- (2) The surviving Spouse and/or surviving eligible dependent children of an eligible active Employee may continue to maintain eligibility for coverage for the period of the Employee's active participation in the Plan, by paying the active self-payment monthly charge determined from time to time by the Board of Trustees. For purposes of this subsection (2), the period of active participation includes the entire period from the Employee's last enrollment as a new Employee, including time during which the employee was not eligible for benefits, but was eligible for reinstatement under Rule 7, Reinstatement of Eligibility. Thereafter, the surviving Spouse may continue coverage indefinitely, subject to payment of the applicable monthly charge, as determined from time to time by the Board of Trustees, if either of the following is true:
 - (A) At the time of his or her death, the Employee was eligible for retirement under the U.A. Local No. 393 Defined Benefit Pension Plan; or
 - (B) Before the end of the period of coverage under Rule 4(a), the Employee would have attained an age which would have made him or her eligible for retirement under the U.A. Local No. 393 Defined Benefit Pension Plan, based on his or her actual Credited Service accrued as of his or her death.
- (3) Notwithstanding the above, coverage under this subsection (c) shall terminate as follows:
 - (A) For the surviving Spouse: when he or she remarries;
 - (B) For eligible dependent children: when they cease to qualify as eligible dependents; and
 - (C) For any individual covered under this subsection (c): when the individual becomes covered under other group health coverage.
- (4) If the coverage for an individual terminates under this subsection (c), and any of his or her original 36-month COBRA coverage period has not elapsed (measured from the Participant's date of death), he or she may elect COBRA coverage for the remainder of the 36-month COBRA coverage period.

(d) **Coordination of Benefits and Removing Dependents:** Except as provided in subsection (c)(4) or under Appendix C, Rules for COBRA Coverage, if a dependent of an eligible Employee is covered under another group health plan, benefits are not terminated, but are subject to the Plan's Coordination of Benefits rules.

You may remove a dependent child one time from the Plan if your dependent child is enrolled in a

different group health plan, Medi-Cal (or other government health program), or an individual medical policy. You must make the request to remove the dependent child in writing and provide proof of other medical coverage. You may re-enroll the dependent child at a later date so long as the child remains an eligible dependent and you complete any enrollment forms or any other documents that may be required by the Administration Office.

You may remove a dependent Spouse or Domestic Partner one time from the Plan if your dependent Spouse/Domestic Partner is enrolled in a different group health plan or Medi-Cal. You must make the request to remove the dependent Spouse/Domestic Partner in writing and provide proof of other medical coverage. You may re-enroll the dependent Spouse/Domestic Partner at a later date so long as (1) the Spouse/Domestic Partner has creditable coverage under a group health plan or Medi-Cal and the Spouse/Domestic Partner has had no lapse in coverage since last enrolled in this Plan and (2) you complete any enrollment forms or any other documents that may be required by the Administration Office.

- (e) **Special Enrollment Provisions:** If you are declining enrollment for yourself or your dependents (including your Spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends, or employer contributions towards your other coverage have ended. In addition, if you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or foster care placement you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, placement for adoption, or foster care placement.

Eligible Dependents may be enrolled into the Plan if they lose eligibility under Medicaid or a State Sponsored Children's Health Insurance Plan and/or upon becoming eligible for a special premium assistance subsidy under Medicaid or a State Sponsored Children's Health Insurance Plan. You must file your enrollment form with the Administration Office within 60 days of your Eligible Dependent losing coverage under Medicaid or a State sponsored Children's Health Insurance Plan or within 60 days of your Eligible Dependent becoming eligible for premium assistance under Medicaid or a State Sponsored Children's Health Insurance Plan.

Rule 5: Health Reimbursement Arrangement (HRA)

The Plan maintains a Health Reimbursement Arrangement (HRA), also called the "Extended Reserve Account," consisting of an account of funds (credit) which can be used to pay a) the monthly charge associated with maintaining eligibility for coverage under the Plan or b) qualified expenses not covered by the Plan.

- (a) **HRA Credit:**
- (1) Credit to an employee's HRA will only be made if the employee is eligible under this Plan and is actually enrolled in the medical coverage provided under this Plan.
 - (2) Employees will not receive credit to their HRA while building their Hour Bank to meet the Initial Eligibility Amount. Once an Employee is eligible and enrolled in this Plan, the Employee shall receive a one-time credit to their HRA in an amount equal to the credit the Employee would have received had they been eligible and enrolled while building their Hour Bank.

(3) Interest Credit: HRAs which have a year-end balance will be credited with a bonus amount annually. The bonus amount will reflect the net rate of return of the Plan's HRA fund for the Plan Year as determined by the Board of Trustees.

(4) Discretionary Credit: The Board of Trustees may, from time to time, provide for the crediting of the HRAs of active, retired Employees and surviving Spouses with an

additional bonus on a one-time basis, subject to any limitations in the Collective Bargaining Agreement or Trust Agreement, but otherwise in an amount subject to terms within their exclusive discretion, with the minutes of such actions deemed a part of this Plan.

***Growth and Earnings Tax-Free:** Funds deposited in the HRA are tax-exempt. At the Board of Trustees' sole discretion, all HRA accounts with a balance at year end will be updated to reflect gains (or losses) on the HRA's investments.*

(b) **Paying for Eligibility/Coverage Under the Plan:**

(1) If an employee exhausts the hours in their Hour Bank, the employee can use their HRA to pay for the monthly charge required for any form of eligibility requiring self-payment. If an employee's HRA is exhausted, and the employee has any months remaining during which they are permitted to maintain eligibility for coverage under a Plan provision requiring self-payment, the employee may self-pay the remaining months.

(2) Using the HRA for self-payments, COBRA Coverage or for retiree coverage shall be at the option of the Employee or Retiree. However, if a Retiree fails to make a timely full or partial monthly payment for Retiree coverage necessary to maintain eligibility for coverage under this Plan, then the Administration Office shall automatically deduct such monthly charge from the Retiree's HRA, if available.

(3) An election to use the HRA for self-payments, COBRA Coverage, or Retiree coverage shall be made in writing, and shall apply until the period of self-payments, COBRA Coverage, or Retiree coverage ends or until the Employee cancels his or her election in writing. If an Employee elects not to use or elects to discontinue the use of his or her HRA during a period of self-payments or COBRA coverage, he or she may not elect later to use the HRA for any of the remainder of that entire period.

(4) Using the HRA balance for coverage of an Employee's surviving eligible dependent(s) shall be mandatory unless the surviving eligible dependent(s) have elected to decline coverage.

(c) **Reimbursement of Qualified Expenses:** Any active, retired, or former Employee, or surviving Spouse who is eligible for benefits under this Plan may be reimbursed from his or her HRA for any qualified expenses that are not otherwise covered under the Plan. In order to qualify for reimbursement through an employee's HRA, they must provide proof, satisfactory to the Board of Trustees, that the claim satisfies all of the following requirements:

(1) The expense must have been for medical care as defined in Internal Revenue Code § 213(d) and as detailed under Internal Revenue Service Publication 502.

(A) Menstrual Care Products: Expenses incurred for menstrual care products as defined in the Internal Revenue Code shall be treated as incurred for medical care.

(B) Medicine or Drugs: Expenses incurred for medicine or drugs with or without a prescription shall be treated as incurred for medical care.

Eligible qualified expenses include:

- *Copayments in excess of usual, customary and reasonable limits, on covered Medical, Dental or Vision services*
 - *Qualified expenses for other or denied Medical, Dental, and Vision services*
 - *Prescription drug program Copayments*
 - *Monthly Self Payments for H&W or COBRA continuation coverage*
 - *Menstrual care products*
 - *Personal Protective Equipment*
 - *Medications with or without a prescription, including OTC medications*
 - *Expenses incurred outside of the United States that otherwise meet the Plan's definition of a qualified expense*
-

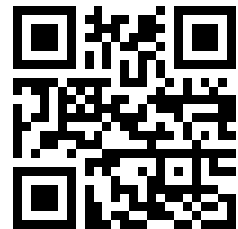
- (2) Individual Health Insurance Premiums: Pursuant to Internal Revenue Service Notice 2013-54 and U.S. Department of Labor Frequently Asked Question Guidance (Part XXII) issued on November 16, 2014, HRA contributions made on or after January 1, 2014 cannot be used to reimburse the premiums of individual health insurance policies.
- (3) The expenses must have been incurred by the active, retired or former Employee, or surviving Spouse or by the covered eligible dependent of the Employee (active Participants) or a dependent within the meaning of Internal Revenue Code §152 (retired and former Employees).
- (4) Former Employees who are no longer eligible for coverage under this Plan may be reimbursed for their and their dependent's qualified medical expenses and for premiums for other group medical insurance coverage. See section (b)(1) above for specific rules about premiums.

(d) **Reimbursement Procedures for HRA Benefits:**

- (1) Benefits will be paid only to an Employee, former Employee, Retiree, or their eligible dependents and only after they have incurred a qualified expense, and submitted a claim with supporting documents. Assignment of HRA benefits is not allowed.
- (2) Claims must be submitted **within (1) one year** from the date the services or supplies were rendered. Payment of claims will be subject to the regular claims payment procedure of the Plan. If an Employee, Retiree, or dependent is aggrieved by the action on a claim, he or she may appeal that action to the Board of Trustees, under the general appeal procedures in Appendix A.

Tip: The HRA comes with a WEX “Bennycard” for point of sale purchase of eligible expenses. It also includes an online portal and an App to assist with claims, reimbursements and more. The Bennycard allows you to access the HRA funds directly without needing to pay directly and then file a reimbursement claim.

Phone: (408) 588-3751
 Website: fundoffice.lb1ondemand.com
 App Store: BeneSys Member Reimbursement



(e) **Upon Death:**

If an Employee dies with a balance remaining in his or her HRA and other coverage is exhausted, the surviving eligible dependents may elect COBRA coverage (see Appendix C). The Employee's HRA may then be used to pay COBRA coverage. If the Employee's HRA falls below the Basic Monthly Charge prior to the ending of COBRA coverage, the surviving dependent(s) will have the right to self-pay the remainder of COBRA eligibility. If an Employee or surviving Spouse eligible for benefits under this Plan dies and there are no dependents eligible for coverage, his or her account shall be forfeited to the general assets of the Plan.

Tip on what's NOT a Qualified Expense: Common claims that require itemized receipts and proof that your doctor ordered the product/service as Medically Necessary are: massage, heating pads, face serums, shoe inserts, testosterone, natural medicines, Botox, and nutritional supplements.

(f) **Opt Out:**

An Employee is permitted to permanently opt out of and waive future reimbursement from the HRA.

(g) **Inter-plan Transfers:**

If an Employee has a HRA that is sponsored by another U.A. Local Union and that plan has executed an inter-plan transfer agreement with this Plan, then the Trustees may, upon receipt of any supporting documents required by the Trustees, order a transfer to that Plan of the Employee's entire HRA balance, regardless of amount. Once the Employee's HRA is transferred, the Employee shall have no further right to reimbursement from this Plan.

(h) **Account Forfeiture:**

If an Employee has never established initial eligibility under the U.A. Local No. 393 Health and Welfare Plan, then any available HRA will be forfeited. A Participant's HRA will be forfeited to the general reserves of the Plan if he or she becomes employed in industry service for an employer that does not contribute to a health and welfare plan benefiting workers in the pipe trades industry under the terms of a Collective Bargaining Agreement.

Rule 6: Termination of Eligibility

(a) **Eligibility:** Eligibility under this Plan will terminate at the following times:

- (1) On the day the Plan is terminated;
- (2) At the end of the month in which his or her Hour Bank has less than the Basic Monthly Charge, unless the Employee or dependent qualifies for, elects, and pays for, any form of continuation coverage provided under the Plan;
- (3) In the case of a Spouse of an eligible Employee, at the end of the month in which a court issues a decree or judgment of legal separation or final dissolution of the Employee and Spouse's marriage, or when the Employee's coverage terminates;
- (4) In the case of a dependent child, at the end of the month in which he or she attains maximum age, or when the Employee's coverage terminates, or
- (5) In the case of an Employee entering military service, upon the Employee's entering full-time military service, exclusive of temporary training periods, as per Rule 17.
- (6) A Domestic Partner and any children of the Domestic Partner cease to be eligible at the end of the month in which the Domestic Partnership is terminated.
- (7) In the case of a disabled dependent child, as per Rule 4(a).
- (8) For Retirees and their eligible dependents: when a Retiree falls 6 months behind in the payment of U.A. Local No. 393 Union Dues or when the Retiree fails to pay for any required premium for Retiree coverage.

9) If an Employee performs any employment of the type covered by a Collective Bargaining Agreement with U.A. Local No. 393 for any employer not signatory or otherwise party to a Collective Bargaining Agreement with the U.A. Local Union having jurisdiction over the respective geographical area, or engages in business for his or her own account without being party to such an agreement, the eligibility of the employee and his or her eligible dependents will be terminated as of the date of commencement of such employment.

(10) An Employee's coverage, and his or her eligible dependents' coverage, will be terminated immediately in the event he or she refuses to leave employment after being notified in writing by the Union that he or she must leave the employment of his or her employer because the employer is not contributing fringe benefit payments.

(11) An Employee's coverage, and his or her eligible dependents' coverage, will be terminated immediately in the event the employee knowingly participates with his or her employer's paying less than the full hourly contract rate of wages and contributions for every hour worked by him or her.

(12) Termination and Suspension of Eligibility on the Grounds of Fraud: Notwithstanding any other provision of this Plan, if any person who is not eligible for benefits receives benefits or coverage as a result of a misrepresentation by the person or by the Participant through whom the person claims eligibility, or accepts benefits or coverage if either the person, or the Participant through who the person claims eligibility, knows that the person is not entitled to benefits or coverage, then the Board of Trustees, in its exclusive discretion, may take any or all of the following actions against the person(s) and/or the Participant(s) and Participant's dependents involved:

- (A) Terminate eligibility for benefits
- (B) Disqualify Hour Bank accruals for a period of time determined by the Board of Trustees, even if contributions are made on behalf of the person or Participant; and
- (C) Suspend eligibility for a period of time determined by the Board of Trustees, regardless of whether or not there is an Hour Bank balance.

(b) **Coverage:** Pursuant to the Affordable Care Act ACA, the coverage will not be rescinded (as defined by the ACA) retroactively except in the circumstances permitted by law, such as failure to pay premiums, fraud or intentional misrepresentation. In such cases of fraud or intentional misrepresentation, a

Losing Coverage Because of Misconduct

You will lose coverage under the Plan immediately if:

- 1. You perform any work of the type covered by a Collective Bargaining Agreement with U.A. Local 393 for any employer not signatory or otherwise party to a Collective Bargaining Agreement with the U.A. Local Union having jurisdiction over the respective geographical area.*
- 2. You go into business for yourself doing work of the type covered by the Collective Bargaining Agreement, without being party to the applicable U.A. agreement.*
- 3. You refuse to leave employment after being notified in writing by the Union that you must leave the employment of your employer because the employer is not contributing fringe benefit payments.*
- 4. You knowingly participate with your employer's paying less than the full hourly contract rate of wages and contributions for every hour worked for him or her.*

You and your family will lose all coverage and benefits except for benefits prepaid for that month (such as HMO coverage), which terminate at the end of the month. In addition, all hours in your Hour Bank will be forfeited, and you will not be eligible for any coverage unless and until you requalify as a new Employee. You may qualify for COBRA coverage, but only if you had a qualifying event under COBRA. COBRA qualifying events do not include events where you continue to work for a delinquent employer, or for an employer who ceased to be signatory, or for an employer with whom you participated in a scheme to pay the Plan less than the full contract rate.

Participant's coverage may be rescinded retroactively upon 30 days' notice. If a Participant fails to promptly inform the Administration Office that he/she (or a dependent or Spouse) has become ineligible for coverage (e.g., following a divorce), enrolls an individual who does not meet the eligibility requirements or knowingly provides false information to obtain coverage for the Participant or an ineligible dependent, that is considered fraud or intentional misrepresentation. The Participant and any individual who obtains benefits from the Plan through misrepresentation or fraud will be jointly and severally liable for any overpayment. This reservation of powers is in addition to any rights of recovery or offset provided elsewhere in this Plan.

- (c) **Hour Bank:** An Employee's Hour Bank will be cancelled when his or her coverage is terminated for cause. If an Employee's coverage is terminated for cause, his or her HRA may be used for COBRA Coverage (see Appendix C), if he or she qualifies for, and elects, COBRA coverage. If funds are left in the HRA after COBRA coverage runs out, see Rule 5 for information about other eligible HRA expenses.

Rule 7: Reinstatement of Eligibility

- (a) An Employee whose benefits have been terminated other than under Rule 6(a)(9) through (12) related to cause or fraud may qualify for reinstatement within 12 months of the termination of his or her coverage under the Hour Bank rules. Such an Employee will be reinstated on the first day of the calendar month following any month in which the employee's Hour Bank is credited with an amount equal to the Basic Monthly Charge.

If an Employee does not reinstate his or her coverage within 12 months from the date he or she was last eligible, his or her Hour Bank will be cancelled. If this occurs, he or she will be treated like a new Employee and will be eligible only in accordance with Rule 3, Initial Eligibility.

- (b) An Employee whose benefits have been terminated for cause, will be treated like a new Employee and will be reinstated only in accordance with Rule 3, Initial Eligibility.
- (c) A disabled Employee who is covered under Rule 9 or who returns to covered employment, shall be reinstated under the Hour Bank rules the first day of the month following the month in which he or she has accrued the Basic Monthly Charge.

Rule 8: Self-Payment Provisions

- (a) An Employee whose Hour Bank has fallen below the Basic Monthly Charge because of unemployment or reduced hours may elect to continue to be eligible for coverage on a month-to-month basis for a period of up to 12 months. The Employee may elect either medical and dental coverage, or medical coverage only. This election must be made at the beginning of the period of self-payment, and shall apply to the entire period. In order to be covered, the employee must satisfy the following conditions:
- (1) The Employee must be registered on the out-of-work list at, and be available for dispatch from, the U.A. Local No. 393 Joint Hiring Hall, for employment under a Collective Bargaining Agreement calling for payments of contributions to this Plan;
 - (2) The Employee must pay the self-payment monthly charge as determined from time to time by the Board of Trustees for the coverage elected by the Employee.
 - (3) The Administration Office must receive the self-payment or authorization to use the employee's HRA by the 15th of the month for the current month's coverage (for example, self-payment for May coverage is due May 15th).
- (b) If an apprentice is dispatched by U.A. Local No. 393 to an employer who
- is not signatory to a Collective Bargaining Agreement with U.A. Local No. 393 and
 - does not pay contributions to this Plan during the period of such employment,
- then the apprentice may elect to continue to be eligible for the Plan's coverage on a month-to-month basis through self-payment by making monthly payments of an amount as determined from time to time by the Board of Trustees. During this time, the apprentice's Hour Bank will be frozen and shall not be used to pay for benefits.
- (c) Disabled members who became disabled from working in the trade while eligible for continuing enrollment are eligible for self-payment.

Self-Payment:

Self-payment is a valuable option that allows an eligible member to continue enrollment for certain benefits for up to one (1) year after his or her Hour Bank has run out. Self-payment means that cash temporarily replaces hours of work as the means for continuing enrollment (paying for coverage).

You may elect to self-pay for medical coverage only or for medical and dental coverage. The Administration Office will invoice you for the cash amount and provide a deadline for monthly payments. The self-payment amount is determined by the Board of Trustees and is lower than the cost of COBRA continuation coverage.

FAQ: *I'm classified as Group A (since I am a commercial plumber). I'm out of work, and I got a notice on June 15th saying my Hour Bank is at 48 hours. How do I stay covered for July and beyond?*

Answer:

Option 1 - Call the Administration Office to ask about the Self-Payment Provisions and if you are eligible. The notice they sent you will show the equivalent CASH cost for the additional 62 hours you need to remain covered in July. You will need to pay this by the 15th of July. Then, on a month-to-month basis, you may continue to make self-payments to extend enrollment for up to 11 more months. Monthly payments are due on the 15th of each month.

Option 2 - No Self-Payment. If you do not qualify for self-payment or don't want to make a self-payment, your enrollment will be suspended at the end of June. It may be reinstated if you go back to work within a reasonable time and a total of at least 110 hours accumulates in your Hour Bank. (See Rule 7, Reinstatement of Eligibility).

Rule 9: Disabled Employees Before Retirement Who Are Not Social Security Disabled

An Employee qualifies for coverage under this Rule 9 if the Employee:

- is part of a classification that is entitled to receive U.A. Local No. 393 Defined Benefit Pension Plan contributions for covered hours worked.
- is disabled, due to sickness or injury, such that he or she is no longer able to perform work covered by a U.A. Local No. 393 Collective Bargaining Agreement, and
- furnishes proof satisfactory to the Trustees that the disability is continuing, and
- furnishes proof that he or she is not gainfully employed at any employment, other than employment in a training program funded by the Plumbing Industry Apprenticeship Non-Profit Corporation, and
- satisfies all of the other requirements defined below.

(a) **Requirements:** If the Employee **was not covered** as an active Employee under the U.A. Local No. 393 Health and Welfare Plan during 9 of the last 10 years, including 80 of the last 120 months, immediately prior to the month of the onset of disability, the Employee will remain eligible only under the following conditions:

(1) First 12 months of Disability: The Employee remains eligible for benefits for the first 12 months of disability at no charge.

(2) Hour Bank Runout:

(A) If an Employee **has applied** for a Social Security Disability Award and has not yet received a determination, including, if applicable, a determination on appeal: After the first 12 months of coverage under this Rule 9, if the employee has an Hour Bank which totals more than the required Basic Monthly Charge, the Employee's Hour Bank **will be charged fifty percent (50%) of the required Basic Monthly Charge** for coverage, and coverage will be provided until the Hour Bank falls below Basic Monthly Charge.

(B) If an Employee **has not applied** for a Social Security Disability Award or has had his or her application for a Social Security Disability Award denied, and, if applicable, his or her appeal denied: After the first 12 months of coverage under this Rule 9, if the Employee has an Hour Bank which totals more than the required Basic Monthly Charge, the Employee's Hour Bank **will be charged the required Basic Monthly Charge for coverage**, and coverage will be provided until the Hour Bank falls below the required Basic Monthly Charge.

An Employee must notify the Administration Office as soon as he or she learns that a determination has been made on his or her application for a Social Security Disability Award and/or on the appeal of the initial determination. If his or her application is denied, he or she shall continue coverage under subsection (c)(2) and/or subsection (d) if eligible. If an Employee intentionally fails to inform the Administration Office that his or her application for Social Security Disability Award has been denied and or his appeal has been denied, then his or her benefits or coverage may be terminated or suspended on the grounds of fraud in accordance with Rule 6.

(3) Self-Payments after the Employee's Hour Bank is Exhausted:

The Employee can continue coverage by paying the current active Employee self-payment monthly charge, subject to periodic proof of continuing disability. For Employees who qualify under subsection (a), the monthly charge due is reduced to one-half of the current active Employee self-payment monthly charge. Coverage under this Rule 9 will be available only until the total period of coverage reaches 36 months.

- (b) **Retirement:**
Notwithstanding the above, eligibility for benefits under Rule 9(a)(3) shall terminate when the Employee becomes eligible to retire under the U.A. Local No. 393 Defined Benefit Pension Plan. At that time, the Employee may remain eligible for benefits only under the Rule 12, Coverage for Retired Employees and their Dependents.
- (c) **Recovery from Disability:**
If the Employee recovers from his or her disability, coverage under this Rule 9 will terminate on the first day of the month after his or her disability ends.
- (d) **COBRA:**
An Employee, dependent or former dependent whose eligibility terminates under this Rule 9 may elect COBRA Coverage, for any period of COBRA coverage he or she may have remaining, less the number of months during which he or she received similar coverage at the same, or a lower, Basic Monthly Charge.

Rule 10: Disabled Employees Before Retirement Who Are Social Security Disabled

An Employee qualifies for coverage under this Rule 10 if the Employee:

- is part of a classification that is entitled to receive U.A. Local No. 393 Defined Benefit Pension Plan contributions for covered hours worked , and
 - is totally and permanently disabled, and
 - has received a determination as such from the Social Security Administration.
- (a) **Requirement A:** If the Employee does not have 10 years of Vesting Credit under the U.A. Local No. 393 Defined Benefit Pension Plan, or was not covered as an active Employee under the U. A. Local No. 393 Health and Welfare Plan during 5 of the last 7 years, including 60 of the last 84 months, immediately prior to the month of the onset of disability, the Employee will remain eligible for benefits for the total number of months that he or she was eligible for benefits before the onset of disability, subject to the following conditions and to the payment of copayments where required:
- (1) First 12 months of Disability: The Employee remains eligible for benefits for the first 12 months of disability at no charge.
 - (2) Hour Bank Runout: After the first 12 months of coverage under this Rule, if the Employee has an Hour Bank which totals more than the Basic Monthly Charge, the Employee's Hour Bank will be charged the Basic Monthly Charge for coverage, and coverage will be provided until the Hour Bank falls below the Basic Monthly Charge.
 - (3) After Hour Bank is Exhausted: Self-payments may be made by the Employee, subject to periodic proof of continuing disability. Coverage under this Rule 10 will be available only until the total period of coverage reaches the total number of months the Employee was eligible for benefits before the onset of disability.
- (b) **Requirement B:** If the Employee has 10 years of Vesting Credit under the U. A. Local No. 393 Defined Benefit Pension Plan and was covered under the U. A. Local No. 393 Health and Welfare Plan during 5 of the last 7 years, including 60 of the last 84 months, immediately prior to the onset of disability, the Employee will remain eligible for benefits for the total number of months that he or she was eligible for benefits before the onset of disability, subject to the following conditions:
- (1) First 12 months of Disability: The Employee remains eligible for benefits for the first 12 months of disability at no charge.

- (2) Hour Bank Runout: After the first 12 months of coverage under this Rule, if the Employee has an Hour Bank which totals more than the Basic Monthly Charge, the Employee's Hour Bank will be charged the Basic Monthly Charge for coverage, and coverage will be provided until the Hour Bank falls below the Basic Monthly Charge.
- (4) After the Hour Bank is Exhausted: Subject to periodic proof of continuing disability, the Employee shall remain eligible by making timely monthly self-payments in an amount equal to **one-half** the current active employee self-payment rate.

Coverage under this Rule 10 will be available only until the total period of coverage reaches the total number of months the employee was eligible for benefits before the onset of disability.

(c) **Retirement:**

Notwithstanding the above, eligibility for benefits under this Rule 10 shall terminate when the Employee becomes eligible to retire under the U.A. Local No. 393 Defined Benefit Pension Plan. At that time, the Employee may remain eligible for benefits only under the Rule 12, Coverage for Retired Employees and their Dependents. In addition, if the Employee recovers from his or her disability, coverage under this Rule 10 will terminate on the first day of the month after his or her disability ends.

(d) **COBRA Coverage:**

An Employee, dependent or former dependent whose eligibility terminates under Rule 10 may elect COBRA Coverage, for any period of COBRA Coverage he or she may have remaining, less the number of months during which he or she received similar coverage at the same, or a lower, Basic Monthly Charge.

Rule 11: Terminally Ill Employees Before Retirement

- (a) An Employee who has a terminal illness and less than 6 months to live may remain covered for up to 36 months following the terminal illness diagnosis at no monthly charge, if the following requirements are met:
 - (1) The Employee is under the age of 55;
 - (2) The Employee provides written certification from 3 physicians attesting that the employee has a terminal illness and has less than 6 months to live;
 - (3) The Employee was covered as an active Employee under this Plan for at least 120 months and had at least 12 consecutive months of coverage as an active Employee under this Plan within 18 months preceding the terminally ill diagnosis date.
- (b) Coverage provided to eligible individuals under this Rule 11 includes months of coverage provided for disability under Rule 9 or Rule 10 and shall not exceed a total of 36 months combined.

Rule 12: Retired Employees and their Dependents

- (a) **Eligibility:** A retired Employee will be eligible for Retiree coverage if he or she satisfies the following four conditions:
 - (1) **Activity Test:**
 - (A) At the time of his or her retirement, he or she was covered as an active Employee during at least nine (9) of the last ten (10) years prior to the month of retirement, or
 - (B) the Employee first started working under the U.A. Local No. 393 Defined Benefit Pension Plan prior to May 1, 2017 and has at least twenty-five (25) years of Benefit Credit under that plan and is at least age 55; or
 - (C) the Employee first started working under the U.A. Local No. 393 Defined Benefit Pension Plan on or after May 1, 2017 and has at least twenty-five (25) years of Benefit Credit under that plan and is at least age 60.

Service for an approved general contractor who is not signatory to the Collective Bargaining Agreement with U.A. Local No. 393 but is signatory to another Collective Bargaining Agreement for another building trade, as determined at the sole discretion of the Board of Trustees, shall be **disregarded** for purposes of satisfying the activity test of Rule 12(a)(1) and his or her years covered as an active Employee shall be frozen until he or she returns to work for a contributing employer and resumes accruing years covered as an active Employee; and

A former Employee who has twenty (20) years of Benefit Credit under the U.A. Local No. 393 Defined Benefit Pension Plan and who works for a municipality in Industry Service in the jurisdiction of U.A. Local No. 393 is **not required** to satisfy the activity test of Rule 12(a)(1) in order to be eligible for Retiree coverage, provided he or she is working either for such municipality or for a contributing employer at the time of his or her retirement.

- (2) **Immediate Enrollment:** Except as provided in subsection (d)(3) below, related to deferral at retirement, he or she enrolls in Retiree coverage at the earlier of:
 - (A) commencement of his or her benefits under the U.A. Local No. 393 Defined Benefit Pension Plan; or
 - (B) commencement of installment benefits under the U.A. Local No. 393 Defined Contribution Pension Plan; and
 - (3) **Pension Pay Status:** The Retiree is:
 - (A) receiving monthly benefits from the U.A. Local No. 393 Defined Benefit Pension Plan, based either on the accrual of 10 or more years of Benefit Credit under that Plan, or on the attainment of age 65 and the tenth anniversary of his or her participation in that Plan; or
 - (B) receiving monthly installments under the U.A. Local No. 393 Defined Contribution Plan under Part 1, Article 7, Section 1(b)(iv) and Part 2, Article 6, Section 1(b)(iv), which states that an employee is entitled to a distribution from that plan when the Employee has attained age 52 with 25 or more Years of Benefit Credit under the U. A. Local No. 393 Defined Benefit Pension Plan, and permanently ceased to perform all Industry Service in the Plumbing and Pipefitting Industry (as those terms are defined in the Defined Benefit Pension Plan).
 - (4) **Union Membership:** He or she is a member in good standing with U.A. Local 393, including payment of union dues.
- (b) **Dependent Eligibility:** Dependents who were covered at the time the Participant retired will continue to be covered while the Participant is enrolled in Retiree coverage for as long as they remain eligible dependents.
- (c) **Forfeit for non-covered work:** Except as otherwise provided in Rule 12(a), if an Employee who is otherwise eligible, performs any employment of the type covered by a Collective Bargaining Agreement with U.A. Local No. 393 for any employer not signatory or otherwise party to a Collective Bargaining Agreement with the U.A. Local Union having jurisdiction over the respective geographical area, or engages in business for his or her own account without being party to such an agreement, the right to Retiree coverage for such Employee and his or her dependents shall be forfeited.
- (d) **Continued Eligibility:**
- (1) Medicare-eligible Retirees and Medicare-eligible dependents must remain enrolled in Medicare Parts A, B and D in order to be covered by the Plan.
 - (2) Continued eligibility of any Retiree is not affected by his or her being covered under another group health plan, except as provided under the PPO Plan's or HMO's Coordination of Benefits rules.

(3) A Retiree who declines Retiree coverage at retirement may not enroll in Retiree coverage at a future date. A Retiree, or eligible dependent who is covered under a group health plan may defer enrollment at the time of retirement, or suspend his or her enrollment during retirement, for as long as such coverage is in effect, under the following rules:

(A) Written Election: The Retiree or eligible dependent must make a written election to do so, and must provide information about the other group coverage, in a form and at times satisfactory to the Board of Trustees.

(i) Deferring Retiree coverage at retirement. A Retiree or eligible dependent may elect to defer all medical coverage, dental coverage or both coverages at the time of retirement.

A Retiree who is covered under his or her Spouse's group health plan and elects to defer enrollment at retirement shall have the hours in his or her Hour Bank converted to an equivalent dollar amount and deposited into his or her HRA upon the Retiree's retirement effective date. Thereafter, there shall be no hours remaining in the Retiree's Hour Bank.

(ii) Suspending Retiree coverage after retirement. A Retiree or eligible dependent may elect to suspend medical coverage, dental coverage or both coverages.

(B) Reenrollment: A Retiree or eligible dependent who deferred or suspended coverage under this rule may reenroll in this Plan only if the group health coverage was continuous and is no longer available to the Retiree or eligible dependent. For purposes of this rule, coverage will be deemed no longer available only if one of the following applies:

(i) The person who was the eligible Employee under the other group health plan (i.e., the Retiree or the Retiree's Spouse, as the case may be) is no longer eligible to be a covered Employee under a group health plan of the person's employer; or

(ii) If the Retiree or eligible dependent was an eligible dependent under the other group health plan, there is no longer an option available for dependent coverage; or

(iii) The person who was the eligible Employee under the other group health plan (i.e., the Retiree or the Retiree's Spouse, as the case may be) has retired and coverage under the other group health plan has changed because of retirement.

Coverage will not be deemed no longer available if the reason that Retiree is no longer covered under the other group health plan is the failure of the Retiree, or the Retiree's eligible dependent, to continue to pay for coverage of the Retiree or the Retiree's eligible dependent, even if the cost of that other coverage has increased significantly.

(C) A Retiree or eligible dependent may recommence coverage under this Plan any time before the 31st day following the later of:

(i) the termination of other medical coverage (without taking into account COBRA coverage), or

(ii) the date of the Retiree's notification of termination.

A Retiree's or eligible dependent's right to recommence coverage is subject to the Retiree providing satisfactory proof of continuous group coverage and verification of the date of the termination or notification.

(D) There shall be no limit on the number of times the Retiree or eligible dependent reenrolls in Retiree coverage, provided that all rules in this section are met.

(e) **Pre-Medicare Early Retiree:** A non-Medicare eligible Retiree or surviving Spouse covered under this Rule 12 may elect coverage in the PPO or HMO; however, coverage under any fully insured plan is subject to the rules of those plans.

(f) **Enrollment Options:** Participants over age 65 or otherwise eligible for Medicare, may elect the Aetna Medicare Advantage Plan or the Kaiser Permanente Senior Advantage Plan (KPSA), provided they are enrolled in both Parts A, B and D of Medicare. KPSA requires Participants to live in the Northern California Service area. Participants may change enrollment from the Aetna Medicare Advantage Plan to KPSA (or vice versa) only once in a consecutive 12-month period.

(g) **Retiree Self-payment:** Retiree coverage is subject to self-payment of a monthly charge, as determined from time to time by the Board of Trustees. The monthly charge varies depending on coverage type:

- Pre-Medicare,
- Medicare, and
- Dental Care Plan.

The first payment for Retiree coverage will be due the first month after which the Retiree's active coverage ends after his or her Hour Bank runs out. After that time, payments must be received by the 15th day of the month for the following month's coverage. Retired Employees may use their HRA to pay the monthly charge.

(h) **Monthly Charge:** The monthly charges for Retiree medical and dental coverage is reviewed annually and set from time to time by the Board of Trustees. Below are the categories of Retirees who each have their own monthly charge set by the Board, typically annually.

(1) Retirees who were eligible for Medicare prior to January 1, 1993

(2) Retirees who were not Medicare eligible on January 1, 1993, but retired prior to July 1, 2009

(3) Retirees who enroll in Retiree coverage on or after July 1, 2009

(i) The Retiree monthly charge for medical coverage for this category is subsidized in accordance with Rule 12(i) regarding the Retiree Health and Welfare Subsidy Schedule on the following page.

(4) Retirees who qualify for Rule 13, Hardship Waiver

(5) Residential Employees and MEST must pay for the full monthly charge of Retiree coverage – Rule 12(i) does not apply to these classifications.

**Retiree Health and Welfare Subsidy Schedule:
Percent of Monthly Charge (Excluding Dental) Paid by Member**

U.A. Local 393 Career Hours	52-54	55	56	57	58	59	60	61	62	63	64+
< 26,000	100%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
26,000	100%	72%	70%	68%	66%	64%	62%	60%	58%	56%	54%
28,000	100%	71%	69%	67%	65%	63%	61%	59%	57%	55%	53%
30,000	100%	70%	68%	66%	64%	62%	60%	58%	56%	54%	52%
32,000	100%	69%	67%	65%	63%	61%	59%	57%	55%	53%	51%
34,000	100%	68%	66%	64%	62%	60%	58%	56%	54%	52%	50%
36,000	100%	67%	65%	63%	61%	59%	57%	55%	53%	51%	49%
38,000	100%	66%	64%	62%	60%	58%	56%	54%	52%	50%	48%
40,000	100%	65%	63%	61%	59%	57%	55%	53%	51%	49%	47%
42,000	100%	64%	62%	60%	58%	56%	54%	52%	50%	48%	46%
44,000	100%	63%	61%	59%	57%	55%	53%	51%	49%	47%	45%
46,000	100%	62%	60%	58%	56%	54%	52%	50%	48%	46%	44%
48,000	100%	61%	59%	57%	55%	53%	51%	49%	47%	45%	43%
50,000	100%	60%	58%	56%	54%	52%	50%	48%	46%	44%	42%
52,000	100%	59%	57%	55%	53%	51%	49%	47%	45%	43%	41%
54,000	100%	58%	56%	54%	52%	50%	48%	46%	44%	42%	40%
56,000	100%	57%	55%	53%	51%	49%	47%	45%	43%	41%	39%
58,000	100%	56%	54%	52%	50%	48%	46%	44%	42%	40%	38%
60,000	100%	55%	53%	51%	49%	47%	45%	43%	41%	39%	37%
62,000	100%	54%	52%	50%	48%	46%	44%	42%	40%	38%	36%
64,000	100%	53%	51%	49%	47%	45%	43%	41%	39%	37%	35%
66,000	100%	52%	50%	48%	46%	44%	42%	40%	38%	36%	34%
68,000	100%	51%	49%	47%	45%	43%	41%	39%	37%	35%	33%
70,000	100%	50%	48%	46%	44%	42%	40%	38%	36%	34%	32%
72,000	100%	49%	47%	45%	43%	41%	39%	37%	35%	33%	31%
74,000	100%	48%	46%	44%	42%	40%	38%	36%	34%	32%	30%
75,000+	100%	25%	25%	25%	25%	25%	25%	25%	25%	25%	25%

- (i) **Retiree Health and Welfare Subsidy Schedule:**
- (1) The Retiree Health and Welfare Subsidy Schedule has been approved by the Board of Trustees and is subject to revision or correction at any time.
 - (2) Those who retire before age 55 will pay 100% of the monthly charge until turning age 55, when the Percent Paid by Member will be adjusted to the applicable 55-year-old payment percentage.
 - (3) Those who retire at age 65 or older will pay the applicable percentage based on the (64+) group.
 - (4) The Percent Paid by Member for those who retire at pre-Medicare age (prior to age 65) will remain fixed throughout retirement. The applicable percentage will be applied to the pre-Medicare monthly charge initially. Then, when the Retiree turns age 65 (Medicare eligible) their fixed applicable percentage will be applied to the Medicare monthly charge.
 - (5) Percent Paid by Member is based on your age at retirement & your Career Hours in U.A. Local 393.
 - (i) Career Hours shall be equivalent to all Benefit Credit Hours under the U.A. Local No. 393 Defined Benefit Pension Plan, including any Career Hours accrued after retirement.
 - (ii) Age at retirement as used in this Rule 12(i) is fixed at your age at initial retirement and cannot be changed, regardless of whether you return to work and resume retirement at a later date.
 - (6) To determine your cost – multiply the current monthly charge for Retiree medical coverage by your applicable Percent Paid by Member.
 - (i) The monthly charge for Retiree medical coverage is updated on a periodic (typically annual) basis by the Board of Trustees.

(7) The Percent Paid by Member is initially fixed at retirement, but may decrease if you accrue additional Career Hours after retirement. In such situations, your Percent Paid by Member may be recalculated at either of the following times:

- (i) when you resume retirement under the U.A. Local No. 393 Defined Benefit Pension Plan or
- (ii) annually, if you are accruing additional Career Hours and your pension under the U.A. Local No. 393 Defined Benefit Pension Plan had not been suspended during that calendar year.

(j) **Suspension of Eligibility for Retiree Coverage when Working After Retirement:** Eligibility shall be suspended for any Retiree who returns

- to work of the type covered under the Collective Bargaining Agreement,
- to any work for which benefits are suspendible under the U.A. Local No. 393 Defined Benefit Pension Plan, or
- to paid work for U.A. Local No. 393 or a related entity in a position for which contributions are made to this Plan.

Eligibility shall be suspended, terminated and/or restored under the following rules:

- (1) **Non-Signatory Employment:** If the Retiree works as an employer, or becomes a significant shareholder of an employer, which is not signatory to a Collective Bargaining Agreement with U.A. Local No. 393 or the U.A. Local Union having jurisdiction in the area of operations of the employer, or works for such an employer, then the Retiree's eligibility shall be terminated immediately. Thereafter, the Employee's eligibility shall not be restored at any time, unless he or she requalifies under Rule 1, Active Employee Eligibility, and eligibility shall not be restored under Rule 12(a) unless the employee requalifies on the basis of 9 new years of coverage.
- (2) **Returning to Bargained Employment:** Unless a Retiree qualifies under subsection (3) below, Retiree coverage for a Retiree who performs works as an Employee covered under, or an employer signatory to, the Collective Bargaining Agreement with U.A. Local No. 393, or performs work for which pension benefits are suspendible under the U. A. Local No. 393 Defined Benefit Pension Plan, shall be suspended immediately upon the performance of such work. Thereafter, the Retiree shall be covered only as provided under Rule 1, Active Employee Eligibility. Once his or her benefits recommence under the U.A. Local No. 393 Defined Benefit Pension Plan, then Retiree coverage for this Plan shall recommence as per this Rule 12(j)(2).
- (3) (A) If the Retiree falls into one of the following categories, then his or her Retiree coverage shall be suspended only as provided in paragraph (B) below
 - (i) The Retiree becomes employed on a paid basis for the Local Union or a related entity in a position for which contributions are made to the Plan.
 - (ii) The Retiree performs work of the type covered by the Collective Bargaining Agreement for an employer who is signatory to a U.A. Local 393 Collective Bargaining Agreement.
 - (iii) The Retiree becomes an Individual Employer, or a significant shareholder of a corporate employer, who or which is signatory to a Collective Bargaining Agreement with U.A. Local 393.
- (B) If an Employee qualifies under paragraph (A) above, his or her eligibility as a Retiree shall be suspended only as follows:
 - (i) A Retiree who qualifies under paragraphs (A)(i) and (A)(ii) shall be eligible for medical benefits as an active Employee on the first day of the month following the month in which the Employee accrues an Hour Bank equal to the Basic Monthly Charge. At that time his or her eligibility as a Retiree shall be suspended in favor of eligibility as an active Employee. Until the Employee qualifies for coverage as an active Employee under this subsection (j)(3)(B)(i), the Employee may maintain coverage by continuing to pay the applicable Retiree self-payment. An Employee who qualifies for self-payment under this rule shall

be eligible only for medical care, and may maintain eligibility for dental coverage only if he or she had previously elected, and had made the required self-payments for, Retiree dental coverage, and continues to make such self-payments.

- (ii) The eligibility of a Retiree who qualifies under paragraph (3)(A)(iii) shall be suspended on the first day of the month following the month in which he or she became an Individual Employer, but he or she shall be eligible to enroll as an Individual Employer immediately.
- (iii) The eligibility of a Retiree for Retiree coverage who qualified under paragraph (3)(A) shall recommence under this Rule 12 when his or her pension benefits recommence under the U. A. Local No. 393 Defined Benefit Pension Plan.

- (k) **Not a Vested Benefit:** Retiree welfare benefits are paid out of current revenues, and the ability of the Plan to continue such coverage is reviewed by the Board of Trustees. The Board of Trustees reserves the power to modify, change or terminate Retiree coverage, including the power to modify the required monthly charge paid by Retirees. In no event shall Retiree coverage, or any particular element of Retiree coverage, be considered vested.

Rule 13: Hardship Waiver

The Hardship Waiver has been established to assist eligible Retirees and surviving Spouses with paying their required monthly charge. A Retiree who qualifies for the Hardship Waiver shall have the entire monthly charge for Retiree coverage waived. Surviving Spouses who continue to qualify for the Hardship Waiver shall have the entire amount of the monthly charge for surviving Spouses waived.

Under the Hardship Waiver, a Retiree or surviving Spouse's required monthly charge will be waived if their "total income" is at or below 300% of the Federal Poverty Level. This amount may be changed from time to time by the Board of Trustees. For purposes of this rule, "total income" includes all of the following items, counting each item of both the Employee and the Employee's Spouse:

- (a) Monthly pension benefits, including from the U.A. Local No. 393 Defined Benefit Pension Plan,
- (b) Equivalent monthly pension benefits from the Defined Contribution Plan,
- (c) Social Security benefits,
- (d) Wages,
- (e) Investment income, including interest, rents and dividends, and
- (f) Capital gains and other similar "one-time" forms of income.

Help for Retirees and surviving Spouses with lower income: *All of the monthly charge for Retiree healthcare will be waived if you qualify for the Plan's Hardship Waiver. To qualify for this benefit, your total income must be at or below 300% of the Federal Poverty Level, along with meeting other requirements. Please refer to the following website for the current Federal Poverty Level: www.healthcare.gov/glossary/federal-poverty-level-fpl/*

Please contact the Administration Office if you believe you qualify.

In order to determine the equivalent monthly pension benefit from (b) and (f) above, the applicant's U.A. Local No. 393 Defined Contribution Plan account balance or the capital gain balance will be converted into an equivalent monthly annuity by multiplying the account balance at retirement by 0.008 (i.e., for each \$1,000 in your account, \$8 is counted as a monthly annuity equivalent).

The Trustees will rely on the applicant to self-report their "total income" and the applicant must complete a statement of income when he or she applies for the Hardship Waiver, and any time that his or her income increases. In addition, the applicant must submit a filed, signed copy of the first page of his or her Federal Income Tax Form 1040 no later than April 30 of each year for the previous year's income.

Rule 14: Eligibility Rules for Individual Employers

- (a) The following persons will, upon compliance with these rules, be eligible for medical and dental benefits under the Plan.
- (1) Individual Employers - Self-employed persons, sole proprietors and bona fide members of partnerships and other unincorporated associations, and officers, directors and shareholders of corporations, who or which are engaged in business in the Plumbing and Pipefitting Industry and are signatory, or otherwise party, to a collective bargaining contract with U.A. Local Union No. 393. The term "Individual Employers" means only those persons who are described in this subsection (1), unless the context otherwise expressly requires, and who are actively engaged in the business, provided all such persons in the business are covered. Notwithstanding any other provision of this rule, an officer shareholder who meets the requirements of the Rule 1(b) above, shall qualify for coverage as an active Employee, and not under these rules as an Individual Employer.
 - (2) Office Employees - Office Employees of a covered Individual Employer who are working at least 20 hours each week and who are not covered by another Taft-Hartley health and welfare plan. Office Employees are only eligible if all such Employees working for the Individual Employer are covered.
 - (3) Dependents of any of the persons described in subsections (1) and (2) above.
- (b) Individual Employers, already party to a Collective Bargaining Agreement with U.A. Local Union No. 393 as of the date hereof, may establish initial eligibility, or if already eligible, continue such eligibility, by making application in writing to the Administration Office on or before the 20th day of the calendar month next following the date hereof, or if not already party to a Collective Bargaining Agreement with U.A. Local Union No. 393, on or before the 20th day of the calendar month following the month in which becoming a party.
- Notwithstanding the foregoing, an Individual Employer who is receiving coverage under this Plan through his or her Hour Bank because of work he or she performed under a Collective Bargaining Agreement as of the date he or she first becomes an Individual Employer shall continue to receive coverage under this Plan through his or her Hour Bank until it is exhausted. Once his or her Hour Bank is exhausted, he or she may receive coverage as an Individual Employer by making application in writing to the Administration Office in accordance with this Rule 14.
- (c) Such application must include the names of all persons eligible for coverage under (a) and (b) above. Each such person will become eligible for benefits as of the first day of the second month following the month the hours are worked, provided payment of the monthly charge, as fixed from time to time by the Board of Trustees, is made for each such person on or before the 20th day of each month. Each such person's coverage will continue provided payment of the required charges is made on or before the 20th day of each successive month thereafter.
 - (d) The Individual Employer must notify the Administration Office of the addition to coverage of each newly hired employee or other person within 30 days of the person becoming eligible.
 - (e) All Individual Employers, office employees and their eligible dependents who enroll in this plan shall be eligible for PPO or HMO coverage.
 - (f) Individual Employers, office employees or their eligible dependents, if eligible at the time of termination of employment, will continue to be eligible subject to COBRA Coverage, except as follows:
 - (1) An Employer shall be deemed to have a termination of employment only if he or she has completely terminated his or her connection to the participating company, or that company has ceased operations.

- (2) No person shall be deemed to have had a qualifying event if the reason that the person's coverage is terminated is because the Individual Employer has failed to make a required payment for coverage or has ceased to qualify to participate in this Plan.
- (g) An Individual Employer in default of any of the provisions of these eligibility rules will be terminated as of the first day of the calendar month for which no payment was made and the eligibility of all persons covered under Rule 14(a) will terminate and may not again be renewed except upon re-application as provided in Rule 14(b) together with proof of insurability satisfactory to the Trustees. Such application may be filed only between the 15th day of January and the 15th day of February of any given year.
- (h) The terms "dependents" and "benefits" as used herein will have the same meaning as in the Eligibility Rules for Employees.
- (i) Individual Employers, their dependents or office employees, are not eligible for the Weekly Short Term Disability Benefit, the Weekly Paid Family Leave Benefit, or the Supplemental Long Term Disability Benefit.
- (j) An Individual Employer may terminate coverage for himself or herself, and for all other persons covered under this section, through the Individual Employer, by providing written notice to the Administration Office at least 30 days in advance of the last day of the last month in which coverage is to be provided under the Plan, but the Individual Employer will remain liable for any unpaid contributions. If notice is received in a timely fashion, coverage will then terminate in accordance with the Individual Employer's request. If notice is received less than 30 days before the last day of the requested termination month, the notice shall be treated as if it was a timely request for termination for the month following the requested termination month. After coverage is terminated, the Individual Employer shall receive a refund of any advance monthly charges paid pursuant to section (c) of this Rule (not including any reserve account of contributions made pursuant to a Collective Bargaining Agreement), less any outstanding premiums, delinquent employer contributions, and other obligations to the Plan.
- (k) Any Individual Employer, as defined in section (a)(1) of this Rule, may elect upon retirement to continue coverage after retirement for himself or herself and his or her dependents if the Individual Employer (and dependent(s), if any) satisfy the following conditions:
- (1) The Individual Employer had been continuously eligible for benefits under the Plan for at least 120 months immediately prior to retirement;
 - (2) The Individual Employer was at least 60 years of age at the time of retirement, or was eligible for an unreduced early retirement from the U.A. Local No. 393 Defined Benefit Pension Plan;
 - (3) The Individual Employer continues to make timely payment of such monthly charge as the Board of Trustees determines applies to that person's coverage. Individual Employers who are eligible for an unreduced early retirement from the U.A. Local No. 393 Defined Benefit Pension Plan shall pay a monthly charge equivalent to the Retiree Self-Pay Amounts as calculated under the "Local 393 – Retiree Health and Welfare Subsidy Schedule" of Plan Rule 12; and
 - (4) If the Individual Employer or dependent is eligible for Medicare, eligibility is maintained under Parts A, B, and D of Medicare.
 - (5) Individual Employers and their eligible dependents are eligible for retirement coverage through either the PPO Plan, Kaiser, or if eligible for Medicare, the Kaiser Senior Advantage Plan or the Aetna Medicare Advantage Plan.

Notwithstanding the above, coverage will terminate immediately upon the occurrence, with respect to the Individual Employer, of any of the events listed in any rule providing for termination of coverage of a Retired Employee, other than the failure of a Retired Individual Employer to maintain membership in Local 393.

Rule 15: Coverage During a Leave Under the Family and Medical Leave Act (FMLA)

If the Employee works for an employer that is required to provide health and welfare plan coverage during a Qualified leave under the Family and Medical Leave Act (FMLA) and the Employee is eligible for, and takes the leave, then the following rules apply:

- (a) The employer must make contributions to this Plan on the Employee's behalf for every period of FMLA leave. The FMLA leave contribution amount for each month of FMLA leave will be equal to the monthly contribution requirement to maintain the Employee's coverage. For example, for Journeyman:

Basic Monthly Charge to Hour Bank X Journeyman Contribution Rate.

If the period of FMLA leave is less than a month, the amount of contribution will be pro-rated accordingly.

- (b) The Employee's employer must report the number of hours of FMLA leave and make the required contributions with its regular monthly reports. The employer must also certify in a form satisfactory to the Trustees that the leave is one for which contributions to this Plan are required by the FMLA.
- (c) The Employee's Hour Bank will not be charged for any period of coverage for which payment is made under these rules. All other Plan rules concerning Hour Bank remain in effect during FMLA leave.
- (d) Crediting of hours for the employee, and the employer's obligation to contribute ends upon termination of FMLA leave. The employer must inform the Administration Office in writing when the Employee's FMLA leave terminates.
- (e) If the Employee does not return to work for the employer at the termination of FMLA leave, the Employee is eligible for COBRA coverage as provided in Appendix C, with the termination of FMLA leave deemed the qualifying event as a termination of employment.

Rule 16: Qualified Medical Child Support Orders

The Plan will comply with any Medical Child Support Order (MCSO) with which it is properly served and which is a Qualified Medical Child Support Order (QMCSO) under applicable federal law. Upon service with an MCSO, the Administration Office will review the MCSO under procedures adopted by the Board of Trustees, and determine within a reasonable time whether the MCSO is a QMCSO. The determination that an MCSO is not a QMCSO is subject to the Appeals Procedures provided in this Plan.

Rule 17: Employees Called to Active Military Service

- (a) **Voluntary Service:** If an Employee is absent from covered employment due to qualifying military service under 38 U.S.C. § 4301 et. seq., and notifies his or her employer, the Administration Office, or the Union of his or her entry into military service, and his or her entry into military service was voluntary, then the Employee may elect any of the following options:
 - (1) To have his or her Hour Bank frozen as of the first day of the month following the commencement of active service, and to have all eligibility and coverage for the Employee and any dependents terminate on the first day of that month; or
 - (2) To have his or her Hour Bank frozen as of the first day of the month following the commencement of active service, and have his or her dependents offered COBRA Coverage (except for the 11-month extension on account of disability); or
 - (3) To continue the eligibility and coverage of the Employee's dependents, at the Basic Monthly Charge against the employee's Hour Bank, until that Hour Bank is exhausted, followed by COBRA Coverage.

- (b) **Default Election:** If an Employee who is eligible under subsection (a) fails to provide proper notice of his or her commencement of qualifying military service, or fails to make an election when offered, the employee shall be deemed to have elected the option of Rule 17(a)(3) above.
- (c) **Active Duty:** If an Employee is absent from covered employment due to qualifying military service under 38 U.S.C. § 4301 et. seq., and notifies his or her employer, the Administration Office, or the Union of his or her entry into such military service, and his or her entry into military service was as a result of a call to active duty, then the Employee's Hour Bank shall be frozen. The period during which the Employee's Hour Bank is frozen will end at the earlier of: 1) the end of the Employee's military service; or 2) 24 months, unless the Employee's period of service is extended by presidential order. While an Employee's coverage is frozen under this subsection (c), coverage shall be provided to his or her dependents at **no monthly charge**. If the Employee's period of service is extended beyond 24 months for any other reason, the options under subsection (a) shall apply.
- (d) **Hour Bank:** Coverage under the Employee's Hour Bank (if any remaining after discharge from active military duty) will recommence if and when the Employee returns to work for a contributing employer or becomes available for work for a contributing employer as shown by application for employment at the Local Union, provided the Employee returns to work or makes such application within 90 days of discharge.

Rule 18: Employees Serving as Public Safety Officers

An Employee may request in writing that his or her Hour Bank be frozen for up to one (1) year during the period he or she is serving as a Public Safety Officer. The Employee and his or her dependents will not be eligible to participate in the Plan while the Hour Bank is frozen.

Coverage under the Employee's Hour Bank will recommence if the Employee returns to work for a contributing employer within one (1) year or becomes available for work for a contributing employer within one year as shown by his or her registering for work on the U.A. Local 393 Building Trades Joint Hiring Hall out-of-work list. The Employee must provide adequate proof to the Administration Office of his service as a Public Safety Officer before coverage will recommence.

BENEFIT RULES

Election of Medical Benefits Provider

Plan Choice: Each covered Employee may elect between the self-funded plan (commonly known as the Preferred Provider Organization Plan or “the PPO Plan”) and health maintenance organization(s) (“HMO(s)”) selected by the Board of Trustees. Such elections may be made when first eligible for benefits, or during open enrollment periods established by the Board of Trustees. At the time of printing this document, the PPO Plan uses the Anthem network of providers, while the HMO is through Kaiser.

Default Election: Effective with September 2024 eligibility, if an eligible employee fails to elect coverage once eligible to do so, he or she shall be deemed to have elected coverage under the PPO Plan. However, no benefits are payable under the PPO Plan for an otherwise eligible Employee until that Employee is properly enrolled. Employees have 90 days from the date they are first eligible for benefits (the date they accumulate enough work hours to meet the Initial Eligibility Amount) to submit an enrollment form and supporting documentation. An Employee’s election of a medical benefits provider also applies to all of his or her eligible dependents.

PPO: PPO Plan Participants receive prescription drug coverage through the Plan’s designated pharmacy benefit manager, under the program approved by the Board of Trustees. At the time of printing this document, Navitus is the PPO Plan’s designated pharmacy benefit manager.

HMO: Kaiser HMO Participants receive medical and prescription drug coverage through Kaiser. The Plan HMO’s benefits and coverage rules are contained in the applicable Evidence of Coverage Document. To the extent there is a conflict between the Formal Plan Rules and the Evidence of Coverage Document, the Evidence of Coverage Document shall govern.

Healthcare Benefits: The following additional benefits are provided by the Plan in conjunction with the elected medical benefits: benefits for dental care, vision benefits, the death benefit, disability benefits, the employee assistance plan (EAP) benefits through Health Advocate Solutions, substance use disorder treatment through Beat It!, and smoking cessation benefits.

Limited Benefits for Former Participants: The Plan will provide up to 30 days of drug and alcohol use disorder treatment through Beat It! and EAP benefits through Health Advocate Solutions to former Participants and their eligible dependents who lost active health coverage under the Plan in the last 6 months. Such coverage is limited to once per lifetime. Please see “Alcohol and Substance Abuse Care” under “Conditions and Limitations for Particular Benefits” for further details.

Please review the relevant sections of this document for more details. Combined, these benefits are referred to as “Healthcare Benefits” under the Plan.

Other Benefits and Coverage

The eligibility rules for Supplemental Long Term Disability Benefits, Retiree Coverage, the SUB Plan and the DCA FSA vary. Eligibility for the PPO or HMO does not automatically mean that you are eligible for these benefits. Please review the relevant sections of this document for more details.

Medical Benefits – PPO Plan

General Rules for Payment of Benefits

If there is a conflict between the Plan and the No Surprises Act or the Patient Protection and Affordable Care Act, then the No Surprises Act and the Patient Protection and Affordable Care Act shall govern.

Priority of Rules: The following schedules of benefits and other rules determine the benefits payable on behalf of eligible Participants and their eligible dependents who are covered under the PPO Plan. Except as expressly provided under a specific provision of this Plan, these rules do not apply to Participants and dependents who have elected coverage through a Plan HMO.

In applying the Plan's schedule of benefits, the following priorities apply:

1. No benefits are paid for the following items:
 - (a) Any expenses which are excluded from the Plan;
 - (b) Any otherwise covered services or supplies if the claim for those services and supplies is submitted more than (1) one year from the date the services or supplies were rendered.

Payments by a Covered Individual for items listed above are not counted toward the Out-Of-Pocket Expense Limitation (“Out-of-Pocket Max”).

2. No benefits are paid on behalf of a Covered Individual in a calendar year until the individual or his or her family has satisfied the applicable Annual Deductible requirement.
3. If there is a specific limitation or special benefit rule for a particular service or supply, then that limitation or rule supersedes any more general schedule which would provide for a different benefit payment.
4. Except where a rule specifically states that it covers care outside of the geographical area of the Plan, the scheduled percentages stated in the rules below apply only to services and supplies rendered within the geographical area of the Plan.
5. Subject to the above, the Plan pays benefits at the stated percentage of the billed charge for a covered service or supply according to the applicable schedule, up to the maximum amount payable under that schedule.
6. Notwithstanding the above, to the extent allowed by U.S. Dept. of Labor Regulation 29 C.F.R. § 2560(b), the Trustees reserve the right to refuse to verify, to a Non-PPO Provider, the availability of benefits under the Plan, without the express written consent of the Participant who is, or whose eligible dependents are, receiving services or supplies for which benefits may be payable under the Plan.
7. The Plan provides "stop-loss" protection for Participants and dependents who have substantial covered expenses in a calendar year, under the Out-Of-Pocket Max. If an individual has satisfied the Out-of-Pocket Max in a calendar year, and if he or she receives a service or supply which is covered under the Out-of-Pocket Max and not subject to a special schedule or limitation, then the schedule of benefits under the Out-Of-Pocket Max rule supersedes any general schedule which would provide for the payment of a lesser benefit payment.

Claims Filing Deadline: *Make sure you submit your claims for reimbursement before the claims filing deadline. You have 12 months from the date of service to submit your claim reimbursement form to the Administration Office.*

Annual Limits: There is no annual limit for Essential Benefits.

Essential Benefits: Coverage for ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. This Plan uses the Utah Benchmark for determining what constitutes an essential benefit.

Annual Deductible: The amount of expenses which a Covered Individual or family must pay each year toward covered charges before benefits are payable under the Plan for that individual or family. The Annual Deductible is \$300 per individual, with a maximum of \$600 per family. After \$600 is paid in the same family unit, all Covered Persons in that family unit will be deemed to have satisfied their respective deductible requirement for covered charges incurred during the rest of the calendar year.

All covered charges are subject to the deductible requirement except:

1. The first \$600 of covered charges for medical care which are due to injuries sustained in an accident and which are incurred within 90 days of the accident, and
2. If two or more Covered Individuals in the same family unit are injured in the same accident, only one deductible of \$300 will be required with respect to covered charges resulting from the accident in excess of the first \$600 incurred within 90 days of the accident due to that accident for that calendar year.

In the event an Employee with an Hour Bank is married to another Employee with an Hour Bank, the combined Annual Deductible for both employees shall be \$300. The maximum family deductible of \$600 shall apply.

Standard Payment Rates and Usual, Customary and Reasonable Charges:

1. The benefits payable for covered charges incurred at a Preferred Provider are not defined in terms of the Usual, Customary and Reasonable rate (“UCR”), but are based solely on the contracted rate in the contract between the Plan and the Preferred Provider. Subject to exclusions, conditions, and limitations for particular types of care, the following general rates apply:
 - (a) For services and supplies provided by Preferred Providers, the Plan pays 90% of the provider’s contracted rate.
 - (b) For services and supplies provided by Non-PPO Providers for which there is a negotiated PPO contract rate, the Plan pays 60% of the UCR rate.
2. Anthem maintains a provider directory. Anthem updates its provider directory every ninety (90) days and will respond to inquiries about the network status of a provider or facility within one business day. If an eligible Participant or eligible dependent receives inaccurate information from Anthem or the Administration Office about a provider or facility’s network status, the individual will be liable only for in-network Coinsurance for the services underlying the inquiry. It is the eligible Participant or eligible dependent’s responsibility to confirm that the provider or facility selected is in-network at the time the individual receives services.
3. Charges above amount on which benefits are determined for a particular service or supply (that is, the PPO contracted rate or UCR rate, as applicable), are not considered allowable charges under the Plan for any purpose.
4. For any specific benefit rule which is defined by UCR other than an applicable contracted Preferred Provider rate, the UCR charge for any service or supply is the amount which the Trustees determine, in their exclusive discretion, after investigation by the Administration Office, Plan Consultant, or other expert engaged for this purpose, to be the fee which is reasonable and is usually and customarily charged for that service or supply by qualified providers in the area of service, except that in no event shall the UCR charge for a service or supply provided to a Medicare-eligible Participant or dependent exceed the Medicare-limiting charge for that service or supply. Unless the Trustees have investigated the UCR charge for a particular service or supply, UCR shall be 90% of the standard rates specified in the reference document then in effect at the Administration Office.

Out-of-Pocket Expense Limitation (Out-of-Pocket Max): Treatment of covered medical conditions is covered at the amounts stated in the applicable benefit schedule, except that when out-of-pocket expenses paid within the same calendar year exceed \$1,800 per person, excluding amounts paid for:

The Out-of-Pocket Max does not apply to:

1. Charges in excess of the applicable contracted Preferred Provider or UCR Rates;
2. If you request a brand-name drug when a generic is available, you will pay the normal 10% payment (with a minimum of \$10), plus the difference in cost between the brand-name and the generic drug. The excess charge and the \$10 copayment are not counted toward your Out-of-Pocket Max;

3. Benefits provided through other organizations, such as organ transplants provided through a separate insurance contract; and
4. All charges paid to Non-PPO Providers (excluding services covered by the No Surprises Act, which include:
 - (a) Emergency Services for Emergency Medical Conditions provided by a Non-PPO Provider or Non-PPO facility (unless the eligible Participant or eligible dependent received proper notice and consented to the out-of-network billing rates for certain post-stabilization services as allowed under the No Surprises Act);
 - (b) non-Emergency Services by a Non-PPO Provider at a PPO facility (unless the eligible Participant or eligible dependent received proper notice and consented to the out-of-network billing rates as allowed under the No Surprises Act); and
 - (c) Non-PPO air ambulance services); and
5. Payments in excess of the \$350 per day maximum benefit payable for out-of-network ambulatory surgery centers (excluding out-of-network providers at in-network facilities which shall be counted toward the Out-of-Pocket Max in accordance with the No Surprises Act unless the eligible Participant or eligible dependent has received notice and consented to an out-of-network billing rate as allowed under the No Surprises Act).

***Please Note:** If you go to Out-of-Network providers, you **are not protected** by the Out-of-Pocket-Maximum.*

The portion of the expenses not paid by the Plan is the responsibility of the Participant. This rule means that you will be responsible for out-of-pocket expenses for the listed items even if the Plan is paying 100% of the applicable contract rate for other covered care for the remainder of that year.

Notwithstanding anything in the Plan to the contrary, the Out-of-Pocket Max shall never exceed the limitations provided for under section 1302(c)(1) of the Affordable Care Act.

PPO Plan Covered Medical Charges

The following charges will be covered by the Plan at the amounts stated in the applicable benefit schedule:

1. Charges made by a surgeon, physician assistant, psychiatrist, psychologist, professional anesthetist, physiotherapist, radiologist, qualified speech therapist, chiropractor, laboratory or any person who is licensed to practice under the State Business and Professions Code or similar law, who performs the services which are payable under this Plan and services which are recognized by such Code or law to be within the scope of his or her license.
2. Charges made for services rendered by a registered professional nurse (R.N.) or a licensed practical nurse (L.P.N.), or a registered nurse practitioner if the nurse practitioner meets all of the necessary requirements.
3. Charges made by a professional ambulance service, railroad or commercial airline for Medically Necessary transportation for a Covered Person from a place where the need for hospitalization arises for covered treatment of an illness or injury to the nearest hospital equipped to treat such illness or injury.
4. Charges made by any other person or institution for the following:
 - (a) Drugs or medicines which are administered by a physician, or which are ordered in writing, and provided through the Plan's pharmacy benefit manager;
 - (b) Blood or blood plasma which has not been replaced on the Covered Individual's behalf;
 - (c) Medical supplies, including, but not limited to:
 - (1) Bandages and surgical dressings and other surgical supplies.
 - (2) Braces (except dental), casts, splints and trusses; drugs and medicines while confined in a hospital.
 - (3) Artificial limbs or eyes. This includes services of an orthotist and prosthetist in connection with evaluation or the fitting of an orthotic or prosthetic device when those services are billed as part of the charge of the artificial limbs or eyes, provided that benefits will cover artificial limbs or eyes only when such devices are:
 - (A) Affixed to the body externally;
 - (B) Required to replace all or any part of any limb or eye; and
 - (C) Required to support or correct a defect of form or function of a permanently inoperative or malfunctioning limb or eye; and further provided that benefits do not extend to the repair or replacement of a prosthetic device occasioned by misuse or loss of the device.
 - (4) Rental or purchase of dialysis equipment, dialysis supplies and rental or purchase of other medical equipment and supplies which are:
 - (A) Ordered by a physician, and
 - (B) Of no further use when medical need ends, and
 - (C) Usable only by the patient, and
 - (D) Not primarily for the Participant's comfort and his or her hygiene, and
 - (E) Not for environmental control, and
 - (F) Not for exercise, and
 - (G) Manufactured specifically for medical use, and
 - (H) Approved as effective and usual and customary treatment of a condition as determined by the Plan, and
 - (I) Not for prevention purposes.Notwithstanding the above, rental charges that exceed the reasonable purchase price of medical equipment are not covered.

For medical equipment or supplies obtained from a Non-PPO Provider at a rate that is less than the negotiated PPO contract rate, the Plan shall pay 90% of the billed charges

for the medical equipment or supplies if the charges are approved in advance by the Administration Office.

5. Charges made by any free-standing surgical facility for medical care, which would have been covered hospital charges if they had been performed as inpatient services in a hospital.
6. Charges for covered care for a newborn infant, but only if the Participant-parent satisfies the enrollment requirements of the Plan.
7. Charges incurred when cosmetic surgery is performed by a licensed physician when the treatment is for injuries sustained in an accident, or when the treatment is for a congenital anomaly of an Eligible Dependent Child.
8. Charges for Services and Supplies Provided Outside United States and Canada, under the following rules:
 - (a) Charges incurred for care provided to eligible Participants and eligible dependents while outside the United States and Canada are paid in accordance with the Plan's benefit rules for services and supplies rendered outside the geographical area of the Plan if the charges were incurred during the first 60 days of such period.
 - (b) After the first 60 days, the benefit rules for services and supplies rendered outside the geographical area of the Plan continue to apply without special limitations to an eligible Participant and to his or her eligible dependents residing with the employee, if a participating employer has requested approval of coverage for a period greater than 60 days connected to covered employment performed outside the United States and Canada. Approval may be given by the Board of Trustees, if in their sole discretion, they have determined that such coverage will pose no undue risk to the Plan.
 - (c) If an eligible Participant or eligible dependent is outside the United States and Canada for more than 60 days, and does not qualify under subsection (b), then benefits are paid in accordance with the Plan's benefit rules for services and supplies rendered outside the geographical area of the Plan, subject to following special limitations:
 - (1) In no event shall the benefits be paid in excess of the contracted rate for similar services or supplies for Preferred Providers in the geographical area of the Plan; and
 - (2) All charges in excess of Plan benefits are the responsibility of the patient, but an eligible Participant or eligible dependent will receive credit towards the Out-of-Pocket Max only for the amounts for which the employee or dependent would have been credited had the services or supplies been rendered in the United States.
 - (d) Direct payments to providers are not authorized for services and supplies rendered outside the United States.
9. Charges incurred for dental care for the following items only:
 - (a) Surgery due to disease, other than a periodontal disease, or injury of the jaw or facial bones; removal of cysts, leukoplakia or malignant tissue; correction of harelip, cleft palate or protruding mandible; or freeing of muscle attachments; or
 - (b) Medical treatment of natural teeth injured in an accident if the treatment is begun within 90 days after the accident and the charges are incurred within one year after the accident.
10. Charges for midwifery services when the services are performed by a nurse-midwife who holds a Certificate of Nurse-Midwife issued by the State of California Board of Registered Nursing.
11. Charges incurred for eligible Participants and eligible dependents for abortions.
12. Charges incurred for eligible Participants and eligible dependents as a result of childbirth and pregnancy and related conditions. There is no fixed limit on the number of days of hospitalization for which hospital

benefits are payable following childbirth. Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

13. Charges for the following items if incurred in connection with a Medically Necessary mastectomy, if the Covered Individual so elects in consultation with her attending physician:
 - (a) Reconstruction of the breast on which the mastectomy has been performed;
 - (b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - (c) Prostheses and physical complications at any stage of mastectomy, including lymphedemas.
14. Charges for contraceptive medications and devices which are administered in a medical office.
15. Charges for services or supplies provided by a licensed hospital, as follows:
 - (a) Charges by a hospital during each day of a period of confinement for room and board only up to the daily room and board rate regularly charged for a semi-private room, except if intensive care is required, in which case the actual expenses incurred in such accommodations will be considered a covered charge.
 - (b) Charges for outpatient treatment.
 - (c) Charges for pre-admission x-ray or laboratory examination.
 - (d) Charges for medications provided by a hospital during confinement.
16. Charges for intrauterine insemination ("IUI").
17. Charges for home infusion therapy. Home infusion therapy is the administration of drugs in the home using intravenous (into the bloodstream), subcutaneous (under the skin), or epidural (into the membranes surrounding the spinal cord) routes. Home infusion therapy includes intravenous delivery of parenteral nutrition when nutritional needs cannot be met by oral or enteral routes, as determined Medically Necessary by a licensed provider.

Conditions and Limitations for Particular Benefits Under the PPO Plan

Air Ambulances and Ground Ambulances

Air Ambulances: Where an eligible Participant or eligible dependent receives medical transport by a rotary-wing or fixed wing ambulance, the Plan pays in accordance with the No Surprises Act. The Plan pays benefits at the following rates, for covered charges in excess of any then applicable deductible:

1. PPO Provider: 90% of the applicable contracted rate, counting the eligible Participant's or eligible dependent's cost-sharing amount toward the Out-of-Pocket Max.
2. Non-PPO Provider: If an eligible Participant or eligible dependent receives medical transport by a rotary-wing or fixed wing ambulance from a Non-PPO Provider, the eligible Participant or eligible dependent will have the same Coinsurance percentage as for a PPO Provider (10% after the applicable deductible) and the Coinsurance percentage will be applied to the lesser of billed charges or the Qualifying Payment Amount, counting the eligible Participant's or eligible dependent's cost-sharing amount toward the Out-of-Pocket Max.

Providers of Air Ambulance services are generally prohibited from Balance Billing eligible Participants or eligible dependents. For purposes of this Air Ambulance benefit, a Qualifying Payment Amount means the Plan's median contracted rate for the item or service in the same geographic region, as adjusted under U.S. Department of Labor Regulation 2590.716-6(c).

Ground Ambulances: The Plan will pay all ground ambulance claims at 90% of UCR.

Alcohol and Substance Use Disorder

Detoxification: The Plan's PPO Providers are Anthem and the organization called Beat It!. After the Annual Deductible is paid, detoxification is covered at 90% of the contracted Preferred Provider Rate for PPO Providers or 60% of UCR rate for Non-PPO Providers. Detoxification benefits are required to be pre-approved by the Plan's PPO Provider.

Residential Treatment and Outpatient Care: The Plan's PPO Providers are Anthem and the organization called Beat It!. After the Annual Deductible is paid, benefits are payable for residential treatment and outpatient care of alcohol and/or substance use disorder at the following rates:

1. First Course of Treatment: 100% when provided by PPO Providers or 60% of the UCR rate when provided by Non-PPO Providers.
2. Additional Courses of Treatment: 90% when provided by PPO Providers or 60% of the UCR rate when provided by Non-PPO Providers.

Acute Detoxification: After the Annual Deductible is paid, acute detoxification is covered at 90% of the contracted Preferred Provider Rate for Anthem PPO Providers or 60% of UCR rate for Non-PPO Providers. Acute Detoxification benefits are required to be pre-approved by Anthem.

Sub-Acute Detoxification, Residential Treatment and Outpatient Care: The Plan's Preferred PPO Providers are Anthem and Beat It!. After the Annual Deductible is paid, benefits are payable for residential treatment and outpatient care for alcohol and/or substance use disorder at the following rates:

1. First Course of Treatment: 100% when provided by PPO Providers or 60% of the UCR rate when provided by Non-PPO Providers.
2. Additional Courses of Treatment: 90% when provided by PPO Providers or 60% of the UCR rate when provided by Non-PPO Providers.

Payments made to Non-PPO Providers are not counted toward the Plan's Out-of-Pocket Max.

Former Participants and their eligible dependents who lost active health coverage under the Plan within the last 6 months are eligible for such coverage for up to 30 days. Such coverage is limited to once per lifetime.

Ambulatory Surgery Centers

The Plan pays benefits at the following rates, for covered charges in excess of any then applicable deductible:

1. PPO Provider: 90% of the applicable contracted rate; and
2. Non-PPO Provider: 60% of the UCR charges up to a maximum of \$350 per day. Such maximum shall apply to all fees incurred, including but not limited to the costs of the facility and the surgeon, except for out-of-network providers at an in-network facility.

Applied Behavioral Analysis (“ABA”) Therapy

After the deductible, the Plan pays 90% of the applicable contracted Preferred Provider Rate (or 60% of the UCR charges for Non-PPO Providers) for ABA Therapy.

Bariatric Surgery

Eligible Participants and eligible dependents are covered for bariatric surgery once per lifetime at 90% the contracted Preferred Provider Rate (or 60% UCR charges for Non-PPO Providers). Follow-up lap-band adjustments will be covered at the 90% of the contracted Preferred Provider Rate (or 60% UCR charges for Non-PPO Providers)

Chiropractic and Acupuncture Care

Acupuncture care is covered up to \$500 per calendar year. No maintenance care is covered.

The plan pays 90% of the PPO contract rate (60% of UCR charges for Non-PPO Providers) for chiropractic care up to \$1,500 per calendar year, for up to 26 visits per year. No maintenance care is covered.

Spinal Decompression Therapy as an alternative to surgery for back pain is covered up to a lifetime maximum of \$2,500, with no deductible or co-insurance.

Cochlear Implants

A written recommendation from an otolaryngologist or state-certified audiologist is required for coverage. After the deductible, the Plan pays 90% of the applicable contracted Preferred Provider Rate (or 60% of the UCR charge for Non-PPO Providers) for Cochlear Implants.

Continuity of Care

Eligible Participants and eligible dependents who are currently receiving treatment at a provider or facility for serious and complex conditions, course of institutional or inpatient care, scheduled nonelective surgery including post-operative care, course of treatment for pregnancy, or are terminally ill, and whose provider or facility has a change in their contractual relationship, (including, but not limited to, changing from an in-network facility/provider to an out-of-network facility/provider) then the eligible Participant or eligible dependent may request to continue to have services provided under that current provider or facility under the same terms and conditions as if no contractual change had occurred. Upon notice to the eligible Participant or eligible dependent of the change in contractual relationship, the eligible Participant or eligible dependent may elect to continue care at that current provider or facility under the same terms and conditions as if no contractual change had occurred for 90 days from the receipt of the notice, or until the individual no longer qualifies for continuing care, whichever is earlier. Such continuity of care shall comply with Section 113 of the Consolidated Appropriations Act of 2020.

COVID-19 Screening, Testing, Treatment and Vaccines

COVID-19 Screening and Testing is covered at 90% of the contracted Preferred Provider Rate (or 60% of the UCR charges for Non-PPO Providers) subject to the Annual Deductible. Treatment of COVID-19 with the administration of Monoclonal Antibodies is covered at 90% of the contracted Preferred Provider Rate (or 60% of the UCR charges for Non-PPO Providers) after the Annual Deductible is paid. COVID-19 vaccines are covered in accordance with the Wellness Program.

Emergency Services for Treatment of an Emergency Medical Condition

This Plan covers Emergency Services for treatment of an Emergency Medical Condition in accordance with the No Surprises Act.

The Plan pays benefits at the following rates, without prior authorization and without regard to any other term or condition of the plan or coverage other than the exclusion or Coordination of Benefits (to the extent not inconsistent with benefits for an Emergency Medical Condition), for covered charges in excess of any then-applicable deductible:

- (a) PPO Provider: 90% of the applicable contracted rate counting the eligible Participant or eligible dependent's cost-sharing amount toward the Out-of-Pocket Max; and
- (b) Non-PPO Provider or Non-PPO emergency facility: If an eligible Participant or eligible dependent receives Emergency Services for treatment of an Emergency Medical Condition from a Non-PPO Provider or Non-PPO emergency facility, the eligible Participant or eligible dependent will have the same Coinsurance as for a PPO Provider (10% after the applicable deductible) and the Coinsurance will be applied to the lesser of billed charges or the Qualifying Payment Amount, counting the eligible Participant's or eligible dependent's cost-sharing amount toward the Out-of-Pocket Max. Where the eligible Participant or eligible dependent receives proper notice and consents to certain post-stabilization services being paid at the out-of-network rate as allowed by the No Surprises Act, the Plan pays 60% of the UCR charge and does not count the eligible Participant's or eligible dependent's cost-sharing toward the Out-of-Pocket limit.

For purposes of this Section, a Qualifying Payment Amount means the Plan's median contracted rate for the item or service in the same geographic region, as adjusted under DOL Regulation 2590.716-6(c).

For purposes of this Section, Emergency Services means, with respect to an Emergency Medical Condition:

- (a) An appropriate medical screening examination that is within the capability of an emergency room of a hospital or independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition;
- (b) Such further medical examination and treatment as are required to stabilize the patient within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable (regardless of the department of the hospital in which such further examination or treatment is furnished); and
- (c) Post-stabilization services furnished by out-of-network providers or out-of-network facilities as part of outpatient observation or an inpatient/outpatient stay related to the emergency medical condition (regardless of the department of the hospital in which such further examination or treatment is furnished), until: (1) the treating provider or facility determines that the individual is able to travel using non-medical transportation or non-emergency medical transportation; and (2) the individual is provided with appropriate written notice to consent to out-of-network treatment and gives informed consent to such out-of-network treatment.

For purposes of this section, an Emergency Medical Condition means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the conditions described below:

- (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- (b) Serious impairment to bodily functions; or
- (c) Serious dysfunction of any bodily organ or part.

Balancing billing for Emergency Services for treatment of an Emergency Medical Condition is generally prohibited.

Erectile Dysfunction Treatment

Surgical implants provided as treatment for erectile dysfunction for eligible Participants and eligible dependents shall be covered at 90% of the applicable contracted Preferred Provider Rate if:

1. The surgical implant is provided by a PPO Provider;
2. The individual has exhausted all available treatment options before receiving the surgical implant; and
3. The surgical implant is pre-authorized by the Plan's independent medical reviewer as Medically Necessary.

Erectile dysfunction drugs are covered as per the formulary rules of the Plan's pharmacy benefit manager.

Flu Shots

Eligible Participants and eligible dependents shall receive reimbursement for Influenza vaccinations (including vaccinations against the H1N1 virus).

Hearing Aids

After a separate \$100 deductible is paid, the Plan pays 80% of the PPO contract rate (or 60% of UCR of Non-PPO Providers) for hearing aids up to \$1,500 per device as Medically Necessary. In addition to other PPO network providers, Costco shall be considered a Preferred Provider for Hearing Aids. This benefit is limited to one device per ear every three years.

Hearing Exams

One hearing exam per ear per calendar year is covered as a Physician's visit according to the standard benefit rules of the Plan. In addition to other PPO network providers, Costco shall be considered a Preferred Provider for Hearing Exams

Home Health Care

After the Annual Deductible is paid, Home Health Care is covered at 90% contracted Preferred Provider Rate (or 60% UCR charges for Non-PPO Providers) up to 100 visits per calendar year.

Hospice Care

1. General Rules. To qualify for these benefits, an individual must have a terminal illness or condition, and his or her physician must certify, in a form satisfactory to the Board of Trustees, that the individual is not expected to live more than six months.

2. Covered Care. Care which is covered under this rule includes: (a) residential hospice care, (b) licensed or certified home nursing care or therapy, and (c) appropriate medical supplies and related items, as approved by the designated case manager. Care covered under this Hospice Care benefit may include items which are not covered under other provisions of the Plan or are specifically excluded, or are intended to have a palliative effect on the Covered Individual's symptoms or maintain the Covered Individual's medical condition. In addition, visits with a licensed therapist, counselor or social worker are covered for the purpose of providing bereavement counseling to the Covered Individual and/or his or her immediate family members, either during the Covered Individual's life or thereafter, in accordance with the PPO contract.

3. Benefits Payable. Please contact the Administration Office to determine whether a particular hospice facility is a PPO Provider:

- (a) For hospice care provided by Preferred Providers, the Plan pays 90% of the provider's contracted rate after the applicable deductible.
- (b) For hospice care provided by Non-PPO Providers, the Plan pays 60% of the UCR charges after the applicable deductible.

Laboratory Services

Covered services performed at a PPO laboratory will be covered at 100% of the provider's contracted rate. Covered services performed at a non-Preferred Provider laboratory will be covered at 60% of the UCR rate. Annual Deductibles apply to the laboratory services benefit unless prohibited by the Affordable Care Act.

Long-Term Acute Hospital Benefits

After the deductible, the Plan pays 90% of the applicable contracted Preferred Provider Rate (or 60% of the UCR charges for Non-PPO Providers) for long-term acute hospital benefits.

Low Level Laser Therapy

Eligible Participants and eligible dependents are eligible for Low Level Laser Therapy up to \$750 annual maximum with no deductible or other Coinsurance applied.

Lumbar Discectomy

All procedures must be pre-certified as Medically Necessary by the Plan's Independent Medical Consultant or the Plan's PPO Provider. After certification and after the Annual Deductible is paid, the Plan pays 90% of the applicable contracted Preferred Provider Rate (or 60% of the UCR charges for Non-PPO Providers) for Lumbar Discectomy.

Mental and Nervous Conditions

Covered charges include those incurred by an eligible Participant or dependent for treatment of mental or nervous disorders. Mental or nervous disorders means a condition that affects thinking, perception, mood and/or behavior. Such conditions are recognized primarily by psychiatric symptoms that appear as distortions of normal thinking and/or perception, moodiness, sudden and/or extreme changes in mood, depression and/or unusual behavior such as depressed behavior, or highly agitated or manic behavior, or by physical manifestations.

Any condition meeting this definition is a mental or nervous disease or disorder no matter what the cause of the condition may be, either physical, mental, organic, or environmental causes, or any combination thereof. Any condition meeting this definition is included within it regardless of whether it produces only emotional symptoms or only physical symptoms such as headaches, sweats, trembling, nausea, or hysterical paralysis, or a combination of both. Plan limitations or exclusions of treatment of mental disease or disorder apply to the treatment of all conditions meeting this definition.

Examples of mental or nervous diseases or disorders include (but are not limited to) those which fall within the diagnosis codes 290 through 290.9 or 293 through 301.9 or 306 through 316 as listed in the International Classification of Diseases, 9th Revision, Clinical Modification, Volumes 1 and 2.

Inpatient: After the Annual Deductible is paid, Benefits shall be paid for covered treatment of Mental and Nervous Conditions at 90% of the applicable contracted Preferred Provider Rate or 60% of the UCR for Non-PPO Providers. Inpatient treatment includes residential treatment for mental health.

Outpatient: After the Annual Deductible is paid, benefits for outpatient treatment of Mental and Nervous Conditions is covered at 90% of the applicable contracted Preferred Provider Rate or 60% of UCR for Non-PPO Providers.

No Surprises Act

This Plan is compliant with the No Surprises Act, Title I of Division BB of the Consolidated Appropriations Act, 2021 ("the No Surprises Act"). To the extent any provision of this Plan is inconsistent with the No Surprises Act, the No Surprises Act shall govern. Notwithstanding any other provision of the Plan to the contrary, and subject to all applicable Plan limitations and exclusions, in accordance with the No Surprises Act, the Plan will apply the PPO in-network Coinsurance percentage to Non-PPO Air Ambulance Services, Emergency Services for Treatment of Emergency Medical Conditions by Non-PPO Providers and Non-PPO emergency facilities (unless the eligible Participant or eligible dependent received proper notice and consented to the out-of-network billing rates for certain post-stabilization services as allowed under the No Surprises Act), and non-emergency services from Non-PPO Providers at PPO facilities (unless the eligible Participant or eligible dependent received proper notice and consented to the out-of-network billing rates as allowed under the No Surprises Act). Notwithstanding any Plan Provision to the contrary, for Non-PPO services covered by the No Surprises Act, the in-network Coinsurance

percentage shall be applied to the lower of the billed charge or the Qualifying Payment Amount. There will be no Balance Billing for services covered by the No Surprises Act.

For purposes of this Section, a Qualifying Payment Amount means the Plan's median contracted rate for the item or service in the same geographic region, as adjusted under DOL Regulation 2590.716-6(c).

For services covered under the Plan and subject to the No Surprises Act, the Plan will pay the provider or facility, subject to all applicable Plan limitations and exclusions, an agreed upon amount, and if there is no agreed upon amount, an amount determined by an Independent Dispute Resolution Entity in accordance with 9816(c) or 9817(b) of the Internal Revenue Code, section 716(c) or 717(b) of ERISA, or section 2799A-1(c) or 2799A-2(b) of the PHS Act.

24/7 NurseLine

Eligible Participants and eligible dependents are eligible to use the Anthem 24/7 NurseLine. This benefit is covered at 100% and is not subject to the deductible.

Organ Transplants

Organ Transplants provided by a PPO Provider will be covered on the same basis as any other illness under the PPO Plan if the Plan's Independent Medical Consultant and the Plan's PPO Provider determine that the procedure is Medically Necessary. Please contact Administration Office as soon as you learn that an Organ Transplant may be necessary so they can contact the Plan's PPO Provider and Independent Medical Consultant to begin their review. Organ Transplants by Non-PPO Providers are not covered.

24/7 NurseLine

*Talk with a registered nurse about symptoms, health-related questions, and more around the clock.
(800) 700-0197*

Physical Therapy/Occupational Therapy

After the Annual Deductible is paid, physical/occupational therapy is covered at 90% of the contracted Preferred Provider Rate (or 60% UCR for Non-PPO Providers). There is a combined limit of up to 20 visits per year. Additional visits may be approved if determined by the Plan's independent medical consultant to be Medically Necessary.

Virtual physical therapy through Hinge Health is covered at 100%.



Virtual physical therapy and more

No copays. No office visits. Reduce joint and muscle pain with quick exercises you can do anytime, anywhere. So you can take the stairs, go hiking, run errands — and everything in between. (855) 902-2777

Podiatry

Benefits will be paid at 90% of the applicable contracted Preferred Provider Rate (or 60% UCR for Non-PPO Providers). Covered charges are charges incurred for podiatry, or the medical care of the feet, and surgical treatment of toenails, except if they are incurred for treatment of weak, strained or flat feet, imbalance of foot, metatarsalgia, bunion, treatment of corns, calluses, toenails (other than the surgical treatment) and orthopedic shoes. Supporting devices for the feet, such as orthotics are covered charges if determined to be Medically Necessary and prescribed by a licensed provider. Open cutting operation of metatarsalgia or bunion, or for a partial or complete removal of nail roots, are covered charges.

Prescription Drug Benefits

The Board of Trustees has contracted with a pharmacy benefit manager ("Pharmacy Benefit Manager") to provide prescription drug benefits to eligible Participants and dependents who are covered under the PPO Plan. No prescription drug benefits are provided, except when the purchase is made through a participating retail pharmacy

of the pharmacy benefit manager, or through the pharmacy benefit manager’s mail order program. Benefits will be paid in accordance with the following table:

Tier	34-Day Retail Copayment	90 Day Mail Order Copayment
Generics	10% with a minimum of \$10* and a \$50 maximum	10% with a minimum of \$10* and a \$50 maximum
Brand (if no generic is available)	10% with a minimum of \$10* and a \$50 maximum	10% with a minimum of \$10* and a \$50 maximum
Brand (if there is a generic available)	10% (with a minimum of \$10*) plus the difference between the cost of the generic and the Brand	10% (with a minimum of \$10*) plus the difference between the cost of the generic and the Brand
*If full price of your prescription drug is less than \$10, your Copayment for that prescription is the full price.		

Benefits for any purchase of prescription drugs are subject to the exclusions and limitations of the Pharmacy Benefit Manager’s plan in effect at the time of the purchase, but not the Plan deductible. The Board of Trustees has delegated to the Pharmacy Benefit Manager the responsibility for full and final determinations of eligibility for prescription drug benefits, interpretation of terms relating to prescription drug benefits, and determinations of claims and appeals concerning prescriptions drug benefits (other than general eligibility for benefits under the Plan). The Pharmacy Benefit Manager’s determinations shall be subject to judicial review only for abuse of discretion.

When you use the Plan’s pharmacy benefit provider your prescription will be filled with a generic drug if available. If a generic is not available, the prescription will be filled with a brand-name drug. In either case, you will pay 10% of the drug cost with a minimum payment of \$10 and a maximum payment of \$50. This Copayment will count toward the Out-Of-Pocket Max.

If you request a brand-name drug when a generic is available, you will pay the normal 10% payment (with a minimum of \$10), plus the difference in cost between the brand-name and the generic drug. The excess charge and the \$10% Copayment are not counted toward your Out-Of-Pocket Max.

Specialty Access Program: You must enroll in the Specialty Access Program administered by the Plan’s pharmacy benefit manager for certain medications that have manufacturer copay assistance available. Once you enroll in the program, you will pay the amount determined by the manufacturer copay assistance program, which may vary based on the medication. Only the amount you have paid out-of-pocket will apply to your annual Out-Of-Pocket Max (except that, as described above, if you request a brand-name drug when a generic is available, your payment will not count toward your Out-Of-Pocket Max). Manufacturer copay assistance will not be considered an out-of-pocket cost and will not apply to your Out-Of-Pocket Max.

Prosthetic Hair Replacement Devices (Wigs and Artificial Hair Pieces)

The Plan will pay up to \$300 per Plan Year for prosthetic hair replacement devices (wigs and artificial hairpieces) following chemotherapy or radiation therapy. All cost-sharing (deductible and co-insurance) for this benefit is waived. There is no limit on the number of prosthetic hair replacement devices a eligible Participant or eligible dependent may receive up to this \$300 per Plan Year limit. The Plan does not cover prosthetic hair replacement devices for the treatment of hair loss or medical conditions unrelated to chemotherapy or radiation therapy.

Qualified Non-PPO Physicians

Charges by a licensed physician which are payable under this Plan shall be covered at the applicable rate, except for services covered by the No Surprises Act as follows:

- (1) An eligible Participant or eligible dependent receives Emergency Services for treatment of an Emergency Medical Condition from a Non-PPO Provider or Non-PPO emergency facility (unless he or she consents to out-of-network billing rates for certain post-stabilization services as allowed under the No Surprises Act)
- (2) An eligible Participant or eligible dependent receives non-emergency services from a Non-PPO Provider at a PPO facility (unless he or she consents to out-of-network billing rates as allowed under the No Surprises Act)
- (3) An eligible Participant or eligible dependent receives Non-PPO air ambulance services.

If an eligible Participant or eligible dependent visits a Non-PPO Provider or Non-PPO facility in the situations described above, the Non-PPO Provider or Non-PPO facility may not Balance Bill. In addition, the eligible Participant's or eligible dependent's cost-sharing will be the same as if he or she had visited a PPO Provider or facility, meaning that once he or she has met the applicable deductible, his or her Coinsurance costs will be applied to the Out-of-Pocket Max and the Coinsurance percentage will be the same as if the eligible Participant or eligible dependent had visited a PPO Provider or facility. The eligible Participant's or eligible dependent's Coinsurance percentage will be applied to the lesser of the billed charge or the Qualifying Payment Amount.

A "visit" with respect to services at a PPO facility includes the furnishing of equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the provider furnishing such items or services is at the facility. These services are not limited based on whether the provider furnishing the services is physically located at the facility.

Smoking Cessation Benefits

The Plan will pay 100% of the costs of smoking cessation benefits with no deductible when provided by a PPO Provider. This benefit is limited to

- (1) Screening for tobacco use; and,
- (2) For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
 - (a) Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
 - (b) All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

Smoking cessation benefits provided by Non-PPO Providers are not covered.

Speech Therapy

After the Annual Deductible is paid, speech therapy is covered at 90% of the contracted Preferred Provider Rate (or 60% UCR for Non-PPO Providers). There is a combined limit of up to 20 visits per year. Additional visits may be approved if determined by the Plan's independent medical consultant to be Medically Necessary.

Supplementary Accident Expense Benefit

The Plan will pay in full the first \$600 of covered hospital and medical charges which result from an accident, provided the expenses are incurred within 90 days after the accident. Additional covered expenses will be paid as regular Plan benefits.

Telehealth Services

Telehealth, video, and online services for provider visits are covered at 90% of the contracted Preferred Provider Rate (or 60% of the UCR charges for Non-PPO Providers) after the Annual Deductible is paid.

Anthem's LiveHealth Online: LiveHealth Online may be used for doctors' visits. There is a \$20 Copayment for each visit. This benefit is not subject to the Annual Deductible.

LiveHealth Online: Speak with board-certified doctors, licensed therapists, psychiatrists and more through live video on your smartphone, tablet, or computer. LiveHealth Online is an easy and convenient way to get the care you need whether you're at home, at work, or on the go!

- 24/7 virtual urgent care with board-certified doctors for the whole family.
- Counseling and talk therapy with licensed therapists.



Transgender Services

Services and supplies provided in connection with gender transition when you have been diagnosed with gender identity disorder or gender dysphoria by a physician shall be covered at 90% of the applicable contracted Preferred Provider Rate (or 60% UCR for Non-PPO Providers) and subject to the applicable deductible. Coverage is provided according to the terms and conditions that apply to all other covered medical conditions, including Medical Necessity requirements, utilization management and exclusions for cosmetic services. Coverage includes, but is not limited to, Medically Necessary services related to gender transition such as transgender surgery, hormone therapy, and psychotherapy. Coverage is provided for specific services that apply to that type of service generally. For example, transgender surgery is covered on the same basis as any other covered, Medically Necessary surgery; hormone therapy is covered under the plan's prescription drug benefits. Transgender services are subject to prior authorization in order for coverage to be provided.

Wellness Program

This benefit consists of physical examinations and health screenings.

1. Physical Examinations for Adults and Well-baby Care

Physical examinations are covered for every eligible Participant and eligible dependent up to the 100% of the contracted Preferred Provider Rate (or 100% of the UCR for Non-PPO Providers). For purposes of this benefit, a physical examination means a general examination of a patient's medical condition which is not given in response to a particular condition, or which, if done in response to a particular condition, includes a comprehensive examination beyond the particular condition.

After payment of the Annual Deductible the Plan will pay 100% of the contracted Preferred Provider Rate (with no deductible) for well-baby care (including immunizations; guidance for parents on safety, nutrition, and behavioral problems; treatment of physical and developmental problems) for PPO Providers (or (after the deductible) 60% of the UCR for Non-PPO Providers) in the first two years of life.

2. The Plan provides coverage for the following items and services at 100% of covered charges at a PPO facility (no Copayment, Coinsurance or deductible shall apply to these items and services): Evidence-based items or services that have in effect a rate of A or B in the current published recommendations of the United States Preventive Services Task Force with respect to the individual involved;

<https://www.uspreventiveservicestaskforce.org/uspstf/>

- Immunizations for routine use in children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- Certain preventive care and screenings for infants, children and adolescents, as set forth in guidelines supported by the Health Resources and Services Administration (HRSA) as provided in Appendix B.

- Screening for obesity in adults;
- For adult patients with a body mass index (BMI) of 30 kg/m² or higher, intensive multicomponent behavioral interventions for weight management, which shall include:
 - Group and individual sessions of high intensity (Limited to 12 sessions per year),
 - Behavioral management activities, such as weight-loss goals,
 - Improving diet or nutrition and increasing physical activity,
 - Addressing barriers to change,
 - Self-monitoring, and
 - Strategizing how to maintain lifestyle changes.
- Other preventive care and screenings for women in guidelines supported by the HRSA, including:

 *Virta Coaching for sustainable weight loss and diabetes reversal is covered at 100% for eligible Participants and dependents. To check your eligibility, visit:*
www.virtahealth.com/join/full

Well-woman visits. Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care (several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors). The well-woman visit should, where appropriate, include other preventive services listed in the HRSA guidelines.

Screening for gestational diabetes. In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.

Human papillomavirus testing. High-risk human papillomavirus DNA testing in women with normal cytology results. Screening should begin at 30 years of age and should occur no more frequently than every 3 years.

Counseling for sexually transmitted infections. Annual counseling on sexually transmitted infections for all sexually active women.

Counseling and screening for human immune-deficiency virus. Annual counseling and screening for human immune-deficiency virus infection for all sexually active women.

Contraceptive methods and counseling. All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity as prescribed.

Breastfeeding support, supplies, and counseling. Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment in conjunction with each birth.

Screening and counseling for interpersonal and domestic violence. Annual screening and counseling for interpersonal and domestic violence.

PPO Plan Exclusions

Notwithstanding anything in this Plan, no benefits will be paid for the following medical care or services, nor will they count toward satisfying the deductible or out-of-pocket expense limit:

1. Those paid for or furnished, to the extent paid for or furnished, under any group health plan arranged through any employer, association, trustee, union or employee benefit association.
2. Those due to war or an act of war.
3. Those due to an accidental bodily injury arising out of or in the course of employment, or a sickness entitling the insured individual to benefits under a Workers' Compensation Act or similar legislation.
4. Those rendered outside the United States and Canada, unless specifically approved in accordance with the Plan.
5. Those rendered for treatment in a Veterans Administration Hospital, either by the hospital or a physician employed by it unless both of the following apply:
 - (a) The treatment is of an emergency nature, and
 - (b) The eligible individual is not entitled to such treatment by reason of his or her status as a veteran or otherwise.
6. Those incurred for the treatment of the following conditions or for performances of the following services:
 - (a) Radial Keratotomy or similar procedures.
 - (b) Treatment of infertility, including in vitro fertilization EXCEPT THAT intrauterine insemination ("IUI") shall be covered as indicated in the Section entitled Covered Medical Charges.
 - (c) Biofeedback and Hypnotherapy.
 - (d) Myofunctional therapy (facial exercises).
 - (e) Behavioral training used for hyperactive children, weight counseling and similar programs aimed at changing behavior. EXCEPT THAT when the services are provided by a PPO Provider the Plan shall cover, without cost sharing, screening for obesity in adults and for adult parents with a body mass index (BMI) of 30 kg/m² or higher, intensive, multicomponent behavioral interventions for weight management as described in the Wellness Program provision of the Plan.
 - (f) Holistic medicine or therapeutic injections.
 - (g) Reversal of vasectomy or reversal of tubal ligation.
 - (h) Routine office visits if claimant is not sick or injured.
 - (i) Cosmetic surgical procedures not specifically covered under the Plan, as well as reversal of cosmetic procedures not Medically Necessary.
 - (j) Temporomandibular Joint Syndrome.
 - (k) Eye refraction care or the fitting of eyeglasses.
 - (l) Organ transplants not listed as covered.
 - (m) Treatment of erectile dysfunction except for such surgical and prescription treatment as specifically authorized under the terms of the Plan
 - (n) Chelation therapy except for toxic exposure confirmed by a Plan-approved doctor of medicine, proven by blood tests conducted by PPO labs.
 - (o) Growth Hormone drugs shall not be covered except for the treatment of Idiopathic Short Stature for dependent children if pre-authorized by the Board of Trustees and determined to be Medically Necessary by an independent medical consultant other than the treating Doctor. Such prescription drug treatment shall be limited to a one-year supply. Annual extensions may be granted at the sole and exclusive discretion of the Board of Trustees after review by the Board of

Trustees and a determination by the plan's independent medical consultant that the treatment continues to be Medically Necessary.

7. Charges which are not Medically Necessary, except for medical services and supplies for which coverage is specifically provided.
8. Charges in excess of the applicable contracted Preferred Provider rates, unless specifically approved under the Plan.
9. Any prescription drugs (or other items covered under the prescription drug program) provided by anyone other than a physician or a hospital during the patient's confinement, unless provided through the Plan's designated pharmacy benefit manager.
10. Any claims submitted over one year from the date of service.
11. Charges made by any provider who is related to you by blood or marriage, unless the care is authorized by the Administration Office. Inquiry in all such cases should be made of the Administration Office before proceeding with treatment by any such practitioner.
12. Charges for any injury you receive while committing or attempting to commit a felony or any illegal activity, except if the injury resulted from mental illness or a condition arising out of acts of domestic violence.
13. Charges for treatment while incarcerated in a Federal or State penitentiary.
14. Treatment of any injury, illness, disease or other condition for which a third party (individual or organization) is or may considered to be responsible.
15. Charges for concierge medicine, concierge care, concierge doctors or any other membership-based healthcare.

Tip: Log onto the member portal to get the out-of-network Medical Reimbursement Form at: www.ualocal393benefits.org

RETIREE COVERAGE AND RULES FOR MEDICARE-ELIGIBLE INDIVIDUALS

Medicare Requirements

No retired Employee or dependent regardless of age, who is eligible for Medicare, will be eligible for **ANY** benefits under this Plan unless he or she has applied for and established coverage for Parts A, B and D of Medicare.

Disabled Retirees who became disabled prior to retirement, having established eligibility for Medicare, will be reimbursed for the cost of the Medicare Part B premium, (providing their retirement date is prior to January 1, 1995).

This Plan elects to be secondary for all Medicare-eligible persons for whom the Plan may be secondary, including active Employees of employers of less than 20 persons, as per the Medicare as Secondary Payer Act, 42 U.S.C. 1395y(b). Any Medicare-eligible retired Employee or dependent for whom the Plan is required to be primary shall be entitled to benefits under the Schedule of Benefits for Active Employees and Dependents as if he or she were not yet eligible for Medicare.

Where necessary to comply with the Medicare Secondary Payer Rules (42 U.S.C. 1395y(b)(1)(A)(i)) a Retiree (and their eligible dependents) who is age 65 or older and currently employed will receive coverage through the plan for eligible employees and their eligible dependents.

Retiree Coverage

The medical and pharmacy benefits for Medicare-eligible Retirees are administered by the Kaiser Senior Advantage Plan, the Aetna Medicare Advantage Plan and the Pharmacy Benefit Manager. The Plans require the Retiree to be enrolled in Medicare Parts A, B and D. Please note, participants are not required to take any additional steps to enroll in Medicare Part D. The Kaiser Senior Advantage Plan, the Aetna Medicare Advantage Plan and the Pharmacy Benefit Manager are Part D Plans and so participants will automatically be enrolled in Medicare Part D when enrolled in these Plans. Plan details are described in the Evidence of Coverages (EOCs).

The Board of Trustees has delegated to the Medicare Advantage Plans and Pharmacy Benefit Manager the responsibility for claims and appeals of all determinations concerning medical benefits (other than for general eligibility under the Plan).

Part D Prescription Drug Plan (PDP)

As of January 1, 2023, the pharmacy benefits for Medicare-eligible Retirees is administered by the Pharmacy Benefit Manager. Plan details are described in the Evidence of Coverage (EOC) and Summary of Benefits provided by the Pharmacy Benefit Manager. The Board of Trustees has delegated to the Pharmacy Benefit Manager the responsibility for claims and appeals of all determinations and interpretation of terms concerning prescription drug benefits (other than for general eligibility under the Plan). The Pharmacy Benefit Manager's determinations shall be subject to judicial review only for abuse of discretion.

In compliance with 42 CFR Section 423.124, all Medicare-eligible Retirees enrolled in Part D shall have adequate access to covered Part D drugs dispensed at out-of-network pharmacies when the Retiree (a) cannot reasonably be expected to obtain such drugs at an in-network pharmacy, and (b) does not access covered Part D drugs at an out-of-network pharmacy on a routine basis. The Plan may require such Medicare-eligible Retiree accessing Part D drugs at an out-of-network pharmacy to assume financial responsibility for any difference between the out-of-network pharmacy's UCR price and the Plan's allowance, consistent with the requirements of 42 CFR Section 423.104(d)(2)(i)(B) and 42 CFR Section 423.104(e).

Aetna Medicare Advantage

- Participants must be enrolled in Medicare Parts A, B and D and enrolled in the U.A. Local No. 393 Navitus MedicareRx Prescription Drug Plan (PDP) to participate in this plan.
- Participants can use any willing Medicare provider, regardless of if the provider is in or out of the Aetna Medicare Network.
- No referrals are needed for all Medicare covered Medical Services.
- Further plan rules can be found in the Aetna Evidence of Coverage (EOC) Manual located at <https://retireefirst.com/local393/>.
- Retiree Advocates at Retiree First are available to answer any Participant questions about the Aetna Medicare Advantage Plan at 408-215-1207 (TTY 711) or Toll-Free 855-460-7487 (TTY 711).

Pharmacy Benefit Manager

- Participants must be enrolled in Medicare Parts A,B and D and enrolled in the U.A. Local No. 393 Aetna Medicare Advantage Plan to participate in this plan.
- Participants can contact Navitus MedicareRx PDP with any questions about their pharmacy benefits:
 - Medicarerx.navitus.com (Log into the Member Portal)
 - Navitus MedicareRx PDP Customer Care is available toll-free at 866-270-3877 (TTY/TDD users should call 711), 24 hours a day, 7 days a week, except on Thanksgiving and Christmas Day.

Kaiser Senior Advantage

- Participants must be enrolled in Medicare Parts A, B, and D to participate in this plan for medical and pharmacy benefits.
- Participants must live in the Northern California Kaiser service area.
- Further plan rules can be found in the Kaiser Senior Advantage Evidence of Coverage (EOC) Manual located at:
<https://www.ourbenefitoffice.com/Ualocal393/Benefits/HealthcareDocuments.aspx>.
- Kaiser Member Services is available to answer any Participant questions at (800) 464-4000.

DENTAL CARE PLAN

Group B Bargained Employees

Active and Retired Employees and their Eligible Dependents:

- Covered dental benefits are provided up to a maximum of \$2,000 per calendar year per Covered Person. Orthodontics are covered up to a maximum of \$2,500 per lifetime for dependent children under age 19.
- There is a lifetime deductible of \$50 per person/\$200 per family, which is waived for orthodontics, and for diagnostic and preventive services received at a PPO Provider.
- Additional coverage details are provided in the chart below.

Service	Coinsurance (Plan Pays)	
	PPO Provider	Premier and Non-Contracted Provider
Diagnostic and Preventive (adults and children)	100%	70%
Basic Services (adults and children)	80%	70%
Major Services (adults and children)	50%	50%

Group A Bargained Employees and Retired Employees

For Eligible Active and Retired Employees and their Eligible Dependents age 19 or older:

- Covered dental benefits are provided up to a maximum of \$3,000 per year per Covered Person
- Orthodontics are not covered.
- There is a lifetime deductible of \$50 per person/\$200 per family, which is waived for orthodontics, and for diagnostic and preventive services received at a PPO Provider.
- Additional coverage details are provided in the chart below.

For Eligible Dependent Children under age 19:

- Covered dental benefits are provided at no charge with no lifetime limit, and orthodontics are covered up to a maximum of \$2,500 per lifetime.

Service	Coinsurance (Plan Pays)	
	PPO Provider	Premier and Non-Contracted Provider
Diagnostic and Preventive (adults)	100%	70%
Diagnostic and Preventive (children)	100%	70%
Basic and Major Services (adults)	80%	70%
Basic and Major Services (children)	100%	70%

Provider Network

Coverage is provided through a contract with Delta Dental Plan of California (Delta Dental), and Delta Dental provides a separate Benefits Highlights sheet and Evidence of Coverage booklet describing in more detail the benefits available through the Plan. There are three tiers of dental providers in the Delta Dental network, and the Plan's Coinsurance is dependent on which tier the dentist or provider participates:

- PPO,
- Premier, and
- Out-Of-Network Non-Contracted Provider.

Annual Maximum

The dental plan may approve advancement of the annual maximum, up to one (1) year, when the services are provided by a licensed dentist, and when they are necessary and customary under the generally accepted standards of dental practice.

VISION PLAN

The Board of Trustees have contracted with VSP for vision benefits and have delegated to VSP all claims and appeals of all determinations concerning vision benefits (other than for general eligibility under the Plan). Retired Participants covered under the Aetna Medicare Advantage Plan do not have vision benefits through VSP.

- Participants must be enrolled in the PPO Plan, the HMO Plan or the Kaiser Senior Advantage Plan to participate in this plan.
- Further plan rules can be found in the VSP Benefits Summary located at: www.ualocal393benefits.org or by logging in at www.vsp.com
- VSP Member Services is available to answer any Participant questions at (800) 877-7195.

WAGE REPLACEMENT BENEFITS

Weekly Short Term Disability Benefit - Active Members Only

The Plan will pay an eligible Employee a taxable weekly benefit of \$150 if he or she is receiving benefits from California's State Disability Insurance Program or a worker's compensation plan. To be eligible for this benefit, the Employee must be eligible for coverage through drawdowns of the Hour Bank (and not through self-payment or COBRA coverage payments). This benefit will be paid in addition to any benefit to which the Employee is entitled under State Disability Insurance, workers' compensation, or any similar law. An Employee does not have to be confined to his or her home to be eligible, but he or she must be under the care of a physician. Individual Employers, office employees, and dependents are not eligible for this benefit.

Benefits will commence with the first day of disability due to an accident, or the 8th consecutive day of disability due to illness. If the Employee is not covered for a full week, one-seventh of his or her weekly benefit will be paid for each day he or she is covered.

There is no limit to the number of times an Employee may receive these benefits for unrelated disabilities. The limits for any single disability are as follows:

1. Except as provided in paragraph 2 below, an Employee may receive the Weekly Short Term Disability Benefit for up to 52 weeks based on any single disability. If an Employee returns to work but is later unable to continue to work because of the recurrence of a disability for which he or she already received Weekly Short Term Disability Benefits, his or her benefits shall be limited to the remainder of the 52 weeks payable based on that disability.
2. If an Employee has performed 26 weeks of covered employment after the first Weekly Short Term Disability Benefit payment based on a particular disability, then he or she shall be eligible for a new period of 52 weeks of benefits upon the recurrence of that disability. There is no limit to the number of times an Employee may qualify for new 52-week periods of benefits based on the recurrence of the same disability or related disabilities, provided that the Employee has performed 26 weeks of covered employment after the first payment of each successive period of 52 weeks of benefits.

Weekly Paid Family Leave Benefit - Active Members Only

The Plan will pay an eligible Employee a taxable weekly benefit of \$150 for up to eight (8) weeks per 12-month period if he or she is receiving benefits from California's Paid Family Leave Insurance Program and provides sufficient proof thereof. To be eligible for this benefit, the Employee must be eligible for coverage through drawdowns of the Hour Bank (and not through self-payment or COBRA coverage payments). Individual Employers, office employees, and their dependents are not eligible for this benefit.

How to File a Claim

You must submit an Application for Short Term Disability or Paid Family Leave Benefits to the Administration Office. Claim Forms can be found at: www.ualocal393benefits.org / Documents / Health Care / Forms and Applications

Proof of receipt of State Disability Insurance (SDI) from California EDD or workers' compensation benefits is required.

Applications must be submitted within one year of the EDD or workers' comp payment period end date.

Supplemental Long Term Disability Benefit

This Plan provides a Supplemental Long Term Disability Benefit for certain Employees who become disabled before qualifying for retirement under the U.A. Local No. 393 Defined Benefit Pension Plan.

If an Employee:

- has not yet attained age 55,
- is totally and permanently disabled so as to be unable to perform any gainful employment,
- has been awarded a Social Security Disability Award,
- has 10 years of vesting credit in the U.A. Local No. 393 Defined Benefit Pension Plan, and
- was covered by this Plan as an active Employee for 5 out of the last 7 years, including 60 out of the last 84 months, prior to the onset of disability,

then the Plan will, during each year of the Employee's disability, pay the Employee a taxable benefit equivalent to 12 times the monthly benefit he or she would have received from the U.A. Local No. 393 Defined Benefit Pension Plan had he or she been eligible for a Disability Retirement under that plan.

The Employee must provide proof of his or her Social Security Disability Award before this benefit will begin, and must also provide proof annually thereafter and on request. Employees must notify the Administration Office immediately of any change in their disability status and/or termination of their Social Security Disability Award. If the Employee receives any benefits when he or she is no longer eligible, the Plan's provisions for reimbursement of overpayment will apply.

The Supplemental Long Term Disability Benefit will terminate upon the occurrence of any of the following:

- 1) attainment of age 55;
- 2) termination of the Employee's Social Security Disability Benefits;
- 3) two months after the Employee has returned to covered employment, even if the Employee continues to receive their Social Security Disability Benefits,
- 4) death of the Employee, or
- 5) payment of a pension benefit from the U.A. Local No. 393 Defined Benefit Pension Plan.

If, after an attempt to return to covered employment, an Employee finds that he or she is still unable to perform such work due to disability, and the Employee is continuing to receive their Social Security Disability Benefits, then this Supplemental Long Term Disability Benefit shall recommence upon the termination of the covered employment and the submission of a new application.

The benefit will be paid according to the following rules:

1. This benefit is separately funded on an annual basis. If the total account balance available in this fund in any one Plan Year is not sufficient to pay the full benefit to all Employees who qualify in that Plan Year, then Employees will receive a proportionate amount available for that Plan Year.
2. 75% of an Employee's annual benefit will be paid in monthly installments. The remaining balance will be paid at the end of the Plan Year, subject to availability of funds.
3. Partial Years: If the Employee's disability begins or the Employee attains age 55 during a benefit year, he or she will be paid for the number of months for which he or she was eligible.
4. If an Employee dies during a Plan Year in which he or she is eligible for this benefit, his or her surviving Spouse will receive any further payments which the Participant would have received in that Plan Year only.
5. In no event will the Supplemental Long Term Disability Benefit fund be liable for greater payment than there are funds available at the time these benefits are due.
6. This payment will be payable in addition to any weekly benefit an Employee may receive under the State Disability Insurance, worker's compensation, or any other benefit that might be available to the Employee.
7. This benefit is not payable in addition to the Weekly Short Term Disability Benefit.

8. Payment of benefits for any eligible Employee will be retroactive to the date of disability indicated in the Social Security Disability Award up to a maximum of 36 monthly installments.

Employees Who Have Applied for Social Security Disability But Have Not Yet Received a Determination

If an Employee would otherwise be eligible for the Supplemental Long Term Disability Benefit except that he or she has not received a Social Security Disability Award, he or she will nonetheless be eligible for up to twenty-four (24) months of Supplemental Long Term Disability Benefit if all of the following criteria are met:

1. The Employee has applied for a Social Security Disability Benefits award and the determination is still pending including the determination on appeal; and
2. The Employee is certified by the Plan's Independent Medical Examiner to be totally and permanently disabled; and
3. The Employee furnishes proof satisfactory to the Trustees that he or she is not gainfully employed.

The Employee must notify the Administration Office as soon as a determination has been made on his or her application for Social Security Disability benefits and/or his appeal of the initial determination. Supplemental Long Term Disability Benefits will terminate immediately if the Employee's Social Security Disability benefit application is denied and, if applicable, his appeal has been denied. If the Social Security Disability benefit application is granted, Supplemental Long Term Disability Benefits shall continue as long as the Employee is eligible under the rules of this Plan.

The twenty-four (24) months of benefits payable under this provision will not be paid on a retroactive basis.

DEATH BENEFIT

(a) Eligibility

A covered active Employee under the Plan (including Employees receiving coverage under their Hour Bank, Employees who are self-paying under Rule 8, disabled Employees receiving coverage under Rules 9 and 10 and terminally ill Employees before retirement under Rule 11) shall be entitled to death benefits as detailed in subsection (b) below, payable to his or her designated beneficiary upon the death of the Employee, if all of the following requirements are met at the time of the Employee's death:

- (a) The Employee was an active Employee covered by the Plan
- (b) The Employee had not yet retired; and
- (c) The Employee had not reached age 65.

An Employee shall not be considered to be a covered active Employee under the Plan if he or she is receiving coverage exclusively under COBRA.

If an Employee loses coverage under the Plan, he or she will lose eligibility for the Death Benefit. An Employee will need to re-establish his or her coverage as an active Employee under the Plan in order to become eligible for the death benefit.

(b) Death Benefits

Lump Sum Death Benefit:

If an Employee satisfies the requirements of subsection (a) above, the Employee shall be entitled to a Lump Sum Death Benefit payable to his or her designated beneficiary. The Lump Sum Death payment is equal to \$50,000.

Additional Benefit:

In addition to the Lump Sum Death Benefit, if an Employee satisfies the requirements of subsection (a) above, the Employee may also be entitled to an Additional Benefit payable to his or her designated beneficiary. This Additional Benefit is equal to \$2,000 times the number of years of Benefit Credit under the U.A. Local No. 393 Defined Benefit Pension Plan earned on or after January 1, 2022.

(c) Payable to Designated Beneficiary

The Employee may designate anyone, or any number of people, as his or her beneficiary for the Employee's death benefits, including his or her trust or estate. However, if the Employee is married when he or she dies and his or her Spouse has not consented in writing to the beneficiary designated on the form he or she had filed, then one half of the Employee's Death Benefit will be paid to his or her surviving Spouse and the form the Employee filed will apply only to the other half. If an Employee becomes divorced, then his or her former Spouse is not entitled to any payment of Death Benefit and any designation of his or her former Spouse as a beneficiary will automatically be revoked as of the effective date listed on the final dissolution of marriage decree.

If the Employee does not designate a beneficiary or if there is no valid beneficiary on file as of the Employee's death, the death benefits will be paid to the Employee's Spouse or registered Domestic Partner; or if none, to the Employee's child(ren), if any; or if none, to the Employee's parent(s), if either is living, or if not, to the Employee's surviving brothers and sisters, and if none, then no benefit will be payable.

Application for death benefits must be received by the Administration Office within 12 months of the death for any benefit to be payable. In a situation where there are multiple beneficiaries, if one beneficiary does not file timely with the Administration Office (within a 12-month period), no benefits are payable to that beneficiary. The appropriate share will be paid to the beneficiaries that have filed the application in a timely manner. A certified copy of the death certificate must be attached with a completed claim form.

(d) **Taxability of Death Benefits**

The death benefit issued from this Plan is a self-insured taxable benefit paid directly from the assets of the Plan. Instructions to Form 1099 clearly indicate that the Form 1099-R is used to report death benefit payments paid by a qualified or nonqualified plan to an estate, or to another person, who has acquired the right to receive the payments solely because of the Employee's death.

(e) **Exclusions**

No death benefits will be paid if:

- (1) The Employee dies while committing or attempting to commit a felony or other illegal activity, or
- (2) The Employee dies as a result of war, whether declared or undeclared, or insurrection; or
- (3) The Employee is receiving coverage exclusively under COBRA at the time of his or her death; or
- (4) Since first becoming a Participant in this Plan, the Employee has worked as an Employee or in a managerial, supervisory, proprietary or any other capacity or as a self-employed person in the plumbing and pipefitting industry anywhere in the United States or Canada for an employer who is not signatory to a Collective Bargaining Agreement with U.A. Local 393 or another Local Union affiliated with the United Association; or
- (5) The Employee at the time of his death was an owner, officer or shareholder of a participating employer who was delinquent in its contribution payments to this Plan.

MISCELLANEOUS RULES

Coordination of Benefits (Non-Duplication Provision)

1. In General:

All self-funded benefits, except disability benefits, are subject to coordination. If you or your dependents are entitled to benefits under any other plan which will pay part or all of the expense incurred for UCR charges for treatment of sickness or injury, the amount of benefits payable under this Plan and any other plans will be coordinated so that the aggregate amount paid will not exceed 100% of the expense incurred.

In no event will the amount of benefits paid under this Plan exceed the amount which would have been paid if there were no other plan involved.

Benefits under this Plan will be coordinated with any group plan providing benefits or services for covered services and supplies, that is:

- (a) Group insurance coverage;
- (b) Blanket insurance coverage which does not contain a non-duplication of benefits or excess policy provision;
- (c) Group Blue Cross, Blue Shield, group practice and other prepayment coverage provided on a group basis;
- (d) Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, employee benefits organization plans, or any other agreement or benefits provided on a group basis; and
- (e) Any group coverage under governmental programs, and any group coverage required or provided by any statute.

2. Which plan pays first:

- (a) If both plans have Coordination of Benefits provisions, the plan that insures you as an Employee pays first.
- (b) If you receive benefits as an active Employee under one plan and as a Retiree or COBRA Participant under another, the plan you have as an active Employee pays first. If you are insured as an Employee under two plans, the plan which has insured you longer is primary.
- (c) If one primary plan does not have a Coordination of Benefits provision, that plan is always primary.
- (d) If a dependent child is covered under two plans, the plan of the parent whose birthday (month and day) is earlier in the year will pay its benefits first, except as follows: If the parents of a dependent child are divorced or legally separated, the plan of the parent with the custody of the child pays its benefits first. If the parent with custody remarries, the order of the payment is as follows:
 - (1) Natural parent with whom the child resides;
 - (2) Stepparent with whom the child resides;
 - (3) Natural parent not having custody of the child.

This order of payment can change if a Qualified Medical Child Support Order is issued (see Rule 16).

Subrogation, Reimbursement and Third Party Liability

1. The Plan does not cover illnesses, injuries or other conditions which are incurred on the job or arise out of or are connected in any way with the employment of the Employee or dependent and are compensable under the Workers' Compensation or Employer's Liability Law or under any other similar law, state or federal. The Fund reserves the right to be reimbursed by an Employee or dependent out of any recovery obtained either through judgment or settlement of any claim for compensation under such law.
2. This Plan does not cover any illness, injury, disease or other condition for which a third party may be liable or legally responsible, by reason of negligence, an intentional act or breach of any legal obligation on the part of that third party.

If any service is provided or medical claims paid in connection to any injury caused by a third party, and the covered Participant and/or eligible dependents receive reimbursement from or on behalf of a third party or from uninsured motorist coverage, the Plan is entitled to recover the full amount of benefits paid under the Plan for such services, up to the gross amount recovered by the covered Participant and/or eligible dependents. The Participant and their eligible dependents are responsible for all expenses incurred to obtain payment for third parties, including attorney fees, which amounts will not reduce the amount due to the Fund as restitution. Accordingly, the Fund expressly rejects the "Common Fund" doctrine with respect to the payment of attorney fees.

Upon settlement of the claim against the third party, insurance company or uninsured motorist coverage, the covered Participant and/or eligible dependents will pay the Plan all amounts to which it is entitled, in accordance with this paragraph. If the covered Participant and/or eligible dependents receive a settlement or judgment from a third party in an amount which is less than anticipated, this in no way affects the Plan's right to recover the full amount for claims paid on behalf of the covered Participant and/or eligible dependents.

The Plan has a right to first reimbursement of any recovery from a third party or any uninsured motorist coverage, even if the covered Participant and/or eligible dependents are not otherwise made whole and without regard to how the recovery is categorized. The Plan will place a lien on such recovery. Accordingly, the Fund does not recognize the "Make Whole Doctrine." In addition, the Fund's right of first reimbursement shall not be affected, reduced, or eliminated by the comparative fault or regulatory diligence doctrines. The assets recovered are owed to the Plan and the covered Participant and/or eligible dependents shall be obligated to pay them over to the Plan. The Plan shall be entitled to enforce this requirement by way of any remedy permitted by law or equity.

The covered Participant and/or eligible dependents must complete and sign an Agreement to Reimburse in such a form or forms as the Plan may require BEFORE any benefits are paid. If the covered Participant and/or eligible dependents refuse to sign an Agreement to Reimburse, or any other such agreement the Plan may require, the covered Participant and/or eligible dependents shall not be eligible for benefits under the Plan for medical claims related to this injury.

If the Plan pays benefits on behalf of the covered Participant and/or eligible dependents and the covered Participant and/or eligible dependents recover any proceeds from or on behalf of a third party or from uninsured motorists coverage, and do not reimburse the Plan, the covered Participant and/or eligible dependents will be ineligible for future Plan benefit payments until the Plan has withheld an amount equal to the amount which has not been reimbursed.

Every covered Employee, and every eligible dependent, are required to advise the Plan in writing within 60 days of any third party against whom the person may have a claim or legal right of recovery and to furnish such information and assistance and execute such papers as the Plan may require to facilitate enforcement of its rights, whether before or after actual payment of benefits.

3. Notwithstanding any Plan Provision to the contrary, the Plan will not enforce its right to reimbursement with respect to the Plan's Weekly Short Term Disability Benefit.
4. The Board of Trustees reserves the right to be reimbursed for any benefits and/or premiums which it paid to, or on behalf of, an individual who was not entitled to have such benefits and/or premiums paid, including overpayments. The Board of Trustees reserves the right to seek recovery of such excess payments, by any legal or equitable means available to it, including restitution from the individual and/or from the Participant through whom the individual claimed eligibility and/or offset of some or all of future benefit payments to, or on behalf of, either the individual or the Participant through whom the individual claimed eligibility for benefits.

Waiver of Class, Collective, and Representative Actions

By participating in the Plan, current and former Participants, Employees, Retirees, dependents, and eligible individuals waive, to the fullest extent permitted by law, whether or not in court, any right to commence, be a party in any way, or be an actual or putative class member of any dispute, claim or controversy relating to the Plan, and current and former Participants, Employees, dependents, Retirees, and eligible individuals agree that any dispute, claim or controversy may only be initiated or maintained and decided on an individual basis.

Rights of States

1. Payment of benefits with respect to an Employee will be made in accordance with any assignment of rights made by or on behalf of such Employee or beneficiary of an Employee as required by a state plan for medical assistance approved under title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of that Act.
2. In enrolling an individual as an Employee or beneficiary or in determining or making any payments for benefits of an individual as an Employee or beneficiary, the fact that the individual is eligible for, or is provided, medical assistance under a state plan for medical assistance under Title XIX of the Social Security Act will not be taken into account.
3. To the extent that payment has been made under a state plan for medical assistance approved under Title XIX of the Social Security Act in any case in which the Plan has a legal liability to make payments for items or service constituting such assistance, payment for benefits under the Plan will be made in accordance with any state law which provides that the state has acquired rights with respect to an Employee to such payment for such items or services.

Limitations on Liability of this Plan and Trust Fund

1. The benefits provided by this Plan are not in lieu of and do not affect any requirement for coverage by Workers Compensation Insurance laws or similar legislation.
2. The provisions of this Plan are subject to and controlled by the provisions of the Trust Agreement, and in the event of any conflict between the provisions of this Plan and the provisions of the Trust Agreement, the applicable provisions of the Trust Agreement will prevail.
3. The benefits provided by this Plan can be paid only to the extent that the Fund has available adequate resources for such payments. If the assets are insufficient to pay benefits as scheduled, they will be prorated and benefits paid accordingly. In the event that at any time the Fund does not have sufficient assets to permit continued payments, nothing contained in this Plan will be construed as obligating any contributing employer to make benefit payments or contributions (other than the contributions for which the contributing employer may be obligated by his or her Collective Bargaining Agreement) in order to provide for the benefits established hereunder. Likewise, there will be no liability upon the Board of Trustees, individually or collectively, or upon any employer, the Union, signatory association or any other person or entity of any kind to provide the benefits established hereunder if the Fund does not have sufficient assets to make such benefit payments.
4. None of the benefits provided for in the Plan is insured except as provided herein, or as thereafter adopted by the Board of Trustees, and there is no liability on the Board of Trustees or any other individual

or entity to provide payment over and beyond the amount in the Fund collected and available for the payment of benefits. Benefits which are provided under insurance contracts and designated provider contracts are payable only to the extent provided in the applicable contract.

Clerical Error

Any benefit to which an Employee would be entitled in accordance with the rules of the Plan will not be withheld or denied to such Employee due to:

1. Clerical error in reporting of hours and contributions by his or her employer or clerical error on the part of the administrator.
2. Failure of any Individual Employer to make payment of contributions promptly and in full.

Right of Examination

The Fund, at its own expense, reserves the right and opportunity to examine the person of an Employee or dependent when and so often as it may reasonably require during the pendency of any claim. Proof of claim forms, as well as other forms, and methods of administration and procedure will be solely determined by the Board of Trustees.

Board of Trustees' Reservation of Authority

In order that the Board of Trustees may carry out its obligation to maintain, within the limits of the funds available to it, a sound economic program dedicated to providing the maximum possible benefits for Employees and dependents, the Trustees expressly reserve the right, in their sole discretion and without notice to eligible individuals, employers or Local Unions, but on a non-discriminatory basis:

1. To terminate or to amend either the amount or conditions with respect to any benefits or provisions of the Plan, even though such termination or amendment affects claims in process and/or expenses already incurred; and
2. To alter or postpone the method of payment of any benefit; and
3. To amend any provisions of this Plan and the procedures for administration of the Plan.

Disclosure of Protected Health Information (PHI) to the Board of Trustees

1. Definitions. Whenever used in these rules of disclosure to the Board of Trustees, the following terms shall have the respective meanings set forth below.
 - (a) Plan means this U.A. Local No. 393 Health and Welfare Plan.
 - (b) Board means the Board of Trustees of the U.A. Local No. 393 Health and Welfare Plan, which is the plan sponsor as defined in ERISA § 3(16)(B).
 - (c) Health Information means information (whether oral or recorded in any form or medium) that is created or received by a health care provider, health plan (as defined in 45 C.F.R. § 160.103), employer, life insurer, school or university, or health care clearinghouse (as defined in 45 C.F.R. § 160.103) that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.
 - (d) Summary Health Information means information that summarizes the claims history, expenses, or types of claims by individuals for whom the Plan provides benefits, and from which the following information has been removed:
 - (1) Names;
 - (2) Geographic information more specific than state;
 - (3) All elements of dates relating to the individual(s) involved (e.g., birth date) or their medical treatment (e.g., admission date) except the year; all ages for those over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older);
 - (4) Other identifying numbers, such as Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers;

- (5) Facial photographs or biometric identifiers (e.g., fingerprints); and
 - (6) Any information the Board does not have knowledge of that could be used alone or in combination with other information to identify an individual.
- (e) Protected Health Information (“PHI”) means Health Information, including demographic information, that is (1) transmitted or maintained in any form or medium, (2) collected from an individual and created or received by a health care provider, health plan, employer, or health care clearinghouse, and (3) identifies the individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the individual involved.
- (f) Public Health, as defined in 45 CFR § 160.103, means population-level activities to prevent disease in and promote the health of populations. Such activities include identifying, monitoring, preventing or mitigating ongoing or prospective threats to the health or safety of a population, which may involve the collection of protected health information. But such activities do not include those with any of the following purposes: (1) to conduct a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating health care; (2) to impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating health care; (3) to identify any person for any of the activities described in paragraphs (1) or (2) of this definition.
- (g) Person means a natural person (meaning a human being who is born alive), trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private.
2. Disclosure of Summary Health Information. The Plan may disclose Summary Health Information to the Board if the Board requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending, or terminating the Plan.
 3. Disclosure of Enrollment Information. The Plan may disclose to the Board information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.
 4. Disclosure of PHI. The Plan will disclose PHI to the Board only in accordance with 45 CFR § 164.504(f) and the provisions of this section.
 5. Permitted Uses of PHI by the Board. PHI disclosed to the Board in accordance with this Section may only be used for the Plan administrative functions that the Board performs.
 6. Certification. The adoption of this section shall constitute certification by the Board that this Plan has been amended to include the provisions required under 45 CFR § 164.504(f).
 7. Obligations of the Board. In addition to the requirements stated above, the Board also agrees to:
 - (a) Not use or further disclose PHI other than as permitted in this Section or as required by law;
 - (b) Ensure that any of its agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Board;
 - (c) Not use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan;
 - (d) Report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses and disclosures in this Section;
 - (e) Make PHI available to individuals in accordance with 45 CFR § 164.524;
 - (f) Make PHI available for individuals’ amendment and incorporate any amendments in accordance with 45 CFR § 164.526;
 - (g) Make the information available that will provide individuals with an accounting of disclosures in accordance with 45 CFR § 164.528;
 - (h) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services for purposes of determining the Plan’s compliance with 45 CFR Part 164;
 - (i) If feasible, return or destroy all PHI received from the Plan that the Board maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Board will limit

further its uses and disclosures of the PHI to those purposes that make the return or destruction of the information infeasible; and

- (j) Ensure that adequate separation between the Plan and the Board, as required by this Section and by 45 CFR § 164.504(f)(2)(iii), is established and maintained.
8. Disclosure Only to Designated Parties. Pursuant to this Section, the Plan will disclose PHI only to the Board, Individual Trustees, or plan providers that have executed valid business associate agreements.
9. Disclosure Only for Designated Purposes. Access to and use of PHI by the parties described in paragraph 8 shall be restricted to Plan administration functions that the Board performs for the Plan. Such access or use shall be permitted only to the extent necessary for these individuals to perform their respective duties for the Plan.
10. Non-Compliance. If any person described in paragraph 8 does not comply with the provisions of this Section or the provisions of 45 CFR § 164.504(f), the Board shall provide a mechanism for resolving the issue of non-compliance, which may include disciplinary sanctions.
11. Statement Required in Privacy Notice. The Plan may not disclose, and may not permit a health insurance issuer or HMO providing services to the Plan to disclose, PHI to the Board except as would be permitted by the Plan in this Section, and only if the appropriate statement is included in the privacy notice of the Plan, the insurance issuer, or the HMO, as required by 45 CFR § 164.520.
12. Disclosure of ePHI. The Board will reasonably and appropriately safeguard electronic PHI (ePHI) created, received, maintained or transmitted to or by the Board on behalf of the Plan. Specifically, the Board will:
 - (a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the Plan,
 - (b) Ensure that adequate separation between the Plan and Board, as required by this Article and by 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures,
 - (c) Ensure that any agent, including a subcontractor, to whom the Board provides this information agrees to implement reasonable and appropriate security measures to protect the information, and
 - (d) Report to the Plan any security incident of which it becomes aware.

Federal Payroll Taxes Incidental to Domestic Partner Coverage

Effective for this Plan September 1, 2005, California state law requires insured health benefit contracts to include provisions offering dependent coverage to a limited group of Domestic Partners and their dependent children. As part of this coverage, this Plan pays the incidental federal employment payroll taxes, in accordance with governing IRS and U.S. Department of Labor rulings. Effective January 1, 2025, Participants with Domestic Partners will be responsible for paying the Employee portion of the payroll taxes associated with coverage of their Domestic Partner under the Plan.

Assignment

The rights, coverage, and eligibility of a Participant, Employee, beneficiary, or dependent under this Plan, or any applicable law, may not be assigned. A direction to pay a provider is not an assignment of any right under this Plan or of any legal or equitable right to institute any court or arbitration proceeding.

Applicable Venue

A Participant or beneficiary shall only bring an action in connection with the Plan in the United States District Court for the Northern District of California.

APPENDIX A: CLAIMS AND APPEALS PROCEDURE

1. Claims and Appeals Procedure for PPO Plan Benefits and Other Matters Within the Discretion of the Board of Trustees

The following claims and appeals procedures shall apply to matters within the discretion of the Board of Trustees of the U.A. Local No. 393 Health and Welfare Plan, except as provided in Section 3 of this Appendix for claims and appeals for disability benefits. Such matters include, but are not limited to:

- Any claim or appeal regarding self-funded benefits, including but not limited to the self-funded PPO Plan, Wellness, Disability benefits, SUB benefits, Death benefit and Hearing Aid benefits;
- Claims and appeals regarding eligibility under the Plan for any type of benefit; or
- Claim and appeals regarding medical and dental benefits when the claimant has made a specific claim for medical or dental care, and the HMO, insurance carrier, or other provider has denied the claim on the grounds that the claimant or family member is not eligible for the benefit under the terms of the Plan.

The procedures specified in this Appendix, plus supplementary procedures adopted by the Trustees, shall be the sole and exclusive procedures available to any individual who is adversely affected by any action of the Trustees, the Administration Office or any other Plan fiduciary or agent. The Board of Trustees reserves full discretionary authority to interpret Plan language and to decide all claims or disputes regarding right, type, amount or duration of benefits, or claim to any payment from this Trust. The Administration Office shall apply the written provision of the Plan to claims, but does not have any discretionary authority to interpret Plan language. The decision of the Board of Trustees on any matter within its discretion shall be final and binding on all parties.

- (a) **FILING A CLAIM:** Participants and family members (hereinafter “claimants”) may initiate a claim for benefits by contacting the Administration Office and following the instructions given to access the benefit. An authorized representative may submit a claim on behalf of a claimant. In the case of a claim involving urgent care, a health care professional with knowledge of the claimant’s medical condition may act as the authorized representative of the claimant.
- (b) **NOTIFICATION OF FAILURE TO FOLLOW PLAN PROCEDURES:** If the claimant fails to follow the Plan’s procedures for filing a claim for benefits, the Administration Office will notify the claimant as soon as possible, but within 5 days following the failure, or if the claim is for urgent care, within 24 hours of the failure. This notification may be oral, unless the claimant or authorized representative requests it in writing.
- (c) **NOTIFICATION OF CLAIM DECISION:**
 - (1) **Time Limits and Requests for Additional Information.**
 - (A) **Urgent Care Claims:** The determination as to whether a claim involves urgent care is determined by the attending provider and the Plan defers to such determination. If a claim is for urgent care, the Administration Office will notify the claimant of its determination as soon as possible, but no later than 72 hours after receipt of the claim by the Administration Office. If the claimant fails to provide sufficient information to determine whether benefits are payable under the plan, then as soon as possible, but no later than 24 hours after receipt of the claim by the Administration Office, the Administration Office will notify the claimant what information is necessary. The claimant will have 48 hours to provide the specified information. The Administration Office will notify the claimant of its decision as soon as possible, but no later than 48 hours after the Administration Office’s receipt of the specified information.

- (B) Pre-service claims: If a claimant makes a claim for benefits before care has been provided to the Participant or family member but the claim is not urgent, the Administration Office will notify the claimant of its decision as soon as reasonably possible, but no later than 15 days after the Administration Office received the claim. The above 15-day time period may be extended for up to one additional 15-day period, but only due to matters beyond the Administration Office's control. If the Administration Office needs a 15-day extension, it will notify the claimant of the following: the reason for the delay; the expected date of decision; and any additional information the Administration Office needs to make the decision. If the Administration Office requires additional information, the claimant will have up to 45 days to provide the specified information. Once the specified information is provided, the Administration Office will notify the claimant of its decision within 15 days.
 - (C) Post-service claims: If a claimant makes a claim after care has been provided, the Administration Office will notify the claimant of its decision as soon as reasonably possible, but no later than 30 days after the Administration Office received the claim. The 30-day time period may be extended for one additional 15-day period, but only due to matters beyond the Administration Office's control. If the Administration Office needs a 15-day extension, it will, before the end of the first 30 day period, notify the claimant of the following: the reason for the delay; the expected date of decision; and any additional information the Administration Office needs to make the decision. If the Administration Office requires additional information, the claimant will have up to 45 days to provide the specified information. Once the specified information is provided, the Administration Office will notify the claimant of its decision within 15 days.
- (2) CONTENTS OF CLAIM DENIAL NOTICE: The Administration Office will provide the claimant with written notice if his or her claim for benefits is denied. If the claim involves urgent care, the information described below may be given orally, so long as a written notification is provided within three days after the oral notification. The notice will include the following information:
- (A) A statement of the specific reason(s) for the denial;
 - (B) Reference to the specific Plan provision(s) on which the denial was based;
 - (C) If the Administration Office's decision relied upon an internal Plan rule, guideline, protocol or similar criterion, either the specific rule, or a statement that the specific rule was relied upon and that a copy of such rule will be provided free of charge upon request;
 - (D) A description of any additional information or documents that the claimant will need to submit if he or she wants the claim to be reconsidered, and an explanation of why that information is necessary;
 - (E) A description of the Plan's appeal procedures, including any expedited appeal procedures available if it is a claim for urgent care benefits; and
 - (F) A statement of the claimant's right to bring a civil action under ERISA § 502(a), if the appeal is unsuccessful.

(d) APPEAL PROCEDURES:

- (1) The claimant may appeal any adverse action within the discretion of the Board of Trustees to the Board of Trustees. With respect to insured benefits and benefits administered by another entity, the Board of Trustees hears appeals only about eligibility issues, and does not hear appeals about unfavorable determinations by any Plan provider on matters within the provider's discretion. The Board of Trustees hears all appeals regarding self-administered benefits.
- (2) SUBMISSION OF APPEAL: Appeals must be in writing, and state in detail the matter or matters involved. To submit an appeal, the claimant must send a letter with any documents and information that he or she wants the Board to consider to the Administration Office.
- (3) TIME LIMITS: The deadline for submission of any appeal to the Board of Trustees is 180 days of receiving the denial of the original claim by the Administration Office. Failure to file an appeal within the 180-day period shall constitute a waiver of the claimant's right to the review of, and of

the claimant's objections to, the denial of his/her claim, whether or not the Plan is prejudiced by the failure.

- (4) **STANDARD FOR REVIEW:** The Board of Trustees has full discretionary authority to decide upon Plan benefits, to interpret the Plan language conclusively, and to make a final determination of the rights of any Participant, beneficiary, or other person with respect to Plan benefits. The Board of Trustees will take into account everything that the claimant submitted, including material that was submitted or considered in the initial benefit determination. The Board of Trustees will not give deference to the initial determination. Neither a person who made the initial determination nor such a person's subordinate shall have a vote in the decision on appeal. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment is Medically Necessary or appropriate, the Board of Trustees shall consult with a health care professional. The health care professional shall not have participated in making the initial benefit determination. The Board of Trustees shall, upon claimant's request, identify the health care professional, regardless of whether the Board of Trustees relied on his or her advice in making the decision.

- (5) **NOTIFICATION:**

(A) **TIME LIMITS FOR NOTIFICATION:**

- (i) **Urgent Care Claims:** The Administration Office will notify the claimant of the Board of Trustees' determination as soon as possible, but not more than 72 hours after receiving the claimant's request for an appeal.
- (ii) **Pre-Service Claims:** The Administration Office will notify the claimant of the Board of Trustees' determination as soon as possible, but not more than 30 days after receiving claimant's request for an appeal.
- (iii) **Post-Service Claims:** The Board of Trustees will render a decision on the appeal at the regularly scheduled meeting immediately following the filing of the appeal, unless the appeal is filed within 30 days of the meeting, in which case the decision may be made at the second meeting following the appeal.

If special circumstances (such as a need for a further hearing) require further extension, the decision will be made no later than the third meeting following the filing of the appeal. In such cases, the Administration Office will notify the claimant in writing of the extension, describing the special circumstances and the date the determination will be made, before the extension begins.

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

- (B) **CONTENTS OF NOTICE:** The Administration Office will send the claimant written notice of the Board of Trustees' decision on appeal. If the appeal has been denied, the notice will include the following information:

- (i) The specific reason(s) for the denial;
- (ii) Reference to the specific Plan provision(s) on which the denial is based;
- (iii) If the decision relied upon an internal Plan rule, guideline, protocol or similar criterion, either the specific rule, or a statement that the specific rule was relied upon and that a copy of such rule will be provided free of charge upon request;
- (iv) If the decision is based on a Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the Plan's terms to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

- (v) A statement that the claimant may view and receive copies of documents, records or other information relevant to the claim, upon request and free of charge; and
 - (vi) The claimant's right to bring a civil action under ERISA § 502(a).
- (6) **Time Limit for Bringing a Lawsuit:** No legal action may be commenced or maintained against the Trust or the Plan more than two (2) years after an appeal for benefits has been denied. No lawsuit may be filed without first exhausting the applicable appeal procedures in this Plan. In any such lawsuit, the determinations of the Board of Trustees are subject to judicial review only for abuse of discretion.
- (e) **Provisions Under the Affordable Care Act:** Effective January 1, 2012, in addition to the claims and appeal provisions above, the following provisions under the Patient Protection and Affordable Care Act (the "Act") are applicable to the Plan:
 - (1) An adverse benefit determination eligible for internal claims and appeals includes a rescission of coverage. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect. An adverse benefit determination eligible for internal claims and appeals also includes compliance with the surprise billing protections under the No Surprises Act.
 - (2) The Plan is required to provide you (free of charge) with new or additional evidence considered, relied upon, or generated by (or at the direction of) the Plan in connection with your claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for you to respond to such new evidence or rationale.
 - (3) The Plan must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to an individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.
 - (4) Notices must be provided in a culturally and linguistically appropriate manner and must include the additional requirements provided under the Act, including: (i) information sufficient to identify the claim involved; (ii) the diagnosis code and its corresponding meaning and treatment code and its corresponding meaning; (iii) a description of available internal appeals and external review processes and how to initiate an appeal; and (iv) the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act.
 - (5) If the Plan fails to strictly adhere to all the requirements of the applicable regulations under the Act as they pertain to your claim or appeal, you are deemed to have exhausted the Plan's internal claims and appeals process, regardless of whether the Plan asserts that it has substantially complied, and you may initiate any available external review process or remedies available under ERISA. However, the internal claims and appeals process will not be deemed exhausted based on de minimis violations.
 - (6) Certain adverse benefit determinations including those involving medical judgment (including but not limited to, those based on the plan's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; the Trustees' determination that a treatment is experimental or investigational; the Trustees' determination whether the plan is complying with the non-quantitative treatment limitation provisions of ERISA section 712 and § 2590.712), a rescission of coverage, and compliance with the surprise billing and cost-sharing protections under the No Surprises Act, are entitled to an external review. The Plan is required to pay the cost of an independent review organization (IRO) to conduct the external review. You are entitled to request an external review after receipt of an adverse benefit determination, in accordance with applicable regulations under the Act, as described below:

Standard External Review

(a) Request for External Review: You may file a request for an external review with the Plan within four months after the date of receipt of a notice of an adverse benefit determination of final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of a notice, then your request must be filed by the first day of the fifth month following the receipt of the notice. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

(b) Preliminary Review: Within five business days following the date of receipt of the external review request, the Administration Office will complete a preliminary review of the request to determine whether:

- (i) You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
- (ii) The adverse benefit determination or the final adverse benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;
- (iii) You have exhausted the Plan's internal appeal process; and
- (iv) You have provided all the information and forms required to process an external review.

Within one business day of completion of the preliminary review, the Plan will issue a notification to you or your authorized representative informing you whether your claim is eligible for external review. If your request is complete, but not eligible for external review, the notification will include the reasons for ineligibility and contact and support information from the Employee Benefits Security Administration. If the request is incomplete, the notification will describe the information or materials needed to make the request complete, and the Plan will allow you to perfect your request for external review within the four-month filing period or 48 hours of your receiving the notification whichever is later.

(c) Referral to Independent Review Organization: The Plan will assign an independent review organization (IRO) that is accredited to conduct an independent external review. The Plan uses three independent review organizations and rotates claims among them to ensure an independent review. The IRO will observe the following procedures:

- (i) The IRO will use legal experts where appropriate to make coverage determinations under the Plan.
- (ii) The assigned IRO will timely notify you of your claim's acceptance for external review. You will be given ten business days to submit additional information to the IRO and the IRO will consider that information in making a determination on your appeal. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.
- (iii) Within five business days after the date of assignment of the IRO, the Plan will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO will notify you and the Plan.
- (iv) Upon receipt of any information submitted by you, the assigned IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal

adverse benefit determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day of making such a decision, the Plan will notify you and the IRO and the IRO will then terminate the external review.

(v) The IRO will review all the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and will not be bound by any decision or conclusions reached during the Plan's internal claims and appeals procedure. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision: (a) your medical records; (b) the attending health care professional's recommendation; (c) reports from appropriate health care professionals and other documents submitted by the Plan, you, or your treating provider; (d) the terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law; (e) appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations; (f) any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law and (g) the opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(vi) The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the claimant and the Plan.

(vii) The assigned IRO's decision notice will contain: (a) a general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider; the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial); (b) the date the IRO received the assignment to conduct the external review and the date of the decision; (c) references to evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the decision; (d) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision; (e) a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or you; (f) a statement that judicial review may be available to you; (g) current contact information for the health insurance consumer assistance or ombudsman.

(viii) After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by you, the Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

(d) Reversal of the Board of Trustees' Decision: Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

- (a) Request for Expedited External Review: You will be permitted to make a request for expedited external review if you receive
- (i) an adverse benefit determination if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to gain maximum function and you have filed a request for an expedited internal appeal; or
 - (ii) a final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received Emergency Services, but have not been discharged from a facility.
- (b) Preliminary Review: Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request is eligible for external review and will immediately send you a notice regarding whether the claim is eligible for external review.
- (c) Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO for review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination of final internal adverse benefit determination to the assigned IRO electronically or by telephone or by facsimile or by any other expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decision or conclusion reached during the Plan's internal claims and appeal process.
- (d) Notice of final external review decision. The assigned IRO will provide notice of the final external review decision, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to you and the Plan.

2. Appeals to HMOs, Insurance Carriers, and Other Providers

If a claim for benefits is denied on grounds other than eligibility under the U.A. Local No. 393 Health and Welfare Plan, the claimant may submit an appeal to the insurance carrier or HMO, pursuant to the appeals procedures of the insurance carrier or HMO. Filing an appeal in a timely manner with an HMO, insurance company, or other provider is the sole responsibility of the claimant.

3. Special Claims and Appeal Procedures for Disability Benefits, Including Eligibility for Benefits Under Rule 9

Filing a Claim for Weekly or Supplemental Long Term Disability Benefits

1. To file a claim for Weekly or Supplemental Long Term Disability Benefits, you must submit a completed Disability Application Form, with proof of disability, to the Plan's Administration Office. The form must be submitted within a reasonable time of the onset of your disability. Along with the claim form, you may submit written comments, documents, records or other information relating to your claim. The Plan will provide you with

access to and/or copies of all documents, records and other information relevant to your claim, upon request and free of charge. An authorized representative may act on your behalf in filing a claim for disability benefits under this Plan

All claims and appeals pertaining to disability benefits (including eligibility for benefits under Rule 9) shall be adjudicated in a manner designed to ensure independence and impartiality of the persons involved in making the determination. Decisions covered by the authority of the Plan regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) making determinations with respect to disability benefits of the Plan will not be made based upon the likelihood that the individual will support the denial of benefits.

Notification Rules If Your Claim For Benefits is Denied

2. Time Limits and Requests for Additional Information. If your claim for disability benefits is denied, the Plan will notify you as soon as reasonably possible, but no later than 45 days after the Plan received your claim. That time period may be extended for up to two additional 30-day periods, but only due to matters beyond the Plan's control. If the Plan needs a 30-day extension, it will notify you, within 45 days of receiving the claim, of the following:
- (a) The reason for the delay,
 - (b) The expected date of decision,
 - (c) The basis on which the decision will be made,
 - (d) Any unresolved issues preventing a decision now, and
 - (e) Any additional information the Plan needs to make the decision.
- You will then have up to 45 days to provide the specified information. The Plan's response period will be extended by any additional time it takes for you to provide the requested information.

Contents of Notice

3. The Plan will provide you with written notice if your claim for disability benefits is denied. The notice will include the following information:
- (a) A statement of the specific reason(s) for the denial;
 - (b) Reference to the specific Plan provision(s) on which the denial was based;
 - (c) Either a copy of the specific internal rules, guidelines, protocols, standards or similar criteria of the Plan relied upon in making the decision or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;
 - (d) A discussion of the decision including an explanation of the basis for disagreeing with or not following the views of:
 - (1) a healthcare professional or vocation professional who treated or evaluated you;
 - (2) the views of healthcare professional or vocation professional consulted by the Plan during the claim determination; or
 - (3) any disability determination made by the Social Security Administration.
 - (e) If the determination is based on a Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
 - (f) A description of any additional information or documents that you will need to submit if you want your claim to be reconsidered, and an explanation of why that information is necessary;
 - (g) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
 - (h) A description of the Plan's appeal procedures. These will be found in a separate document, and must be followed if you wish to appeal the denial of benefits; and
 - (i) A statement of your right to bring a civil action under ERISA § 502(a), if your appeal is unsuccessful.

Appeal Procedures

4. Time Limits. If your claim for disability benefits has been denied, you may appeal the denial to the Board of Trustees. Appeals must be in writing. To submit an appeal, send a letter with any documents and information that you want the Board to consider, to:
U.A. Local No. 393 Health and Welfare Plan
c/o BeneSys Administrators
6293 San Ignacio Avenue
San Jose, California, 95119
For your appeal to be timely, you must submit your appeal within 180 days of receiving a denial of benefits. If you do not submit an appeal within 180 days of receiving a denial, you will be deemed to have waived your objection to the denial.
5. The Board of Trustees has full discretionary authority to decide upon Plan benefits, to interpret the Plan language conclusively and to make a final determination of the rights of any Participant, beneficiary, or other person with respect to Plan benefits.
6. Standard for Review. In deciding the appeal, the Board of Trustees will take into account everything that you submitted, even material that was submitted or considered in the initial benefit determination. The Board of Trustees will not give deference to the initial determination. Neither a person who made the initial determination nor such a person's subordinate will take part in the decision on appeal.
7. In deciding an appeal that is based in whole or in part on a medical judgment (including experimental, investigational, and Medically Necessary or appropriate decisions), the Board of Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The Board of Trustees will identify to you any medical or vocational experts whose advice was obtained by the Plan in connection with the decision, whether or not the advice was relied upon in making the decision. The health care professional consulted on appeal will not be an individual who was consulted in connection with the initial benefit denial, or such a person's subordinate.
8. Upon request and free of charge, you or your representative will be provided with or have reasonable access to all documents, records, and other information relevant to your claim for benefits.

Notification of the Board's Decision on Appeal

9. Time Limits. The Board of Trustees will render a decision on appeal at the meeting immediately following the filing of the appeal, unless the appeal is filed within 30 days of the meeting, in which case the decision may be made at the second meeting following the appeal.
10. If special circumstances (such as the need for a hearing) require further extension, the decision will be made no later than the third meeting following the filing of the appeal. In such cases, the Plan will notify you in writing of the extension, describing the special circumstances and the date that the determination will be made, before the extension begins.
11. The Plan will notify you of the decision as soon as possible, but no later than 5 days after the decision is made. The Plan's response period will be extended by any additional time it takes for you to provide the requested information.
12. Contents of Notice. The Plan will send you written notice of the Board of Trustees' decision on appeal. If your appeal has been denied, the notice will include the following information:
 - (a) The specific reason(s) for the denial;
 - (b) Reference to the specific Plan provision(s) on which the denial is based;
 - (c) Either a copy of the specific internal rules, guidelines, protocols, standards or similar criteria of the Plan relied upon in making the decision or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;
 - (d) A discussion of the decision, including an explanation of the basis for disagreeing with or not following the views of:
 - (1) a healthcare professional or vocation professional who treated or evaluated you;
 - (2) the views of healthcare professional or vocation professional consulted by the Plan during the claim determination; or
 - (3) any disability determination made by the Social Security Administration.

- (e) A statement that you may view and copy any documents, records or other information relevant to your claim, upon request and free of charge;
 - (f) If the decision is based on a Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the Plan's terms to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
 - (g) A description of any further appeal procedures, and your right to receive information about the procedures, and your right to bring a civil action under ERISA § 502(a) within two (2) years after the denial and the calendar date which the period to bring a civil action expires; and
 - (h) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance or managed-care regulatory agency."
13. The Administration Office shall automatically provide to you, free of charge, any new evidence or rationales, if any, as soon as possible and sufficiently in advance of the date on which the appeal determination is to be made in order to give you a reasonable opportunity to address the new evidence or rationale prior to that date. You shall have the right to review and respond to new evidence or rationales considered, relied upon or generated by the Plan in connection with your claim during the pendency of any appeal.
14. All notices and disclosures under this Section 3 shall be provided in a culturally and linguistically appropriate manner. The Administration Office will also provide customer service with oral language services in an Applicable Non-English language and provide written notices in the Applicable Non-English language upon request. An Applicable Non-English Language shall mean, with respect to an address in any United States County to which a notice is sent, a Non-English Language in an Applicable Non-English Language if ten percent or more of the population residing in the county is literate only in the same Non-English Language, as determined in guidance published by the U.S. Secretary of Labor.
15. Time Limit for Bringing a Lawsuit. No legal action may be commenced or maintained against the Trust or the Plan more than two (2) years after an appeal for benefits has been denied. In any such lawsuit, the determinations of the Board of Trustees are subject to judicial review only for abuse of discretion.

No lawsuit may be filed without first exhausting the appeals procedures in this Section 3 or showing that the Plan was not compliant with the above procedures, unless the Plan's action qualify as (i) de minimis; (ii) non-prejudicial; (iii) attributable to good cause or matters beyond the Plan's control; (iv) in context of an ongoing good-faith exchange of information; and (v) not reflective of a pattern or practice of non-compliance.

APPENDIX B: YOUR RIGHTS UNDER ERISA

As a Participant in the U.A. Local No. 393 Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan Participants are entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administration Office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administration Office copies of documents governing the operation of the plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administration office may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administration Office is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA Coverage rights.

Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA Coverage, when your COBRA 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.

Certificates of creditable coverage will be automatically provided by this plan, when coverage ceases. Certificates will also be provided upon request. To request a certificate of creditable coverage contact:

U.A. Local No. 393 Health and Welfare Plan
c/o BeneSys Administrators
6293 San Ignacio Avenue
San Jose, California 95119

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a health and welfare or vacation benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court, although your right to sue may be limited if you have not used the Plan's appeal procedures. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file 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 is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administration Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, which is the San Francisco Regional Office, 90 7th Street, Suite 11300, San Francisco, CA 94103 (415) 625-2481, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

APPENDIX C: RULES FOR COBRA COVERAGE

1. If you are an EMPLOYEE enrolled in this group health plan and you lose health coverage because of:
 - (a) A reduction in hours, or
 - (b) Termination of your employment through resignation, layoff, firing, retirement, strike or lockout, unless the cause of your termination was gross misconduct,then, except as provided in item 8 below, you and your eligible dependents are entitled to continue your health coverage by paying for it yourself for up to 18 months (or up to 29 months if you or one of your dependents are totally and permanently disabled when you lose coverage or within 60 days of losing coverage, and at the end of the first 18 months you (or your disabled dependent) qualifies for a Social Security Disability Award). For purposes of this rule, eligible dependent means any person who was an eligible dependent immediately before the Employee had a COBRA qualifying event, or a child who would have qualified as an eligible dependent but was born while the Employee was covered through COBRA.
2. If you are the SPOUSE OF AN EMPLOYEE who is enrolled in this group health plan, you are also covered by the plan, and you lose your coverage because:
 - (a) Your Spouse has died,
 - (b) You and your Spouse have divorced or legally separated, or
 - (c) Your Spouse loses coverage because of a reduction in hours or termination of employment as a result of resignation, layoff, firing, retirement, strike or lockout, or your Spouse qualifies for Medicare,then, except as provided in item 9 below, you are entitled to continue your health coverage by paying for it yourself for up to:
 - (1) 18 months: if your Spouse loses coverage because of a reduction in hours or termination of employment, or
 - (2) 36 months: if your Spouse dies or you and your Spouse divorce.
3. If you are the DEPENDENT CHILD OF AN EMPLOYEE enrolled in this group health plan, and you were covered by the plan, and you lose your coverage because:
 - (a) Your parent covered by the plan has died, or
 - (b) Your parent covered by the plan has lost his/her benefits because of a reduction in hours or termination of employment as a result of resignation, layoff, firing, retirement, strike or lockout, or
 - (c) You cease to be a dependent under the provisions of the plan (for example, you reach the maximum age under the Plan), or
 - (d) Your parent covered by the plan qualified for Medicare,then, except as provided in Rule 9 below, you are entitled to continue health coverage by paying for it yourself for up to:
 - (1) 18 months: if your covered Employee parent loses coverage because of a reduction in hours or termination of employment, or
 - (2) 36 months: if your covered Employee parent dies, or if you no longer qualify as a dependent under the terms of the plan.
4. Coverage of Spouse or Dependent of Medicare-Eligible Employees.

If an Employee becomes entitled to Medicare and no coverage is lost, but a later subsequent qualifying event occurs (such as loss of employment), the Spouse and each dependent child of the Employee are entitled to 36 months of COBRA coverage from the date the Employee becomes eligible for Medicare. If, during an 18-month COBRA coverage period, a former Employee becomes entitled to Medicare, the eligible Spouse or dependent children of the former Employee who are COBRA beneficiaries are entitled to continue their coverage for a total of 36 months from the date of the original qualifying event instead of the original 18 months.
5. Notice and Deadlines.
 - (a) You and your dependents must inform the plan administrator where you want the notices

regarding your COBRA rights sent. Notify the plan administrator whenever you or your dependents change address.

- (b) You must notify the plan administrator within 60 days after you lose coverage because of:
 - (1) Divorce or legally separate; or
 - (2) The end of a dependent child's eligible dependent status.
- (c) Your employer or you must inform the plan administrator in the event of an Employee's death.
- (d) The plan administrator will notify you of a qualifying event arising from the loss of coverage due to termination of employment, reduction of hours or Medicare eligibility.
- (e) After receipt of notice from you or your employer that a COBRA qualifying event has occurred the plan administrator will notify you of your rights and obligations for continuation coverage. You will be asked to choose between:
 - (1) Core coverage – medical, pharmacy and vision coverage only, or
 - (2) Core plus non-core coverage – medical, pharmacy, vision and dental coverage.Core plus non-core coverage will require a higher monthly charge than core coverage only.
- (f) You must make your first payment for continuation coverage retroactive to the date you lost coverage under the Plan, within 45 days after you have elected to self-pay, and you must make monthly payments thereafter by the 15th day of each month for the next month's coverage.

6. Automatic Coverage for Dependents of Covered Employees Choosing Continuation Coverage. When a covered Employee chooses to continue coverage, coverage for his or her Spouse and dependents will continue automatically unless the Spouse independently declines coverage. But, if a covered Employee chooses not to continue coverage, his or her Spouse and eligible dependents may still choose coverage. In all circumstances, anyone electing COBRA coverage must pay for it.

7. Transfer Rights.

If you are covered by a regional plan (like an HMO that covers a limited geographic area), and relocate to another area where the covered Employees' employer has an active workforce, you are entitled to elect the coverage available to active Employees working in that area. Under no circumstances would such a transfer prolong your applicable period of COBRA coverage.

8. Conversion Privilege.

At the end of the applicable continuation-of-coverage period, if you are covered under a Plan HMO, you may be entitled to enroll in an individual conversion plan provided by that HMO. You will be advised of this right if it applies to you.

Notwithstanding any other provisions of this Appendix:

- (a) The period of eligibility for benefits under COBRA Coverage for any individual will be reduced by the period of time during which the individual received other continuation coverage for which the monthly charge was equal to, or less than, the charge for the equivalent COBRA coverage, including but not limited to coverage provided under Formal Eligibility Rules 4(f), 9, 10, and 11; and
- (b) An individual's COBRA Coverage will terminate upon his or her becoming eligible for coverage under another group health plan without a pre-existing condition exclusion applicable to the individual, or upon the end of the application of a pre-existing condition exclusion to him or her.
- (c) An Individual Employer shall be deemed to have a qualifying event on the grounds of termination of employment only if the Individual Employer's company entirely ceases operations, or the Individual Employer totally severs all ties to the company.

GENERAL INFORMATION AND MAILING ADDRESS FOR THE PLAN

Plan Name: U.A. Local No. 393 Health and Welfare Plan

Type of Plan: The plan is a welfare benefit plan providing medical (including prescription drugs and vision), dental, disability, death, supplemental unemployment and dependent care FSA benefits.

Plan Number: The Plan Number is 501.

Employer Identification: 94-6401544

Plan Administrator: The Plan is administered by a joint Board of Trustees consisting of Employee Trustees appointed by U.A. Local No. 393 and Employer Trustees appointed by the participating Employer Associations. The Board of Trustees is assisted in the administration of the Plan by BeneSys Administrators, a third party Administrator.

Address of Plan Administrator: The address and telephone number of the Board of Trustees and the Trust Fund Office are:

U.A. Local No. 393 Health and Welfare Plan
c/o BeneSys Administrators
6293 San Ignacio Avenue
San Jose, California 95109

Address of PPO Network Administrator: Medical benefits are provided either through the self-funded indemnity plan, commonly known as the PPO Plan, or through one or more Health Maintenance Organizations selected by the Board of Trustees. The PPO Plan is administered by a contract administrator, BeneSys Administrators. The PPO network is contracted through Prudent Buyer Network, which is the only source of information about whether a provider participates in the Plan's preferred provider network. The address of Prudent Buyer Network is:

Prudent Buyer Network
P.O. Box 6007
Los Angeles, CA 90060-0007
(800) 688-3828
www.anthem.com/ca

Plan Sponsor: The Plan is sponsored by the Board of Trustees of the U.A. Local No. 393 Health and Welfare Plan.

Plan Year: January 1st through December 31st

Agent for Service of Legal Process: Kraw Law Group, APC at the address below. Legal process may also be served on any Trustee at his or her regular place of business or on the Administration Office.

Kraw Law Group, APC
605 Ellis Street, Suite 200
Mountain View, CA 94043

Board of Trustees: The U.A. Local No. 393 Health and Welfare Plan Board of Trustees consists of representatives of Employees from U.A. Local No. 393 and representatives of employers and the signatory employer associations. The current members of the Board are:

CONTACT INFORMATION

Employee Trustees

Eric Mussynski (Chairman)
Business Manager, U.A. Local Union 393
6299 San Ignacio Ave., San Jose, CA 95119

Frank Austin
U.A. Local Union 393
6299 San Ignacio Ave., San Jose, CA 95119

Karl Baumheckel
U.A. Local Union 393
6299 San Ignacio Ave., San Jose, CA 95119

Ed Nichols
U.A. Local Union 393
6299 San Ignacio Ave., San Jose, CA 95119

Employer Trustees

Alex Hall (Co-Chairman)
Executive Vice President, Northern California Mechanical
Contractors Association
6299 San Ignacio Ave., San Jose, CA 95119

James R. Lowder
President, All Temperature Service Air Conditioning Inc.
6299 San Ignacio Ave., San Jose, CA 95119

Susan Nichol
Executive Director, Silicon Valley Contractors
Association
6299 San Ignacio Ave., San Jose, CA 95119

Michael Vlaming
Executive Director, UMIC, Inc., Industrial Contractors
6299 San Ignacio Ave., San Jose, CA 95119

Greg Conn (Alternate Trustee)
VP Operations, Therma
6299 San Ignacio Ave., San Jose, CA 95119

CONTACT INFORMATION

ADMINISTRATION OFFICE

BeneSys Administrators
6293 San Ignacio Avenue, San Jose, CA 95119
(408) 588-3751

PLAN CONSULTANT

Mr. Brad Gates, Northwest Plan Services
160 West Santa Clara Street, Suite 1550
San Jose, CA 95113
(844) 629-1949

PLAN ACTUARY

Mr. Jason Birkle, Northwest Plan Services
160 West Santa Clara Street, Suite 1550
San Jose, CA 95113
(844) 629-1949

INVESTMENT CONSULTANT

Mr. Don Grijalva, Raymond James
575 Market Street, Suite 3900 San Francisco, CA 94105
(408) 533-9113

PLAN AUDITOR

Ms. Jessica Roster, Withum
5000 Executive Parkway, Ste 400, San Ramon, CA 94583
(925) 277 9100

LEGAL COUNSEL

Mr. George Kraw, Ms. Katherine McDonough, and
Ms. Stephanie Sorenson, Kraw Law Group, APC
605 Ellis Street, Suite 200 Mountain View, CA 94043
(650) 314-7800

COLLECTIONS COUNSEL

Mr. Matthew Minser, Esq.
Saltzman & Johnson Law Corporation
1141 Harbor Bay Parkway, Suite 100, Alameda, CA 94502
(510) 906-4710

Plan Funding & Collective Bargaining Agreement: The Plan is funded by contributions from employers who are signatory to, or members of an employer association which is signatory to, a Collective Bargaining Agreement with U.A. Local 393. The Plan is also funded in some cases by monthly payments by former Participants, former dependents, and individual employers. The amount of contributions required of signatory employers is determined by the Collective Bargaining Agreement. The Board of Trustees determines the amount of monthly payments of others from whom such payments are required. The DCS FSA Plan is funded by elective deferrals by Employees working for an employer signatory to a Collective Bargaining Agreement with U.A. Local No. 393.

U.A. Local No. 393 currently has Collective Bargaining Agreements with the following employer associations:

Industrial Contractors-UMIC, Inc. 447 Georgia Street Vallejo, CA 94590 (707) 552-6040	Northern California Mechanical Contractors Association P.O. Box 159 Benicia, CA 94510 (800) 640-5152	Silicon Valley Contractors Association 400 Reed Street, Suite 10 Santa Clara, CA 95050 (408) 727-5887
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A complete list of employers and employee organizations sponsoring the U.A. Local No. 393 Health and Welfare Plan may be obtained by Participants and beneficiaries upon written request, and is available for examination by Participants and beneficiaries.

The reserve assets of the fund are held in trust by a qualified bank, and managed by professional investment management companies.

Obtaining Copies Of Plan Documents: The following documents are available for examination or copying:

- Collective Bargaining Agreement calling for contributions to the Plan
- Detailed schedule of benefits of the Plan
- Any other document defining the benefits payable under the Plan
- Plan's procedures for determination of the qualified status of a medical child support order (QMCSO)

There may be a charge for copies of any document, except for QMCSO procedures or the detailed schedule of benefits, both of which are available for no charge. All requests for copies of documents must be in writing. Examination of documents will be allowed only upon reasonable notice, and only during normal business hours.

Supplemental Unemployment Benefit Plan (“SUB Plan”) SUMMARY PLAN DESCRIPTION

SUB Rule 1: Who is Eligible for SUB Benefits?

The following Participants, upon compliance with these SUB Rules, are eligible for the benefits available under the Supplemental Unemployment Benefit Plan (the “SUB Plan”):

- **Building Trades Employees:** Employees and former Employees of employers signatory to U.A. Local 393 Collective Bargaining Agreement who contributed to the SUB Plan.
- **Service Plumbers:** Building Trades Plumbing Service Journeyman and Apprentices working under the Northern California Refrigeration and Air Conditioning or the National Service and Maintenance Agreements
- **Residential Plumbers:** Employees working as a residential plumber for an employer signatory to a U.A. Local No. 393 Collective Bargaining Agreement.

Construction Tradesmen and MEST are not eligible to receive SUB Benefits.

SUB Rule 2: SUB Benefit Credit (“credit”)

This SUB Rule 2 only applies to Building Trades Employees and Service Plumbers. Residential Plumbers do not accumulate SUB Benefit Credits.

- (a) **Account:** A SUB Benefit Credit Account will be established for each eligible Employee for whom employer contributions have been made to the SUB Plan.
- (b) **Accrual Rate:**
 - (1) Each Employee will earn one (1) credit for performing, in any month, at least 40, but no more than 80, hours of employment requiring contributions to this Plan.
 - (2) A second credit will be earned for performing more than 80 such hours in any month.
- (c) **Maximum SUB Benefit Credit:** The maximum credit an Employee may accrue is 26 credits.
- (d) **Crediting Procedures:**

No credits are available for use until the Employee has accumulated 26 credits in a 24-month period. All credits earned prior to the 24-month period in which the Employee satisfied the 26 credit requirement are not eligible to be credited, and will be cancelled.
- (e) **Break in Contributions:**

After an Employee has accumulated 26 credits in a 24-month period, if the Employee suffers a break in contributions to this Plan of 60 months, all of his or her credits will be cancelled, and the Employee's account is subject again to SUB Rule 2(d) above.
- (f) **Use of SUB Benefit Credit:** One (1) credit will be cancelled (used) for each weekly SUB payment.

SUB Rule 3: Rules for drawing earned SUB Benefits

- (a) To be eligible to receive SUB Benefits, you must satisfy all four (4) of the following requirements:
 - (1)
 - (A) You must be receiving California State Unemployment Insurance benefits ("UI"); or
 - (B) You must satisfy the following requirements:
 - (i) You must have been laid off from your last employment, and provide written verification thereof from your employer;
 - (ii) You must have applied for UI and have been denied solely on the grounds of having insufficient earnings in your UI base contribution period, and you provide a copy of such denial of your UI claim; and
 - (iii) You must provide written verification from U.A. Local No. 393 that you are available for employment in the Plumbing and Pipefitting Industry.
 - (2) You must be both:
 - (A) **Unemployed.** However, you will not be considered unemployed if your unemployment was due to being expelled or terminated by the U.A. Local No. 393 Joint Apprenticeship training program for insubordination, bad behavior, misconduct, or delinquency. The

Board of Trustees have sole and absolute discretion in determining whether an individual is unemployed.

- (B) **Registered** on U.A. Local 393's Building Trades Joint Hiring Hall A, B, Apprentice, Residential or Plumbing Service out-of-work list continuously since your last covered employment .
- (3) Building Trades Employees and Service Plumbers must have accumulated 26 credits in accordance with SUB Rule 2(d), not thereafter suffered a break in service under SUB Rule 2(e) or had your credits cancelled under SUB Rule 6 or SUB Rule 7, and have at least one (1) credit remaining.
- (4) Residential Plumbers must have not depleted the once per lifetime 22-week benefit.
- (b) Notwithstanding SUB Rule 3(a), no SUB Benefits will be paid under the following circumstances:
 - (1) You will not receive SUB Benefits during the one-week waiting period for UI, or if you qualify under SUB Rule 3(a)(1)(B), for the first week after the termination of your last employment (your "SUB waiting period").
 - (2) You are not eligible for SUB Benefits if you are receiving Social Security, Workers' Compensation, State Disability Insurance, Disability or Paid Family Leave benefits of any kind from the U.A. Local No. 393 Health and Welfare Plan or pension benefits of any kind from the U.A. Local No. 393 Defined Benefit Pension Plan.
 - (3) You will not be eligible for partial weeks of unemployment (workshare). Notwithstanding the above, this subsection 3(b)(3) will not be effective for the period of January 1, 2024 through December 31, 2027.

SUB Rule 4: Amount of SUB Benefits

- (a) **Building Trades and Service Plumbers:** Until further action of the Board of Trustees, the weekly benefit amount for Building Trades and Service Plumbers is \$200.
- (b) **Residential Plumbers:** The weekly benefit amount for a Residential Plumber is \$100 for up to 22 weeks. Once a Residential Plumber has exhausted this once per lifetime 22-week benefit, there is no ability to requalify for further residential SUB Benefits. A Residential Plumber will not be eligible for the residential SUB Benefit for any week he or she has contributions paid on his or her behalf.

SUB Rule 5: How to apply for SUB Benefits

- (a) **Initial Claim:** You must apply for SUB Benefits, in writing, within 180 days from the end of the covered week as printed on the California State Unemployment Insurance ("UI") check stub or 180 days following your receipt of a successful appeal with the Employment Development Department ("EDD"), whichever is later. If you fail to submit your SUB Benefit Application within that deadline, your SUB payment starting date will be the date your written SUB Benefit Application is received, and all SUB Benefits for a preceding period will be lost.
- (b) **Continuing Claims:** Subsequent SUB Benefit Applications for continuing claims must be filed within 180 days from the end of the covered week as printed on the California State Unemployment Insurance ("UI") check stub or 180 days following your receipt of a successful appeal with the Employment Development Department EDD, whichever is later. If you fail to file a continuing claim within that deadline, your claim will be considered a new claim, with the starting date the date your continuing claim is received, and all benefits for a preceding period will be lost.
- (c) Filing must be in writing and mailed to the Administration Office with the proper forms and check stubs, in accordance with SUB Rule 5(a) and 5(b) above. SUB Benefit Applications are available from the Administration Office (www.ualocal393benefits.org), or you may call (408) 588-3770 to request one.
- (d) The following is necessary in order to file the initial claim for benefits:
 - (1) You must complete and sign a SUB Benefit Application.
 - (2) You must complete and sign an IRS Form W-4.
 - (3) You must submit a copy of your UI check stub.
- (e) A continuing claim requires only a copy of your UI check stub, with your name, address and telephone number.

SUB Rule 6: Termination for Cause

- (a) If an Employee performs any employment of the type covered by a Collective Bargaining Agreement with U.A. Local 393 for any employer not signatory or otherwise party to an agreement with U.A. Local 393 (without the approval of U.A. Local 393) or engages in such business for his or her own account without being party to such an agreement, then the eligibility of the Employee will be terminated and his or her SUB Benefit Credit Account will be cancelled as of the date of commencement of such employment.
- (b) An Employee's SUB Benefit Credit Account will be cancelled in the event he or she refuses to leave employment after being notified in writing that his or her employer is not paying contributions to the SUB Plan.
- (c) An Employee's SUB Benefit Credit Account will be cancelled if the Employee knowingly participates with his or her employer in paying less than the full hourly contracted rate of wages and/or SUB Plan contributions for every hour worked by him or her.
- (d) An Employee whose SUB Benefit Credit Account is cancelled under this SUB Rule 6 will have his or her credits calculated under SUB Rule 2(b) as if he or she was a new Employee, starting with the first hour of covered employment after the misconduct.

SUB Rule 7: Fraud

If an eligible Employee commits a fraud against the Plan, any SUB Benefit Credit Account will be cancelled and he or she will be permanently barred from having an account and from receiving any SUB Benefits from this Plan. For purposes of this Plan, fraud includes, but is not limited to:

- (1) filing a false claim for SUB Benefits; and
- (2) continuing to draw SUB Benefits after he or she starts working, including working in self-employment or as an Employee of another person or company, regardless of whether he or she is paid or not.

SUB Rule 8: Reservation of Rights

The Board of Trustees reserve the right to amend any provision of the SUB Plan.

Dependent Care Assistance Flexible Spending Account Plan (“DCA FSA”) SUMMARY PLAN DESCRIPTION

Introduction

This Dependent Care Assistance Flexible Spending Account Plan (“DCA FSA”) allows you to pay for eligible dependent care expenses with pretax dollars. The U.A. Local No. 393 Health and Welfare Plan allows Employees who enroll to contribute some of their hourly wage, before withholding for federal income, Social Security (FICA) and most state taxes, to the DCA FSA. The contributions can be used to pay for eligible dependent care expenses, such as day care, preschool, or after-school care. The Plan is intended to qualify as a Dependent Care Flexible Spending Account under Sections 106, 125, and 129 of the Internal Revenue Code (“the Code”), as amended, and the Treasury Regulations thereunder.

Summary of How the Plan Works

- You must enroll by submitting a DCA FSA Election Form with U.A. Local 393 that specifies how much you would like contributed to your DCA FSA, subject to the IRS limits.
- You pay your dependent care expenses as usual. You will need to keep receipts and other documentation of expense.
- After the dependent care has been provided, you submit a Reimbursement Request Form with receipts to the Administrative Office. All claims for the Plan Year must be submitted by April 15th of the following year.
- The Administrative Office will process your reimbursement claim for the amount of the claim or, if less, the amount remaining in your DCA FSA. See the Submitting A Claim Section for more details.
- The IRS requires that all money contributed to your DCA FSA in a Plan Year (January 1st – December 31st) be used in that Plan Year or the Grace Period (through March 15th of the following year). Any money remaining in your DCA FSA will be **forfeited**. It is very important when you enroll, you make your contribution decision based on a careful estimate of the dependent care expenses you will incur during the Plan Year.
- If a claim reimbursement request is denied, you can appeal to the Board of Trustees by submitting a written appeal within 180 days of receiving the denial notice. Once the Board hears your appeal, their determination will be sent to you no later than 5 days after the decision is made. If your appeal is denied, you have a right to bring a civil action under ERISA § 502(a). No legal action may be commenced or maintained against the Trust or Plan more than two (2) years after an appeal for benefits is denied. In any such action, the determinations of the Board of Trustees are subject to judicial review only for abuse of discretion.

The DCA FSA is a way to save money (taxes) while taking care of your family so that you can continue to work.

Who Can Enroll and Open Enrollment

You are eligible to enroll in the DCA FSA if you are not a 1% or more owner of a participating employer and you meet the criteria of either (1) or (2) below:

- (1) (a) you are working for an employer who makes contributions to the U.A. Local 393 Health and Welfare Plan pursuant to the U.A. Local 393 Master Labor Agreement **and**
(b) you are eligible for coverage under the U.A. Local No. 393 Health and Welfare Plan; or
- (2) (a) You are an officer or an Employee of U.A. Local No. 393 or an Employee of the Lloyd E. Williams Pipe Trades Training Center **and**
(b) you previously worked under the U.A. Local 393 Master Labor Agreement or another Collective Bargaining Agreement benefitting pipefitters and related classifications.

Open Enrollment: In November before the beginning of each Plan Year (January 1st – December 31st) there will be an open enrollment period during which an Employee may submit a DCA FSA Election Form with U.A. Local 393 that specifies the hourly amount to be deferred to the Employee’s DCA FSA. This form must be completed annually and can be found at www.ualocal393.org/fringe-benefits.

Special Enrollment Periods to Revoke or Change your Election

The Board of Trustees, at their discretion, may establish special enrollment periods during the Plan Year where you can revoke or change your contribution election. However, your contribution election cannot be revoked or changed

during the Plan Year unless during the Plan Year you have one of the following events which affects your eligibility for benefits under this Plan:

- (1) a change in your marital status because of marriage, death of Spouse, divorce or legal separation, or annulment;
- (2) a change in the number of your qualifying dependents because of birth, death, adoption or placement for adoption;
- (3) a change in your or your Spouse's employment status because of termination or commencement of employment, strike or lockout, a commencement or return from an unpaid leave of absence;
- (4) your dependent either satisfies or ceases to meet the definition of Qualified Dependent defined below.

You may also change or revoke your election during the Plan Year if

- (1) you demonstrate, to the satisfaction of the Trustees a significant increase or decrease in the cost of dependent care imposed by a provider who is not your relative;
- (2) you change your child care provider during the Plan Year; or
- (3) there is a change in the number of hours of care provided by your child care provider.

If you first become eligible under the U.A. Local No. 393 Health and Welfare Plan after open enrollment for the Plan Year and otherwise meet the requirements for enrollment, you may still enroll by submitting the DCA FSA Election Form to U.A. Local 393 within sixty (60) days of your initial eligibility under the U.A. Local No. 393 Health and Welfare Plan. Contributions will be deducted for hours worked starting in the month following when the form is submitted to U.A. Local 393.

The hourly amount specified on the DCA FSA Election Form will be deducted from your wages and sent to the Plan on a pretax basis (before federal, state, and Social Security (FICA) taxes). The specified hourly contribution will be deducted until the IRS maximum contribution limit is reached.

Please note that it could take several pay periods before the elections are entered in your employer's payroll system.

Warning! *This is a use it or lose it benefit!*

It is very important when you enroll, you make your contribution decision based on a careful estimate of the dependent care expenses you will incur during the Plan Year because you will **forfeit** amounts contributed to the Plan that are unused at the end of the Plan Year or the Grace Period.

Contribution Limits

There is no minimum contribution limit. The maximum contribution limit is determined by the IRS, and subject to change. The maximum that can be contributed is the lesser of:

- \$7,500 per Plan Year (January 1st – December 31st), this is reduced to \$3,750 if you are married but file separate tax returns
- Your total earned income
- Your Spouse's total earned income

In general, the maximum contribution limits are the same regardless of the number of dependents you have, and whether you are single or married. If your Spouse is also eligible to participate in another dependent care flexible spending account, your combined contributions should not exceed the maximum contribution limit.

If your Spouse is incapable of self-care or is a full-time student and you claim one dependent, his or her earned income is considered to be \$250 per month (\$3,000 per year). If your Spouse is incapable of self-care or a full-time student and you claim two or more dependents, your Spouse's earned income is considered to be \$500 per month (\$6,000 per year).

Qualified Dependents

The Plan can only reimburse eligible dependent care expenses for Qualified Dependents as defined under Section 129 of the Code. A Qualified Dependent includes:

- Your child under age 13 in your custody, whom you claim as a dependent on your tax return;
- Your legal Spouse who is physically or mentally incapable of self-care and who lives with you at least half the year; and
- Your dependent age 13 or older who lives with you, is physically or mentally incapable of self-care, and whom you claim as a dependent on your tax return.

If care is provided outside of your home for your legal Spouse or dependent age 13 or older, the Spouse or dependent must live in your home at least eight (8) hours each day.

Divorced Individuals: If you are divorced and you are the custodial parent, your child is a Qualifying Dependent even if you do not claim the child as a tax dependent. A divorced, non-custodial parent cannot be reimbursed under this Plan, even if the divorced non-custodial parent claims the child as a tax dependent.

Eligible Dependent Care Expenses

Eligible Dependent Care Expenses, as defined by Section 129 of the Code, can be reimbursed by the Plan. Eligible Expenses must meet the following requirements:

- The expense must be for a Qualifying Dependent, defined above, and be necessary so that you (and your Spouse, if married) can work or look for work (you must have income during the year). Or, if your Spouse is not working or seeking work, he or she must be a full-time student or incapable of self-care.
- If care is provided by a day care center, the center must charge a fee. If the center cares for six or more dependents who don't reside there, it must comply with all state and local licensing laws and applicable regulations.
- The Eligible Dependent Care Expense must be incurred during the Plan Year (January 1st – December 31st) or the Grace Period (through March 15th of the following year). You incur expenses when the care is provided, not when you are billed or when you pay for the care.

Examples of Eligible Dependent Care Expenses for Qualifying Dependents:

- Before and after school care
- Preschool and nursery school expenses
- Extended day programs
- Au pair and nanny services (the amount paid for the care of the dependent)
- Babysitting expenses (in and outside your home)
- Summer day camp
- Elder day care expenses

Examples of ineligible dependent care expenses:

- Overnight camp
- Expenses attributable to a disabled Spouse or tax dependent living outside your household
- Tuition for Kindergarten or above
- Food expenses, unless inseparable from care
- Incidental expenses, such as extra charges for events or activities, unless inseparable from care
- Educational expenses
- Amounts paid to your Spouse, your child under age 19, a parent of your child who is not your Spouse, or a person for whom you or your Spouse is entitled to claim as a dependent on your tax return

Submitting A Claim

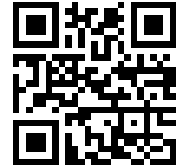
To submit a claim, you must file a Reimbursement Request Form with receipts to the Administration Office. You can file online, via the App or by mail. If you file by mail, please use the paper claim form posted at www.ualocal393benefits.org.

Online: <https://fundoffice.lh1ondemand.com>

App: BeneSys Member Reimbursement

Mail paper claim form and receipts to:

U.A. Local No. 393 DCA FSA
c/o BeneSys Administrators
P.O. Box 2460
San Jose, CA 95109



If the expense is an Eligible Dependent Care Expense for a Qualified Dependent, the Administration Office will send you reimbursement for the amount of the claim or, if less, the amount remaining in your DCA FSA. If your expenses are not clearly Eligible Dependent Care Expenses, the Administration Office may ask you for additional information to determine whether reimbursement is allowed. Please notify the Administration Office if you want to receive reimbursement through direct deposit.

DCA FSA Claim Filing Deadline

All claims for the Plan Year must be submitted by **April 15th** of the following year. For a copy of the Reimbursement Request Form, contact the Administrative Office at: (408) 588-3751.

***Warning! This is a
use it or lose it
benefit!***

Unused Monies at the End of the Plan Year

The IRS requires that all money contributed to your DCA FSA in a Plan Year (January 1st – December 31st) be used in that Plan Year or the Grace Period (through March 15th of the following year). Any monies remaining in your DCA FSA at the end of the Grace Period are **forfeited** to the Plan.

Annual Statement

Annually, on or before January 31st, the Plan will send each enrolled Employee a written statement showing the Employee's contributions to the Plan and the Eligible Dependent Care Expenses reimbursed by the Plan in the previous Plan Year. You can also check your balance and claim history online at <https://fundoffice.lh1ondemand.com> or via the App.