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

SUMMARY PLAN DESCRIPTION
November 1, 2019

Introduction Local 393 Benefits

At a Glance

Health and Welfare Plan

Local 393's Health and Welfare Plan provides the following coverages:

- Medical benefits through your choice of the following plans:
  - Preferred Provider Organization (PPO), or
  - Health Maintenance Organization (currently Kaiser Permanente HMO)
- Drug and alcohol abuse treatment
- Dental benefits
- Disability income
- Paid Family Leave
- Vision Benefits

Also included are explanations of:

- How to enroll yourself and dependents
- How to use Basic Reserve Account and other options to retain eligibility

Supplemental Unemployment Benefit Plan (SUB)

SUB is designed to add to your State Unemployment Insurance benefits when you are laid off.

This Booklet

This booklet contains the summary plan description of your benefits under the Health and Welfare Plan and the Supplemental Unemployment Benefit Plan (SUB). It has been written to help you receive those benefits for which you are eligible.

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

The Board has authorized BeneSys Administrators and the members' advocate to respond in writing to your written questions. If you have a question about your benefits, you should write to BeneSys Administrators or the members' advocate for a definitive answer. To obtain an accurate answer, you will need to provide complete and accurate information about your situation.

As a courtesy to you, the members' advocate or BeneSys Administrators may also respond informally to oral questions. Oral information and answers are not binding upon the Board and cannot be relied on in any dispute concerning your benefits.

Please note that the precise benefits provided under the Plans are defined by the Formal Plan and provider contracts. These documents are available for inspection at BeneSys Administrators, and copies of these documents are available, at no cost in some cases, or at a reasonable copying cost in other instances.

Contact BeneSys Administrators for further information. If there is any conflict between the summaries in this booklet and the Plans' Formal Rules or contracts, the Formal Rules and the contracts will be followed.

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Section 1 Medical Benefits

Medical benefits from the Local 393 Health and Welfare Plan pay toward the covered health care bills of you and your enrolled family members. Doctor, hospital, surgery, prescription drug, ambulance, and many other medical services and supplies are included.

Choice of Two Medical Plans

The provider of your medical care will be one of two health care options:

- Preferred Provider Organization Plan (PPO) or
- Health Maintenance Organization (HMO)

You choose which option is right for you and your eligible dependents. You will find access to nearly every type of medical service and supply through either option. The major differences are these:

- PPO provides more flexibility in *choice* of doctors, hospitals, specialists, and laboratories than HMO.
- Your share of costs will be higher with PPO than with HMO.

For You and Your Family

You may enroll in either PPO or HMO when first eligible for Local 393's Health and Welfare Plan. (If your application does not specify an option, your choice will be considered to be HMO). You have 90 days from the date you become eligible for benefits to submit an enrollment form and switch to PPO. You may transfer from plan-to-plan as often as once a year. Enrollment is described in more detail on page 68 of this booklet.

All eligible family members are covered in the same option that you choose for yourself, if they are properly enrolled. No benefits are payable for any person who is not properly enrolled.

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 Fund 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 had Creditable Coverage under a group health plan or MediCal 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 Fund Office.
Retiree Medical/ Dental Coverage	Medical and dental coverage continues for qualified members into retirement. At age 65, retirees become eligible for Medicare supplemental coverage from PPO or HMO.
Details About PPO and HMO	The details about PPO start on page 5 and the details about HMO on page 41.

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TIPS ON GETTING STARTED

To enroll for medical benefits from Local 393's Health and Welfare Plan:

- Read about PPO, starting on page 5. Read about HMO, starting on page 41.
- Choose which option is right for you.
- Obtain and complete enrollment forms for PPO or HMO from BeneSys Administrators.

Then, select a PPO physician or an HMO facility:

- If PPO, review the Anthem Blue Cross website of preferred providers. (www.anthem.com/ca) Hundreds of names of doctors, hospitals, and laboratories will be listed. The Plan pays more of the cost when you select preferred providers from the Prudent Buyer Network. You pay more when you select someone not in the Prudent Buyer Network. Names are added and dropped from the Network each year. To inquire about someone not currently listed, call the Plan's administrative service: BeneSys Administrators at (408) 588-3751, or check with Prudent Buyer Network at 1-800-688-3828.

- If HMO, review the Kaiser Permanente booklet of approximately 150 HMO hospitals and medical centers. Select the Kaiser Permanente medical center most convenient for you and establish a relationship with a doctor there who will coordinate your health care needs throughout the Kaiser Permanente system. The Plan pays nearly all costs for services obtained from or at the recommendation of your Kaiser Permanente physicians. The Plan pays no costs for services obtained elsewhere (except in emergencies).

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TIPS ON ENROLLING IF PPO IS YOUR CHOICE

Complete the Local 393 Health and Welfare Enrollment Form. Attach copies of:

- Marriage Certificate
- Birth Certificate for yourself and each dependent
- Legal adoption/guardianship/foster care documents, if applicable
- Medical child support orders, if applicable

If you are enrolling in PPO, you must file an enrollment form with the Fund Office and select PPO. Any time you change anything regarding your enrollment, such as moving, marrying, divorcing, or acquiring a new dependent, contact BeneSys Administrators at (408) 588-3751 right away so that your enrollment forms can be updated within 31 days.

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TIPS ON MAKING BEST USE OF PPO

To receive maximum benefits from PPO:

Select a doctor from the Prudent Buyer Network directory of PPO providers. These doctors are in private practice in their own offices throughout the local geographic area. All have agreed to charge no more than the contract rate for providing care to PPO members.

If you do not know any of the doctors, ask friends for recommendations or ask for interviews with one or more of the Prudent Buyer Network physicians. Find out if the physician in whom you are interested practices at a hospital that is listed in the Prudent Buyer Network directory.

Allow one of the PPO providers to serve as your "family doctor" for the entire family. Alternatively, you may select a different primary care physician for each enrolled family member. For example, women may prefer a gynecologist and children a pediatrician as their primary care physicians. The value of a primary care physician is having someone to call for advice for regular care, phone-in prescriptions, and after-hours urgent care.

Visit or call your Primary Care Physician first for all medical care. Each time you need medical care, start by visiting or calling the primary care physician you select from the Prudent Buyer Network provider directory. The visit will usually be covered at 90%, after the yearly deductible. Lab tests will be covered at 100%, if they are performed by a PPO lab facility.

Change Primary Care Physicians whenever you like. The choice of PPO physicians is entirely up to you, but it is always best to have a primary care physician to call for advice or referrals.

Ask Your Primary Care Physician's advice before seeing a specialist or entering the hospital. Because the specialist or hospital may need information from your primary care physician, it is recommended that you permit your primary care physician to arrange for all services and supplies, including laboratory tests, x-rays, specialists, surgery, and hospitalization. Remind your doctor that you are part of the PPO network and prefer a laboratory, specialist, or hospital that is listed in the Prudent Buyer Network directory.

Going Out-of-Network costs you more. While you are free to go outside the network to obtain medical services and supplies on your own, the cost of services goes up. PPO will pay only 60% of the usual, customary, and reasonable (UCR) charges for bills from non-network providers.

The important point to keep in mind is that your best health care buys occur when you start your medical care with a primary care physician from the PPO list of providers and obtain in-network specialist and hospital referrals from the primary care physician.

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AVOID PPO BENEFIT REDUCTIONS!
USE EMERGENCY ROOM FOR MEDICAL EMERGENCIES ONLY

PPO discourages you from using emergency rooms for complaints -- even for urgent care -- that can be treated by your primary care physician. That's because the cost of treatment in a hospital emergency department is significantly higher than in a doctor's office. PPO reserves emergency benefits for acute and severe conditions that in the opinion of the Board of Trustees could, if medical attention is not provided *immediately*:

- Permanently damage the patient's health, or
- Result in serious medical problems or impairment to bodily functions, or
- Result in serious and permanent dysfunction of any bodily organ or part.

For medical needs that do not meet one or more of the above conditions, contact your primary care physician. When you use the emergency room for a non-emergency, you will pay the first $100 of ER charges and 40% of the balance. Normal PPO benefits will be reduced from 90% to 60%.

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TIPS ON REDUCING REJECTED MEDICAL CLAIMS

Be aware that not every medical service or supply is covered. The Plan does not pay toward services and supplies that are not covered or are not medically necessary.

- PPO members, refer to the Not Covered list on page 29.
- HMO members, refer to the Not Covered list in the booklet issued by Kaiser Permanente.

Follow the rules for emergency care:

- PPO members, see section titled "What to Do in an Emergency" on page 25.
- HMO members, refer to emergency care section in the Kaiser Permanente booklet.

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• About PPO

Preferred Provider Organization Plan

If you enroll, PPO pays benefits when you or your enrolled family members become ill or injured and require medical care.

To help keep you well and promote early detection of disease, PPO pays for checkups, health screenings, and mammograms. It also covers the cost of smoking cessation and alcohol and drug abuse rehabilitation programs.

Who Can Be Covered By PPO

If you enroll yourself, also enroll your dependents. See Section 4 for details on enrolling in the Health and Welfare Plan. It is important to enroll new dependents within 31 days after you acquire them, and to drop children from coverage once they cease to qualify as your eligible dependents in the Plan.

Neither you nor your dependents will be covered until you or they are properly enrolled. Follow the checklist on page 2 to be sure you produce the necessary proofs of age, marriage, adoption, divorce, or qualified medical child support orders, to keep your enrollment current. If you need help with documentation, contact BeneSys Administrators.

How PPO Works

In PPO, you have a choice in determining your level of benefits. When you or an enrolled family member needs medical care, you can choose a "preferred provider" from the Prudent Buyer Network booklet and receive generous benefits, generally 90% of the bill after the deductible.

Or, you may visit a doctor or hospital outside the "preferred provider" network. In that case, PPO generally will pay 60% of the usual, customary and reasonable charge from the non-PPO provider after the deductible.

Example:
An Office Visit

Suppose the contract amount for a doctor's visit to a "preferred provider" is $100, while the usual, customary and reasonable amount charged by a nearby non-PPO doctor is $125.

Assuming you had already satisfied the deductible, PPO will pay $90 of the "preferred provider's" bill (90% X $100), and you will pay $10 (10% x $100).

Of the non-PPO doctor's bill, PPO will pay $75 (60% x $125), and you will pay $50 (40% x $125).

$100 PPO Visit	$125 Non-PPO Visit
You pay $10	You pay: $50 (40% x $125)

• Save Money

Use Preferred Providers

PPO is a self-funded plan of Local 393. There is no insurance company paying the part of the bill that you don't pay. That payment responsibility falls to the Plan. Every dollar spent for medical care and plan administration comes out of the Plan, so every dollar you save benefits you and your brothers and sisters of Local 393 and their families.

To save you and your brothers and sisters of Local 393 money, the Board of Trustees has contracted with Prudent Buyer Network and the hundreds of physicians, hospitals, laboratories, and other medical providers listed in the Prudent Buyer Network directory. They have agreed to charge no more than "contract rates" for their respective services to members of Local 393 who enroll in PPO.

Non-Preferred Providers Cost More

While you are free to go outside the network to obtain medical services and supplies on your own, the Plan's reimbursement rate drops from 90% to 60% of usual, customary and reasonable charges.

Select Providers From Prudent Buyer Network Directory

The Prudent Buyer Network provider directory includes a selected group of hospitals, laboratories, hospices skilled nursing facilities, home health care agencies, and other providers throughout Northern California. The provider directory is available online (www.anthem.com/ca).

To know whether a particular doctor or provider is in the network, or to nominate a doctor for inclusion in the network, call BeneSys Administrators at (408) 588-3751 or contact Prudent Buyer Network at 1-800-688-3828.

It is your responsibility to find out whether a provider you have selected is part of the most current Prudent Buyer Network preferred provider list. When in doubt, call BeneSys Administrators at (408) 588-3751.

• The Deductible

The Deductible

The deductible is the "first dollar" amount you pay out-of-pocket each year before your PPO benefits become available. The deductible amount for each person covered by PPO is **$300** per year. However, PPO contains several provisions that limit the number of deductibles you have to pay. You must satisfy the applicable annual deductible requirement before benefits are paid out for you or your dependent's behalf.

Example:
Individual $300 Deductible

Member's doctor bill in January:	$ 350
Member pays the first $300 as the year's deductible	- 300
Remainder:	$ 50
PPO pays 90%	- 45
Member pays 10%	$ 5
Total paid by member ($300 + $5)	$ 305

Since the deductible ($300) has been met, the Plan will continue to pay toward the member's eligible medical bills for the rest of the year.

Member's doctor bill in February:	$ 300
PPO pays 90%	-270
Member pays 10%	$ 30

$600 Family Deductible – When your family members are covered under PPO, **$600** is the maximum your family pays in any one year. In other words, once $600 in deductible expenses have been paid by the family, no further deductibles need to be paid in that year. The $300 or $600 maximum deductibles do not include the required $100 special deductibles for hearing aids or for care in an emergency room that does not qualify as emergency care.

Example:
$600 Family Deductible

For a family of three or more PPO enrollees, the $600 family deductible can be satisfied by combining the family's eligible expenses. No family member's share of the deductible can be more than $300.

Family Member	Initial Expenses Of Year	Expenses Counted Toward Family Deductible
Father	$ 550	$ 300
Mother	200	200
Son	175	100
Daughter	0	0
Total	**$ 925**	**$ 600**

The family deductible has been satisfied. The $250 in the father's expenses that did not count toward the family deductible, plus all future expenses for the entire family until the end of the calendar year, will be eligible for PPO payments.

If you and your spouse are both employees with a Basic Reserve Account, the combined annual deductible for both of you is $300. The maximum family deductible of $600 shall apply.

Supplementary Accident Expense Benefit – The Plan will pay 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.

Common Accident Provision – There is a special deductible provision if two or more enrolled family members are injured in the same accident. No deductible will be applied to the first $600 in covered charges to treat injuries resulting from the accident if those charges are incurred within 90 days of the accident. After the initial $600 of covered charges, only one deductible of $300 will be required for all injured family members, even if those family members have not yet satisfied their individual deductible for the year.

Expenses That Do Not Count Toward Deductible

Expenses that are excluded from payment by PPO cannot be used to satisfy the deductible.

Example:
Excluded Expenses Don't Satisfy Deductible

Member's health spa bill in January	$500
PPO rate of reimbursement	0%
(health spa excluded from coverage)	
Member pays 100%	$500
Portion of payment that counts toward deductible	$ 0

Expenses Not Subject To Deductible

For certain medical care, PPO begins to pay from the "first dollar" of expense, with no deductible. For example:

- If two or more covered persons in the same family are injured in the same accident, no deductible will be applied to the first $600 in covered charges to treat injuries resulting from the accident if those charges are incurred within 90 days of the accident. After the initial $600 of covered charges, only one deductible of $300 will be required for all injured family members, even if those family members have not yet satisfied their individual deductible for the year.

- Routine physical exams. The Plan pays 100% of the contracted Preferred Provider Rate (or UCR for non-PPO providers).

- Prescription Drugs. The Plan pays all but the applicable copay, before and after the deductible.

- Vaccinations of enrolled family members, except for travel, are paid at 100%, with no deductible.

- Smoking Cessation benefits within certain quantity limits when provided by programs approved by PPO. Check with BeneSys Administrators for more information; non-PPO providers are not covered.

- 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.

• Copayments

Overview

Copayments are the share of the cost of a health care service that you are responsible for paying after the deductible.

For care from a preferred provider, PPO generally pays 90% of the contract rate, and you pay 10%. Your 10% share is your copayment. Your copayments for care from a preferred provider count toward the annual-out-of-pocket maximum.

For care from a non-PPO provider, PPO pays only 60% of the usual, customary and reasonable charge and you pay 40%. ***Your copayments, plus any extra amount you pay above usual, customary and reasonable charges, do not count toward the annual out-of-pocket maximum.***

Prescription Drugs: When you use a RxEDO pharmacy (or Costco for mail-order), 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. Effective January 1, 2015, this co-payment will count toward the out-of-pocket maximum.

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 maximum

Your benefits will be reduced to 60% and a supplementary deductible of $100 will apply if you use emergency services for anything other than a medical emergency. No deductibles, copayments, or payments for charges in excess of the contract rate will be counted toward the out-of-pocket maximum.

If you limit your medical care to PPO providers from the Prudent Buyer Network, your out-of-pocket expenses will be substantially lower because there will be no charges higher than the contract rates, and the Plan will pay a higher percentage of the approved charges.

• The Most You Pay For PPO (Stop-Loss Benefit)

Annual Limit

To help protect you against catastrophic medical costs, PPO provides out-of-pocket protection.

This means that the most you will have to pay for eligible medical expenses from PPO providers each calendar year is $1,800 per enrolled person.

Once the out-of-pocket maximum is reached, your copayments are eliminated, and PPO begins to pay 100% of the covered expenses that you formerly shared through copayments.

Payments Counting Toward the Out-of-Pocket Maximum

- Bills from PPO-Providers: The 10% copayments you make on the "contract rate" bills from PPO providers.
- When you use a RxEDO pharmacy (or Costco for mail-order), 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. Effective January 1, 2015, this co-payment will count toward the out-of-pocket maximum.

Payments Not Counting Toward the Out-of-Pocket Maximum

- **All payments made to a Non-PPO Provider, including all of the 40% copayment to Non-PPO Providers.**
- Extra payments to non-PPO providers for charges higher than usual, customary, and reasonable rates.
- 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 maximum.
- Deductibles, copayments or payments for changes in excess of the contract rate will not be counted toward the out-of-pocket maximum if you use emergency services for anything other than a medical emergency.
- Payments in excess of the $350.00 per day maximum benefit payable for out-of-network ambulatory surgery centers.

None of the expenses above are subject to payment by the Plan, even after the out-of-pocket maximum has been met.

PPO Providers Save You Money

You will reach your stop-loss limit more quickly if you use PPO Providers from the Prudent Buyer Network.

Example 1
$1,800 Maximum Using PPO Provider

Suppose you are seen for a broken leg by a **PPO provider** and the bill, determined by BeneSys Administrators to be within the contract rate, is $15,300. If this is your first medical bill of the year, you will pay the first $300 as your deductible and this will count toward the maximum you will pay.

PPO contract rate fee: $15,300
-**300 deductible paid by you (deductible counts toward the maximum you will pay).**
$15,000 remaining

The remaining $15,000 will be shared 90-10 by the Plan and you, with the Plan paying 90% ($13,500) and you paying 10% ($1,500).

Remaining fees after deductible: $15,000
X 90%
$13,500 paid by the Plan
$ 1,500 paid by you

Your total copayment this illness: $1,500.

Your copayment, $1,500 with the $300 deductible, satisfies the $1,800 out-of-pocket maximum. Approved care for the rest of the calendar year will be covered at 100%.

Suppose you have an additional $5,000 in approved medical expenses that are within contract rates. Since you've satisfied the deductible and the out-of-pocket maximum, the Plan pays 100%.

Using Non-PPO Providers Costs More

Using a Non-PPO provider costs you more. If the provider charges more than the usual customary and reasonable rate, you pay the difference. The Plan's payment rate drops from 90% to 60% of the usual, customary, and reasonable charges. You pay the difference. Your payments do not count toward the out-of-pocket maximum.

Example 2
Copayments Using Non-PPO Provider

Suppose you had received the care described above from a **non-PPO provider**, who charged $13,750. Suppose the Plan recognized as usual, customary and reasonable (UCR) only $12,750 of the charges.

You will pay the extra $1,000 above the UCR charge.

Non-PPO Provider Charge	$13,750
UCR Charge	-$12,750
Difference	**$ 1,000 paid by you**
Remaining	$12,750
	- 300 deductible paid by you
	$12,450 remaining

The remaining $12,450 will be shared 60-40 by the Plan and you, with the Plan paying 60% ($7,470) and you paying 40% ($4,980).

Remaining fees after deductible: $12,450
X 60%
$ 7,470 paid by the Plan
$ 4,980 paid by you

Your total copayment this illness: $**4,980** (40% X $12,450)

Copayment counting toward out-of-pocket maximum:	$0 (for Non-PPO Provider)

• AFFORDABLE CARE ACT

This Plan is compliant with the Affordable Care Act. This means that dependent children are covered until the end of the calendar month in which the child reaches age 26, your out-of-pocket expenses will never exceed limits set by the Affordable Act, all PPO preventive care as defined by the Affordable Care Act is covered at no cost to you, and there are no annual or lifetime limits on Essential Health Benefits (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). Note that this Plan uses the Utah Benchmark to determine what is an Essential Health Care Benefit.

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Usual, Customary and Reasonable Charges from Non-PPO Providers

Charges from PPO providers are already discounted for you, because they were negotiated by Local 393 as part of its PPO network services.

Charges from non-PPO providers who do not have a negotiated rate with PPO or are located outside the Prudent Buyer Network area must meet the Plan's "usual, customary and reasonable" (UCR) standard in order to be fully covered. You are responsible for paying any charges that exceed usual, reasonable and customary.

Charges are considered "usual, customary and reasonable" if they fall within the range generally charged by health care providers in the providers' area of service. For a Medicare-eligible participant, UCR cannot exceed the Medicare limit for that service or supply.

Would you like to know whether the cost of a treatment or service you are considering from an out-of-network provider is usual, reasonable and customary? Call BeneSys Administrators at (408) 588-3751 for assistance. The call can save you money, because you are responsible for any charges that are not usual, customary and reasonable.

To assist BeneSys Administrators in evaluating whether charges for a procedure are usual, customary and reasonable, you should provide the medical name of the procedure to be performed, the proposed charge, and the providers' zip code. This information should also appear on your provider's bill.

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Questions About Whether a Service Is Covered Or How Much the Plan Pays?

The Plan Administrator maintains the complete schedule of PPO benefits. If you have a question about whether a medical service or supply is covered and how much the Plan pays in benefits for that service or supply, call BeneSys Administrators at (408) 588-3751.

• Services Covered 100% With No Deductible

- **PPO Preventive Care as Defined by the Affordable Care Act including**

Preventive Health Services for Adults
Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
Alcohol Misuse screening and counseling
Aspirin use to prevent cardiovascular disease for men and women of certain ages
Behavioral interventions for weight management for adults with a BMI of 30 kg/m² or higher
Blood Pressure screening for all adults
Cholesterol screening for adults of certain ages or at higher risk
Colorectal Cancer screening for adults over 50
Depression screening for adults
Diabetes (Type 2) screening for adults with high blood pressure
Diet counseling for adults at higher risk for chronic disease
Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over, living in a community setting

Hepatitis B screening for people at high risk
Hepatitis C screening for adults at increased risk, and one time for everyone born 1945–1965
HIV screening for everyone ages 15 to 65, and other ages at increased risk
Immunization vaccines for adults--doses, recommended ages, and recommended populations
Diptheria
Hepatitis A
Hepatitis B
Herpes Zoster
Human Papillomavirus
Influenza (Flu Shot)
Measles, Mumps, Rubella
Meningococcal
Pneumococcal
Tetanus, Diphtheria, Pertussis
Varicella

Obesity screening and counseling for all adults
Statin preventive medication for adults 40 to 75 at high risk
Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
Syphilis screening for all adults at higher risk
Tobacco Use screening for all adults and cessation interventions for tobacco users
Tuberculosis screening for certain adults without symptoms at high risk

Preventive Health Care for Women
Anemia screening on a routine basis for pregnant women
Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer
Breast Cancer Mammography screenings every 1 to 2 years for women over 40
Breast Cancer Chemoprevention counseling for women at higher risk
Breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
Cervical Cancer screening for sexually active women
Chlamydia Infection screening for younger women and other women at higher risk

Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs).
Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before

Domestic and interpersonal violence screening and counseling for all women
Folic Acid supplements for women who may become pregnant
Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
Gonorrhea screening for all women at higher risk
Hepatitis B screening for pregnant women at their first prenatal visit
HIV screening and counseling for sexually active women
Human Papillomavirus (HPV) DNA Test every 3 years for women with normal cytology results who are 30 or older
Osteoporosis screening for women over age 60 depending on risk factors
Preeclampsia prevention and screening for pregnant women with high blood pressure

Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
Sexually Transmitted Infections counseling for sexually active women
Syphilis screening for all pregnant women or other women at increased risk
Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
Urinary tract or other infection screening for pregnant women
Well-woman visits to get recommended services for women under 65

Preventive Care For Children
Alcohol and Drug Use assessments for adolescents
Autism screening for children at 18 and 24 months
Behavioral assessments for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
Bilirubin concentration screening for newborns

Blood Pressure screening for children at the following ages: 0 to 11 months, 1 to 4 years , 5 to 10 years, 11 to 14 years, 15 to 17 years.
Blood screening for newborns

Cervical Dysplasia screening for sexually active females
Depression screening for adolescents
Developmental screening for children under age 3
Dyslipidemia screening for children at higher risk of lipid disorders at the following ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
Fluoride Chemoprevention supplements for children without fluoride in their water source
Fluoride varnish for all infants and children as soon as teeth are present

Gonorrhea preventive medication for the eyes of all newborns
Hearing screening for all newborns
Height, Weight and Body Mass Index measurements for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
Hematocrit or Hemoglobin screening for children
Hemoglobinopathies or sickle cell screening for newborns
Hepatitis B screening for adolescents at high risk,
HIV screening for adolescents at higher risk
Hypothyroidism screening for newborns

Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:

Diphtheria, Tetanus, Pertussis
Haemophilus influenzae type b
Hepatitis A
Hepatitis B
Human Papillomavirus
Inactivated Poliovirus
Influenza (Flu Shot)
Measles, Mumps, Rubella
Meningococcal
Pneumococcal
Rotavirus
Varicella
Iron supplements for children ages 6 to 12 months at risk for anemia

Lead screening for children at risk of exposure
Maternal depression screening for mothers of infants at 1, 2, 4, and 6-month visits

Medical History for all children throughout development at the following ages: 0 to 11 months, 1 to 4 years , 5 to 10 years , 11 to 14 years , 15 to 17 years.
Obesity screening and counseling
Oral Health risk assessment for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.
Phenylketonuria (PKU) screening for this genetic disorder in newborns
Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
Tuberculin testing for children at higher risk of tuberculosis at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.\
Vision screening for all children.

The list of preventive services covered at 100% in-network with no deductible changes periodically. You can find an up-to-date list at https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=3

- **Low Level Laser Therapy** up to $750 annual maximum, with no deductible or other coinsurance.
- **Flu Shots**, including the H1N1 vaccination for participants and their eligible dependents.
- **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 other coinsurance.

• Services Covered 100% After Deductible

After the deductible, PPO pays 100% of the contract rate for:

- Laboratory tests and radiology (see page 25); (except services required to be covered with no deductible under the Affordable Care Act) (or 60% of usual, customary, and reasonable fee if local non-PPO lab or radiologist).

• Services Covered at 90% After Deductible

After the deductible, PPO pays 90% of the contract rate for services of PPO providers, or 60% of usual, customary, and reasonable fee of non-PPO providers for:

Inpatient Care

- Surgery and anesthesiology, whether in or out of the hospital. (However, if the anesthesiologist or the radiologist is not a PPO doctor, then benefits will be paid at 90% of the lesser of the billed rate or the UCR charge for such services).
- Ambulatory surgery center (non-PPO maximum $350 per day including non-PPO providers at PPO facilities)
- Bariatric surgery – once per lifetime
- Blood or blood plasma
- Hospital room and board, up to the semi-private room rate
- Stays in a hospital's intensive care department
- Medications provided during a covered hospitalization
- Treatment in a hospital outpatient department.
- Inpatient hospital care
- Inpatient rehabilitative care
- Maternity care (including delivery and Caesarean section) only those services not required to be covered at 100% under the Affordable Care Act will be covered at the 90% level)
- Mental and nervous conditions (see page 22)
- Nursery charges and doctor expenses for newborns from date of birth
- Organ transplants (see page 29)
- Physician visit
- Surgeon/assistant surgeon
- Skilled nursing facility

Outpatient Care

- Acupuncture (Up to $500 per year)
- Alcohol and Substance Abuse Treatment
- Allergy testing
- Ambulance (see page 17)
- Chiropractic Care (Up to $1500 per year for up to 26 visits per year)
- Durable medical equipment
- Emergency Care if qualified emergency. Substantially less if not (see page 25)
- Home Health Care: 100 visits per calendar year
- Maternity care (only those services not required to be covered at 100% under the Affordable Care Act will be covered at the 90% level)
- Mental health services
- Outpatient surgery (Ambulatory surgery centers have a non-PPO maximum $350 per day including non-PPO providers at PPO facilities)
- Physician care
- Physical Therapy/Occupational Therapy: Combined limit of up to 20 visits per year; Up to10 additional visits may be approved if determined

by the Plan's Independent Medical Consultant to be medically necessary.

- Pre-certified Percutaneous lumbar discectomy
- Prenatal/Postnatal office visits (only those services which are not required to be covered at 100% under the Affordable Care Act will be covered at the 90% level)
- Rehabilitative therapy (physical, speech)
- Speech therapy for dependent children under the age of 6 who have not enrolled in elementary school (including kindergarten)

Covered Licensed providers include

- Physician
- Surgeon
- Assistant surgeon
- Psychologist
- Psychiatrist
- Anesthesiologist
- Physiotherapist
- Radiologist
- Qualified speech therapist
- Chiropractor
- Registered nurse
- Licensed practical nurse (LPN)
- Any other individual licensed to perform the services payable under the Plan which are within the scope of his or her license

Ambulance Service

Ambulance service by a professional ambulance service, railroad, or commercial airliner for medically necessary transport of an enrolled family member. Transport must be from the place where need for hospitalization arises for covered treatment of an injury or illness to the nearest hospital equipped to treat such illness or injury or with the approval of the Plan for movement from a non-PPO facility to a PPO hospital or facility.

Drugs and Medicines

Drugs or medicines administered by a doctor or ordered in writing and provided through RxEDO or covered under Medicare.

Blood

Blood or blood plasma which has not been replaced on the covered person's behalf.

Medical Supplies

- Medical supplies, including (but not limited to):
    - Bandages, surgical dressings and other surgical supplies
    - Braces (except dental), casts, splints and trusses
    - Drugs and medicines while confined in a hospital
    - Artificial limbs or eyes, including the services of an orthotist and prosthetist for evaluation or fitting when required to support or correct a defect of form or function of a permanently inoperative or malfunctioning limb or

eye. No benefits are payable for repair or replacement caused by misuse or loss of device.

- Dialysis equipment rental or purchase, and dialysis supplies.
- Rental or purchase of other medical equipment and supplies which are ordered by a doctor. No benefits are paid for rental charges which exceed the reasonable purchase price.

Equipment and supplies, including for dialysis, must be manufactured specifically for medical use, usable only by the patient, and of no further use when medical need ends. They cannot be intended primarily for the patient's comfort or hygiene, or for exercise or control of environment, or for prevention purposes.

If an eligible person obtains medical equipment or supplies 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 BeneSys Administrators.

Free-Standing Surgical Facility
Surgery in a free-standing surgical facility for medical care that would have been covered if it had been performed in a hospital inpatient setting. Note that there is $350.00 per day maximum benefit payable for out-of-network ambulatory surgery centers (including out-of-network providers at in-network facilities).

Certain Cosmetic Surgery
Cosmetic surgery by a licensed physician for treatment of participant or eligible dependent of any age due to accidental injury or for an eligible dependent child whose treatment is for a congenital anomaly (birth defect).

Certain Dental Treatment
Dental treatment for a participant or eligible dependent due to accidental injury to natural teeth when treatment begins within 90 days to one year after the accident, and dental surgery for non-periodontal disease, injury to the jaw or facial bones, removal of cysts, leukoplakea or malignant tissue, correction of harelip, cleft palate, or protruding mandible, or freeing of muscle attachment.

Women's Services

- Midwife services when services are performed by a legally-certified nurse mid-wife or qualified registered nurse practitioner
- Maternity care for an enrolled wife or daughter, including pregnancy, childbirth, and related conditions, except elective abortion. 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 issuer for prescribing a length of stay not in excess

of 48 hours (or 96 hours). (only those services not required to be covered at 100% by the Affordable Care Act, will be covered at 90%)

- **Women's Health and Cancer Rights Notice:** Mastectomy when medically necessary, and, if elected, breast reconstruction or surgery and reconstruction of the other breast to produce a symmetrical appearance. Also covered are prostheses and physical complications at any stage of mastectomy, including lymphedemas.

Podiatry

Podiatry (including the surgical treatment of toe nails), or medical care of the feet, except for treatment of weak, strained or flat feet, imbalance of foot, metatarsalgia, bunion, treatment of corns, calluses, non-surgical treatment of toenails and orthopedic shoes or other supporting devices for the feet. Open cutting operation of metatarsalgia or bunion, or for a partial or complete removal of nail roots are covered.

Speech Therapy

Services of a qualified speech therapist for restoratory or rehabilitory speech therapy for speech loss or impairment that is the result of an illness or necessary after surgery to correct a congenital anomaly for an eligible dependent child under age 6 and not yet in elementary school (including kindergarten).

Erectile Dysfunction

Surgical implants provided as treatment for erectile dysfunction for eligible Employees, Individual Retirees, Dependent Spouses and Domestic Partners shall be covered at 90% of the applicable contract preferred provider rate if:

- The surgical implant is provided by a PPO provider
- The individual has exhausted all available treatment options before receiving the surgical implant
- The surgical implant is pre-authorized by the Plan's independent medical reviewer as medically necessary.

Erectile dysfunction drugs remain covered under the terms described in the Plan's prescription drug program.

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% of 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 benefit. Transgender services are subject to prior authorization in order for coverage to be provided.

Other
Emergency care (see page 25).
Hospice care (see page 26).

• Services Covered at 80% After Deductible

After the deductible is paid, the Plan pays 80% of the PPO contract rate (or 60% of UCR of non-PPO providers) for:

- Hearing aids (see page 26), after a separate $100 deductible is paid, up to $1,500 per device as medically necessary.

• Wellness Benefit and Well-Baby Care

PPO Wellness Benefit

Effective as of January 1, 2012, 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 recommendations of the United States Preventive Services Task Force with respect to the individual involved; (See page 13 for a list of services included)
- 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).
- Other preventive care and screenings for women in guidelines supported by the HRSA, including:

  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.

Well-Baby Care 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 60% of the UCR (after the applicable deductible) for non-PPO providers) in the first two years of life.

Smoking Cessation 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.

• Remote Services

- **24/7 NurseLine** is a toll-free number where registered nurses are on-call to answer health-related questions for participants and eligible dependents in the language of their choice. The dedicated toll-free

number is **1-866-670-1565.** This benefit is covered 100% and is not subject to the annual deductible.

- **LiveHealth Online** is an online service using webcams for a virtual consultation with doctors and psychiatrists, who can diagnose, recommend, and prescribe medication for non-emergency medical & behavioral health issues. There is a $20 copay for each visit. This benefit is not subject to the annual deductible.

• Treatment for Alcoholism, Drug Abuse, And Mental/Nervous Conditions

PPO Benefits

PPO provides benefits for inpatient and outpatient treatment of alcoholism, drug abuse, and/or chemical dependency.

Detoxification

When a participant or eligible dependent needs detoxification, PPO pays 90% of the applicable contracted Preferred Provider rate for PPO Providers or 60% of UCR charges for non-PPO providers, after the annual deductible is paid. Detoxification treatment must be pre-authorized by the Plan's PPO provider.

Beat It!
1-800-828-3939

Hospital and Outpatient Treatment of Alcoholism, Drug Abuse

You and your enrolled family members (in both PPO and Kaiser) are eligible for alcohol, drug, and chemical dependency treatment through Beat It. The covered individual, employer or family member may call a toll-free number to refer a family member or self. The number is (800) 828-3939. Within 24 hours, a confidential meeting will take place to discuss the case and follow up with inpatient or outpatient services.

After the annual deductible is paid, benefits are payable for residential treatment and outpatient care of alcohol and/or substance abuse at the following rates:

1. First Course of Treatment: 100% for residential treatment or outpatient care provided by Beat It! or 60% of the UCR rate for residential treatment or outpatient care provided by non-PPO providers.

2. Additional Courses of Treatment: 90% for residential treatment or outpatient care provided by Beat It! or 60% of the UCR rate for residential treatment or outpatient care provided by non-PPO providers.

Hospital and Outpatient Treatment of Mental/Nervous Conditions

When treatment is received as an inpatient at a PPO hospital or qualified treatment facility, PPO pays 90% of the applicable contracted Preferred Provider rate after the annual deductible is paid. When treatment is received as an inpatient at a non-PPO hospital or treatment facility, PPO pays 60% of the UCR charges, after the annual deductible is paid. Inpatient treatment includes residential treatment. for mental and nervous conditions.

For outpatient care, PPO pays 90% of the applicable contracted Preferred Provider rate for PPO providers or 60% UCR charges for non-PPO providers after the annual deductible is paid.

Mental or nervous disorder 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. The symptoms may also appear by physical manifestations, such as headaches, sweats, trembling, nausea, hysterical paralysis, or a combination.

Plan limitations or exclusions of treatment of mental disease or disorder apply to the treatment of all conditions meeting this definition.

Examples of qualifying mental or nervous diseases or disorders are those which fall within the diagnosis codes 290 through 290.9, or 293 through 301.9, or 306 through 316 of the International Classification of Diseases, 9th Revision, Clinical Modification, Volumes 1 and 2.

To inquire about other diagnosis codes that qualify, call BeneSys Administrators in advance at (408) 588-3751.

• Prescription Drugs

Under PPO you can purchase prescription drugs two ways:

1. Go to any RXEDO participating pharmacy.

Go to any RXEDO participating pharmacy. Call BeneSys Administrators at (408) 588-3751 or RXEDO at 1-888-879-7336 for the names of participating pharmacies in your area.

To use a RXEDO pharmacy, just show your prescription card. If you're buying prescriptions for other enrolled members of your family, you must show their prescription cards. You should carry copies of your prescription card at all times.

You pay a copayment in accordance with the chart below at the time of purchase for a 34-day supply. There is no medical claim form to file and no deductible to satisfy.

34-Day Retail Co-Payments	
Generics	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
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

Prescriptions filled over-the-counter are limited to a 34-day supply.

2. Use the Costco Mail Order Drug Program

Use the Costco mail order drug program for 90-day supplies of maintenance medications. To get started in the Costco Mail Order program, please use one of the following options to get your order quickly and conveniently.

1. Log on to www.pharmacy.costco.com to register for an account, complete a patient profile and place order.

2. Call toll free at 1-800-607-6861 – A Costco associate will be able to give you the necessary information to get started in the mail order program.

3. If you are an existing Costco Mail Order Pharmacy patient, it is not necessary to create a new account. Prior to requesting your order, please log into your account to verify and update insurance, payment, and shipping information.

If you have any questions on how to get started using Costco Mail Order/Online Pharmacy, please visit www.pharmacy.costco.com or contact the pharmacy at 1-800-607-6861; Monday - Friday 5am – 7pm (PST) and Saturday 9:30am – 2pm (PST). Maintenance medication is any prescription drug that is taken for an ongoing medical condition. You will pay a copayment in accordance with the chart below:

90 Day Mail Order Co-Payments	
Generics	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
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

Generic vs. Brand Name Drugs. When you use a RxEDO pharmacy (or Costco mail-order), 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 co-payment will count toward the out-of-pocket maximum effective January 1, 2015.

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 maximum

No Other Pharmacies or Non-PPO Claims. PPO pays no benefits toward the cost of prescription drugs that are filled outside the two methods described above.

Questions about pharmacy benefits. The Board of Trustees has delegated to RxEDO the responsibility for appeals concerning prescription drug benefits. For questions, assistance, or appeals, contact RxEDO at the number or addresse listed above.

Erectile Dysfunction Drugs Prescription treatment of Erectile Dysfunction will be covered if pre-authorized by the Plan's designated pharmacy benefit manager and determined to be medically necessary. Such prescription treatment shall be limited to six tablets per 30 days.

Growth Hormone Drugs Growth Hormone Prescription Drug treatment will be covered to treat dependent children who have been diagnosed with Idiopathic Short Stature, provided it is determined to be medically necessary by an independent medical consultant other than the treating Doctor and is pre-authorized by the Board of Trustees. The prescription drug treatment shall be limited to a one-year supply. Annual extensions may be granted at the discretion of the Board of Trustees after a determination by the plan's independent medical consultant that the treatment continues to be medically necessary.

• Laboratory Services

Lab 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.

• What To Do in an Emergency

Medical Emergency If you have a **medical emergency**, go to the nearest emergency facility for treatment. If it is a PPO hospital or emergency facility, the Plan will pay 90% of the contract rate. If it is a non-PPO provider, the Plan will pay the greater of 90% of the UCR charges, 90% of the applicable contracted preferred provider rate or 90% of the amount that would be paid under Medicare up to the applicable Out-Of-Pocket limit, counting the member's share towards the Out-Of-Pocket limit. After the Out-Of-Pocket limit has been reached, the Plan pays 100% of the applicable rate.

Your benefits will be reduced to 60% and a supplementary deductible of $100 will apply if you use emergency services for anything other than a **medical emergency**. No deductibles, copayments, or payments for charges in excess of the contract rate will be counted toward the out-of-pocket maximum.

PPO defines a **medical emergency** as a situation in which a sickness or injury could reasonably expect to be life-threatening or cause serious harm to bodily functions, organs, or parts, or permanently damage the person's health unless treated *immediately*. Examples are:

- Convulsions
- Apparent heart attacks
- Severe bleeding from cuts or wounds
- Severe allergic reactions to food, drugs, or insect bites
- Loss of consciousness

- Severe difficulties in breathing
- Sprains
- Fractures
- Injuries requiring stitches

If you receive emergency care at a PPO hospital, but are treated by a non-PPO doctor, the Plan will pay up 90% of the lesser of the billed rate or the UCR charge for such service.

For routine sicknesses or injuries that require medical attention, go to your doctor's office or call your primary care physician. He or she will advise whether your condition is a medical emergency requiring immediate care in an emergency facility.

• Hospice Care

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 (6) months.

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 care 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.

Benefits Payable

Please contact the Fund Office to determine whether a particular hospice facility is a PPO provider:

- For hospice care provided by Preferred Providers, the Plan pays 90% of the provider's contracted rate, after the applicable deductible.
- For hospice care provided by non-PPO providers, the Plan pays 60% of the Usual, Customary, and Reasonable charges after the applicable deductible.

• Hearing Care; Hearing Aids, And Vision Care

Routine Hearing Exams

Routine hearing exams are covered at 90% of the contract rate for PPO providers of one hearing exam per ear each calendar year. EPIC Hearing Healthcare and Costco are now preferred providers.

EPIC
Please contact EPIC toll free at 866-956-5400 for more information about the EPIC hearing services program and to locate an Epic hearing services provider near you.

COSTCO
Please visit https://www.costco.com/hearing-aid-center.html to learn more about the Costco hearing aid center and find the Costco hearing center location nearest you.

Hearing Aids

After you pay a deductible of $100 per device, the Plan pays 80% of the cost of a device (or 60% of UCR for non-PPO providers), up to a maximum benefit of $1,500 per device. The Plan covers one device per ear as medically necessary.

EPIC Hearing Healthcare and Costco are now preferred providers of hearing aids.

EPIC
Please contact EPIC toll free at 866-956-5400 for more information about the EPIC hearing services program and to locate an Epic hearing services provider near you.

COSTCO
Please visit https://www.costco.com/hearing-aid-center.html to learn more about the Costco hearing aid center and find the Costco hearing center location nearest you.

Vision Care

Vision care is provided through a contract with VSP. Below is a summary of the benefits with VSP.

VSP Exhibit
U.A. Local 393 Funds
Group #30036513

Copay	$10 Exam/$25 Materials Copay
Exam Every:	12 Months
Lenses Every:	12 Months
Frame Every:	24 Months
Diabetic EyeCare Plus	$20 per visit
VSP PROVIDER	
Examination	Covered after copay
Contact Lens Exam (Fitting & Evaluation)	Standard and Premium fit: Covered in full after copay. Member receives 15% off of contact lens exam services; member's copay will never exceed $60
Lenses:	
Single Vision	Covered after copay
Lined Bifocal	Covered after copay
Lined Trifocal	Covered after copay
Lenticular	Covered after copay
Copay on Lens Options:	The most popular lens options are covered-in-full with a copay, saving our members an average of 20-25%.
Frames	$150.00
Elective Contact Lenses*	$130.00
Necessary Contact Lenses	Covered after copay
	*Contact Lenses are in lieu of spectacle lenses and frames once every 12 months
NON-VSP PROVIDER	
Examination	$45.00
Lenses:	
Single Vision	$30.00
Bifocal	$50.00
Trifocal	$65.00
Lenticular	$100.00
Frames	$70.00
Elective Contact Lenses*	$105.00
Necessary Contact Lenses	$210.00
	*Contact Lenses are in lieu of spectacle lenses and frames once every 12 months

• Organ Transplants

Coverage under PPO or Medicare Supplemental Plan

Organ Transplants are covered on the same basis as any other illness, under the PPO or Medicare Supplemental Plan, if the Plan's Medical Consultant and the Plan's PPO provider determine that the procedures are medically necessary. If your doctor determines that you need an Organ Transplant, please contact BeneSys Administrators immediately at (408) 588-3751 so that they can have the Plan's Medical Consultant and PPO Provider begin their review. There is no non-PPO coverage for Organ Transplant.

After the deductible, the PPO will pay 90% of the contract rate for the procedures for PPO providers.

Your 10% copayments for PPO providers count toward the annual out-of-pocket maximum.

• Treatment Outside U.S. And Canada

First 60 Days Of Travel Only

Charges for services and supplies provided outside the United States and Canada are covered the same as any out-of-area expenses, provided they were incurred during the first 60 days of travel. Coverage for stays longer than 60 days require approval of the Board of Trustees.

• Services Not Covered by PPO

Overview

While almost every medical service and treatment is covered by PPO, certain exclusions do apply. The Plan does not cover charges that exceed the "contract rates" for PPO providers or the "usual, customary and reasonable" rate for non-PPO providers. In addition, the Plan does not cover charges or recognizes any deductible or out-of-pocket maximum you make for:

- Hospital care, surgery or other medical treatment found to be unnecessary.
- Services and supplies:
    - For the treatment of a work-related injury or illness for which coverage is provided under Workers' Compensation;
    - For treatment in a Veteran's Hospital unless the treatment is of an emergency nature, and the patient is not a veteran;
    - For treatment outside the U.S. and Canada after the first 60 days of travel, unless specifically approved;
    - For treatment of injury or illness resulting from an act of war.
- Charges:
    - Which are higher than the preferred provider contract rates, unless specifically approved;
    - Made by a provider who is related to you by blood or marriage, unless authorized by the Administration Office.

Inquiries in such cases should be made before proceeding with treatment;
    - For treatment of injuries that resulted from committing or attempting to commit a felony or any illegal activity as determined by the Board of Trustees, except if the injury resulted from mental illness or a condition arising out of acts of domestic violence;
    - For treatment while incarcerated in a state or federal penitentiary;
    - In excess of the amount that would be paid by Medicare for durable medical equipment or related equipment, such as for dialysis;
- Prescription drugs provided by anyone except through a physician or hospital during the patient's stay or through the Plan's pharmacy benefits manager (currently RxEDO), or covered under Medicare;
- Any claims submitted over one year from the date of service;
- Radial keratotomy (surgery of the cornea) or similar procedures;
- Sterilization reversal;
- Treatment of infertility, including in vitro fertilization or artificial insemination;
- Elective abortion;
- Biofeedback and hypnotherapy;
- Myofunctional therapy (facial exercise);
- Behavioral training used for hyperactive children;
- Weight counseling and similar programs aimed at changing behavior except for obesity screenings and behavioral interventions covered under the Wellness Program;
- Holistic medicine or therapeutic injections;
- Routine office visits if not sick or injured;
- Cosmetic surgery not specifically covered under the Plan, as well as reversal of cosmetic procedures not medically necessary;
- Temporomandibular joint syndrome;
- Eye refraction care or the fitting of eyeglasses;
- Organ transplants not listed as covered;
- Treatment of erectile dysfunction is not covered, except for certain surgical and prescription treatment as specifically indicated in the plan.
- Chelation therapy except for toxic exposure confirmed by a Prudent Buyer Network PPO physician and proven by blood tests conducted by PPO labs.
- For treatment of any injury, illness, or disease or other condition for which a third party (individual or organization) is or may be considered responsible.
- Growth Hormone drugs 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.
- Payments in excess of the $350.00 per day maximum benefit payable for out-of-network ambulatory surgery centers.

• BeneSys Administrators And Members' Advocate

BeneSys Administrators

The Board of Trustees engages BeneSys Administrators to provide assistance to you in using PPO or other parts of the Health and Welfare Plan. The BeneSys customer service line is answered by trained representatives who can give you information and answer your questions. You can call BeneSys Administrators at (408) 588-3751 to:

- Check on PPO features and procedures;
- Find out whether a hospital, doctor, or laboratory you are considering is part of the current list of PPO providers;
- Find out if your pharmacy is a RxEDO network pharmacy;
- Obtain pre-treatment certification for organ transplants or hospice care
- Discuss treatment options;
- Discuss emergency care coverage;
- Request claim forms;
- Ask for assistance in filing claims;
- Discuss the status of a claim or any problems with claims processing
- Update enrollment if you marry, divorce, acquire a dependent child through birth or adoption, or have a change of address;
- Change your choice of provider organizations from PPO to HMO or from HMO to PPO.

Members' Advocate

The Board of Trustees has engaged a Members' Advocate and encourages you to contact the advocate for special assistance. For example, if you are new to the plan and having difficulty obtaining the documents necessary to enroll, such as marriage, birth, or divorce certificates, your advocate may be able to help.

Once enrolled, if you have questions about how benefits work in PPO or HMO, she can advise you. There is no charge for the Members' Advocate services. Please Contact BeneSys Administrators at (408) 588-3751 if you would like the contact information for the Members' Advocate. As a courtesy to you, the Members' Advocate or BeneSys Administrators may also respond informally to oral questions. Oral information and answers are not binding upon the Board and cannot be relied on in any dispute concerning your benefits.

• Claims for Benefits

Claim Forms

Claim forms are available by calling BeneSys Administrators.

If you would like to know in advance of treatment how much of a service will be reimbursable, BeneSys Administrators will assist you.

When filing a claim, be sure to include the proper form, original, itemized bills, receipts, and pertinent information, such as the nature of the illness or details of the accidental injury. For disability claims, the Plan will provide

you with access and/or copies of all documents, records, and other information relevant to your claim upon request and free of charge.

The person filing the claim can be you, your representative, or, in the case of a claim involving urgent care, a health care professional with knowledge of the patient's medical condition.

You or your representative must file all claims for benefits within one year in which the expense was incurred. Otherwise, the claim will not be paid.

How Soon the Plan Responds to Claims

The Board of Trustees has established response times to your claim for benefits.

Failure to Follow Plan Procedures: If you did not follow the Plan's procedures for filing a claim, you will hear from the Administration Office within five days on pre-service claims, or, if the claim is for urgent care, within 24 hours. In most cases, the office will call you, unless your authorized representative requests a response in writing.

Notification of Claim Decision – Urgent Care: A determination of whether a claim involves urgent care is made by the attending provider and the Plan shall defer to such determination. Urgent care claims are answered within 72 hours. If the office responds that it needs more information to approve the claim, you will have 48 hours to supply it.
The office will then rule on the claim as soon as possible, but no later than 48 hours after receipt of the necessary information.

Notification of Claim Decision – Pre-Service Claims: Non-urgent care claims that are filed before care is provided will be answered within 15 days after receipt. In some instances, an additional 15 days may be needed. If so, you will be notified of the reasons and advised of any additional information that may be needed. You will have up to 45 days to provide the specified information. After that, you will be notified of the payment decision within 15 days.

Notification of Claim Decision – Post-Service Claims: Claims that are filed after care has been provided will be processed within 30 days after receipt. In some instances, an additional 15 days may be needed. If so, you will be notified of the reasons before the original 30 day period has expired and advised of any additional information that may be needed. You will have up to 45 days to provide the specified information. After that, you will be notified of the payment decision within 15 days.

Notification of Claim Decision – Disability Claims 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:

- The reason for the delay
- The expected date of the decision
- The basis on which the decision will be made

- Any unresolved issues preventing a decision now
- Any additional information the Plan needs to make a decision

You will have up to 45 day 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.

If A Claim Is Denied

Any notice of denial will contain an explanation of the reasons for the denial and a specific reference to the provisions of the Plan on which the decision is based. A copy of the provision or rule relied upon will be provided free of charge upon request. The notice will also contain a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request (for disability claims, you will automatically receive the internal rule, guideline, or protocol, or a statement that such internal rule, guideline or protocol does not exist).

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 determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

The notice also will describe the Plan's appeal procedures (for urgent care claims this will include an explanation of the expedited procedures) and a statement of your right, if the appeal is unsuccessful, to bring a civil action under Section 502(a) of the Employee Retirement and Income Security Act.

Disability Claim Denials Will Also Include This Additional Information:

- An explanation of the basis for disagreeing with or not following the views of (a) a healthcare or vocation professional who treated or evaluated you (b) the views of healthcare professional or vocation professional consulted by the Plan during the claim determination and (c) any disability determination made by the Social Security Administration.

- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

- The internal rule, guideline, or protocol, or other similar criterion on which the decision was based or a statement that such internal rule, guideline or protocol does not exist)

Appeals Procedures

After receiving a denial of any benefit within the discretion of the Board of Trustees, you or your authorized representative may appeal. All appeals must be in writing, and addressed as an appeal to the Administration Office. You should identify your request as an appeal and include any additional information you want the Board to consider.

The deadline for submission of appeals is 180 days after receiving the denial of the original claim by the Administration Office. Failure to file an appeal within 180 days will constitute a waiver of your right of review. You may receive assistance with your appeal from the Members' Advocate, but ultimately the responsibility for filing an appeal is yours.

In reviewing your appeal, 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. The Board will take into account everything you submit, including material that was submitted as part of the initial claim. The Board will not give deference to the original determination, and no person or person's subordinate who made the initial determination will have a vote in the decision on appeal.

In deciding an appeal that is based in whole or in part on medical judgment, the Board will consult with a health care professional. The health care professional will not have participated in the initial claim decision. If requested, the Board will identify the health care professional, regardless of whether it relied on the health care professional's advice in making the decision.

For disability appeals, the Trust Fund 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.

The Board of Trustees' decision will be made within:

- 72 hours for urgent claims
- 30 days for pre-service claims
- At the regularly scheduled meeting immediately following the filing of the appeal for post-service claims. If the appeal is filed within 30 days before the meeting, the decision may be made at the second meeting following the appeal. If additional time is needed, the decision will be made no later than the third meeting following the filing of the appeal. Before the extension is taken, you will be notified in writing of the circumstances causing the extension and the date the determination will be made.

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Within five days after the Board's decision is made, you will be notified in writing. A denied appeal will include an explanation of the reasons for the denial. It will make specific reference to the provisions of the Plan on which the decision is based. It will invite you to view and receive copies of documents, records, or other information relevant to the claim upon request and free of charge. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request (for disability claims, you will automatically receive the internal rule, guideline, or protocol, or a statement that such internal rule, guideline or protocol does not exist)

If the claim was denied because treatment was determined to be not medically necessary or experimental in treatment, an explanation of the scientific or clinical judgment for the decision will be provided free of charge upon request.

A denial notice also a statement of your right, if the appeal is unsuccessful, to bring a civil action under Section 502(a) of the Employee Retirement and Income Security Act.

For Disability Appeals, the notice will also include the following additional information:

- The exact calendar date on which the period to bring a lawsuit expires.
- The internal rule, guideline, or protocol, or other similar criterion on which the decision was based or a statement that such internal rule, guideline or protocol does not exist)
- An explanation of the basis for disagreeing with or not following the views of (a) a healthcare or vocation professional who treated or evaluated you (b) the views of healthcare professional or vocation professional consulted by the Plan during the claim determination and (c) any disability determination made by the Social Security Administration.

Legal Action Against the Plan: No legal action may be commenced or maintained against the Trust or the Plan more than two (2) years after an appeal has been denied. In any such lawsuit, the determinations of the Board of Trustees are subject to judicial review only for abuse of discretion. Legal action may only be initiated after you have exhausted all internal appeals described in this SPD, or if the Plan significantly deviates the procedures described above.

By participating in the Plan, current and former Participants, Employees, Retires, 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 class,

collective, representative action arising out of or relating to 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 or decided on an individual basis.

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.

Appeals to HMOs, Insurance Carrier And Other Providers

If your claim for medical or dental benefits from an HMO, insurance carrier, or other provider is denied on grounds of eligibility, the Board of Trustees hears your appeal.

For all other appeals of denied claims for benefits from an HMO, insurance carrier or other provider, you must submit the appeal to the insurance carrier or HMO, following the appeals rules they have set forth. You may receive assistance from the Members' Advocate or BeneSys, but ultimately, the responsibility for filing an appeal is yours. Filing an appeal with an insurance carrier or HMO in a timely manner is solely your responsibility.

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.

(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. Effective April 1, 2018, this provision applies to disability claims and appeals.

(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 an 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 if applicable. Effective April 1, 2018 this provision applies to disability claims and appeals.

(5) If the Plan fails to strictly adhere to all the requirement 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 is 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 minimus violations.

(6) Certain adverse benefit determinations including those involving medical judgment or a rescission of coverage 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

(1) 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.

(2) 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:

(a) 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;

(b) 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;

(c) You have exhausted the Plan's internal appeal process; and

(d) 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.

(3) 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:

(a) The IRO will use legal experts where appropriate to make coverage determinations under the Plan.

(b) 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.

(c) 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 adverse final internal adverse benefit determination. Within one business day after making the decision, the IRO will notify you and the Plan.

(d) 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.

(e) 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 IROS'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.

(f) 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.

(g) 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.

(h) 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.

(4) 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

(1) Request for Expedited External Review: You will be permitted to make a request for expedited external review if you receive (1) 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 (2) 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 the 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.

(2) 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.

(3) 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.

(4) 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.

• Health Maintenance Organization, Kaiser

About HMO

If you do not fill out an enrollment form, you will automatically be enrolled in Kaiser Permanente, a California HMO (Health Maintenance Organization).

The Health and Welfare Plan pays for your enrollment in an HMO the same as if you had enrolled in PPO.

With your HMO enrollment, you agree that Kaiser Permanente will provide all your medical services, including doctor, specialist, hospital, outpatient, laboratory, home health care, hospice, mental health, emergency, vision exams, hearing exams and hearing aids, speech, occupational, and physical therapy, prescription drugs, well-baby care, and preventive care. There are no annual deductibles to pay or claim forms to file.

But it is important to understand that **all** medical services, except covered emergencies, must be obtained from or with the permission of the HMO. **You pay 100% of the charges for medical services and supplies obtained from any source except Kaiser Permanente, except in an emergency.**

Kaiser Permanente, not the Health and Welfare Plan Trustees, sets the rules and conducts the appeals process for denied claims. It is the final authority in determining whether any services and supplies you may request, in or out of the HMO, are medically necessary and covered benefits.

Kaiser Permanente Locations

You may choose from any of the more than 150 California locations, and you are not limited to receiving care from just one location. Kaiser Permanente hospitals are open seven days a week, and all provide 24-hour emergency care. All medical offices provide same-day urgent care appointments, and many have evening and weekend appointments. Prescriptions are filled on-site.

The Plan will provide you a booklet containing the names and locations of all Kaiser Permanente facilities in northern California. For more information about the services of any location, contact Kaiser Permanente member service call center at 1-800-464-4000.

What You Pay; What HMO Pays

With an HMO, nearly all your medical care is covered, with little out-of-pocket cost to you.

You have no annual deductible to pay. Copayments, are very small. There is no lifetime maximum to benefits while you and your eligible family members are actively enrolled.

Benefits From Kaiser Permanente

The following is a summary of benefits and their copayments in 2019 from Kaiser Permanente. Consult your HMO booklet for a complete list and description of current coverages and benefits.

KAISER PERMANENTE
SUMMARY OF BENEFITS

93 UA LOCAL 393 - PLUMBERS TRUST Active

93 UA LOCAL 393 - PLUMBERS TRUST

Principal Benefits for Kaiser Permanente Traditional HMO Plan (9/1/19—8/31/20)

Health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call our Member Service Contact Center.

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

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

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

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

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

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	$20 per procedure
Allergy injections (including allergy serum)	$3 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Covered individual health education counseling	No charge
Covered health education programs	No charge

Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge

Emergency Health Coverage	You Pay
Emergency Department visits	$50 per visit

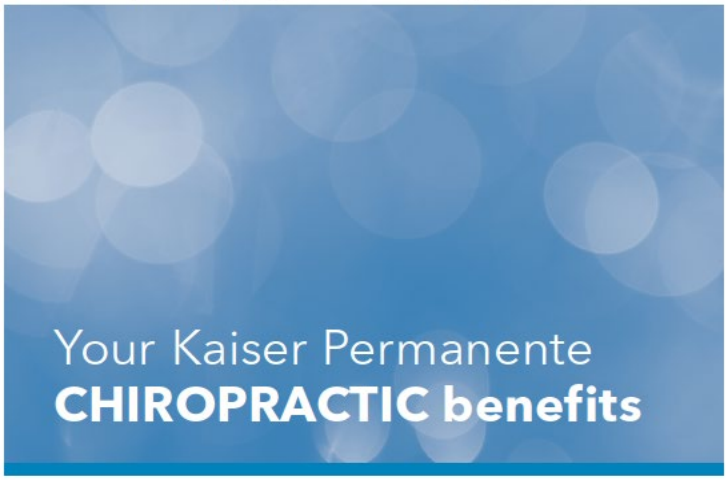
Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

Ambulance Services	You Pay
Ambulance Services	$50 per trip

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy or through our mail-order service	$10 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy or through our mail-order service	$20 for up to a 100-day supply
Most specialty items at a Plan Pharmacy	$20 for up to a 30-day supply
Durable Medical Equipment (DME)	**You Pay**
DME items as described in the *EOC*	No charge
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	$20 per visit
Group outpatient mental health treatment	$10 per visit
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	No charge
Individual outpatient substance use disorder evaluation and treatment	$20 per visit
Group outpatient substance use disorder treatment	$5 per visit
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge
Other	**You Pay**
Hearing aid(s) every 36 months	Amount in excess of $2,500 Allowance per aid
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the *EOC*	No charge
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

Provided by American Specialty Health Plans of California, Inc. (ASH Plans)



When you need chiropractic care, follow these simple steps:

1. Find an ASH Plans Participating Provider near you:
   - Go to **ashlink.com/ash/kp**, or
   - Call **1-800-678-9133** (TTY **711**), Monday through Friday, from 5 a.m. to 6 p.m. Pacific time
2. Schedule an appointment.
3. Pay for your office visit when you arrive for your appointment.

(See the reverse for more details.)

American Specialty Health Plans of California

KAISER PERMANENTE

YOUR KAISER PERMANENTE CHIROPRACTIC BENEFIT

Second Opinions

You may request a second opinion in regard to covered Services by contacting another Participating Provider. A Participating Provider may also request a second opinion in regard to covered Services by referring you to another Participating Provider in the same or similar specialty.

Your Costs

When you receive covered Services, you must pay your Cost Share amount as described in the *Chiropractic Services Amendment* of your Health Plan *Evidence of Coverage*. The Cost Share does not apply toward the Plan Out-of-Pocket Maximum described in the Health Plan *Evidence of Coverage*.

Emergency and Urgent Chiropractic Services

We cover Emergency Chiropractic Services and Urgent Chiropractic Services provided by both Participating Providers and Non–Participating Providers. We do not cover follow-up or continuing care from a Non–Participating Provider unless ASH Plans has authorized the services in advance. Also, we do not cover services from a Non–Participating Provider that ASH Plans determines are not Emergency Chiropractic Services or Urgent Chiropractic Services.

Getting Assistance

If you have a question or concern regarding the services you received from an ASH Plans Participating Provider or another licensed provider with which ASH contracts, you may call ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**), weekdays from 5 a.m. to 6 p.m. Pacific time.

Grievances

You can file a grievance with Kaiser Permanente regarding any issue. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied with Services you received. You may submit your grievance orally or in writing to Kaiser Permanente as described in your Health Plan *Evidence of Coverage*.

Exclusions and Limitations

- Services for asthma or addiction, such as nicotine addiction
- Hypnotherapy, behavior training, sleep therapy, and weight programs
- Thermography
- Experimental or investigational services
- CT scans, MRIs, PET scans, bone scans, nuclear medicine, and any other types of diagnostic imaging or radiology other than X-rays covered under the "Covered Services" section of your *Chiropractic Services Amendment*
- Ambulance and other transportation
- Education programs, nonmedical self-care or self-help, any self-help physical exercise training, and any related diagnostic testing
- Services for pre-employment physicals or vocational rehabilitation
- Air conditioners, air purifiers, therapeutic mattresses, chiropractic appliances, durable medical equipment, supplies, devices, appliances, and any other item except those listed as covered in your *Chiropractic Services Amendment*
- Drugs and medicines, including non-legend or proprietary drugs and medicines
- Services you receive outside the state of California except for Emergency Chiropractic Services and Urgent Chiropractic Services
- Hospital services, anesthesia, manipulation under anesthesia, and related services
- For Chiropractic Services, adjunctive therapy not associated with spinal, muscle, or joint manipulations
- Dietary and nutritional supplements, such as vitamins, minerals, herbs, herbal products, injectable supplements, and similar products
- Massage therapy
- Services provided by a chiropractor that are not within the scope of licensure for a chiropractor licensed in California
- Maintenance care (services provided to members whose treatment records indicate that they have reached maximum therapeutic benefit)

CHIRO 158 NCAL_469 SCAL (9/16)

YOUR KAISER PERMANENTE CHIROPRACTIC BENEFIT

Definitions

ASH Plans: American Specialty Health Plans of California, Inc., a California corporation.

Chiropractic Services: Services provided or prescribed by a chiropractor (including laboratory tests, X-rays, and chiropractic appliances) for the treatment of your Neuromusculoskeletal Disorder.

Emergency Chiropractic Services: Covered Chiropractic Services provided for the treatment of a Neuromusculoskeletal Disorder which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a reasonable person could expect the absence of immediate Chiropractic Services to result in serious jeopardy to your health or body functions or organs.

Neuromusculoskeletal Disorders: Conditions with associated signs and symptoms related to the nervous, muscular, or skeletal systems. Neuromusculoskeletal Disorders are conditions typically categorized as structural, degenerative, or inflammatory disorders, or biomechanical dysfunction of the joints of the body or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs, and synovial structures), and related neurological manifestations or conditions.

Participating Provider: A chiropractor who is licensed to provide chiropractic services in California and who has a contract with ASH Plans to provide Medically Necessary Chiropractic Services to you.

Urgent Chiropractic Services: Chiropractic Services that meet all of the following requirements:

- They are necessary to prevent serious deterioration of your health, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy.
- They cannot be delayed until you return to the Service Area.

This is only a summary and is intended to highlight only the most frequently asked questions about the benefit, including cost shares. Please refer to the *Chiropractic Services Amendment of the Kaiser Foundation Health Plan, Inc., Evidence of Coverage* for a detailed description of the chiropractic benefits, including exclusions and limitations, Emergency Chiropractic Services, and Urgent Chiropractic Services.

Kaiser Foundation Health Plan, Inc. (Health Plan), contracts with American Specialty Health Plans of California, Inc. (ASH Plans), to make the ASH Plans network of Participating Providers available to you. You can obtain covered Services from any Participating Provider without a referral from a Plan Physician. Your Cost Share is due when you receive covered Services. Please see the definitions section of your *Chiropractic Services Amendment of the Kaiser Foundation Health Plan, Inc., Evidence of Coverage* for terms you should know.

American Specialty Health Plans of California

KAISER PERMANENTE

Please recycle. September 2016

CHIRO 158 NCAL_469 SCAL (9/16)

Reimbursement for Out-of-Plan Emergency Services

Out-of-Plan emergency services are medically necessary health services and supplies that you receive immediately from a non-Kaiser provider because of a sudden, unforeseen injury or illness. Kaiser Permanente will reimburse you for these expenses if you file a claim and Kaiser Permanente determines that:

- The services and supplies would have been covered by Kaiser Permanente had they been authorized or prescribed by a Kaiser Permanente physician.
- The time required for you to reach one of the Kaiser Permanente hospitals or medical offices would result in negative health consequences.
- Transfer to one of the Kaiser Permanente facilities would pose serious risk to your health or would be unreasonable due to the nature of our condition and the distance involves. The decision to transfer you to another facility is made at Kaiser Permanente's discretion with the attending physician's concurrence.

If You Receive Out-of-Plan Emergency Services: Call Kaiser Permanente within 24 hours (or as soon as you can) after you are admitted to a non-Plan hospital. The number to call is printed on your Kaiser Permanente ID card. Kaiser Permanente will make arrangements for any necessary continued hospitalization you may need, or for transferring you to an approved hospital, if necessary.

By notifying Kaiser Permanente of your hospitalization as soon as possible, you will protect yourself from potential liability for payment for services and supplies you receive after transfer to one of Kaiser Permanente's facilities would have been possible.

Obtain an emergency claim form by calling the Kaiser Permanente Member Service Call Center toll free at 1-800-464-4000. Complete and mail the claim form within 90 days or as soon as possible, but no later than 12 months after the event. Attach all your bills from the non-Plan provider. If you have paid any bills, attach your receipts.

Complete and return any forms that Kaiser Permanente sends to you, including consents for the release of medical records, releases, and claims for any other benefits to which you may be entitled.

• Medicare

About Medicare

Medicare is the federal health insurance program available to you at age 65. It is also available if you are under age 65 and one of the following apply:

1. You are disabled and you have been entitled to social security disability benefits for at least 24 months. Note: There is a 5-month waiting period between the date you file your social security disability application and the date you become entitled to social security disability benefits.

2. You have end-stage renal disease (ESRD) and you or your spouse are (1) receiving monthly social security benefits or (2) currently or fully insured under the Social Security Program. Your child with ESRD will also be entitled to Medicare if you or the child's other parent are (1) receiving monthly social security benefits or (2) currently or fully insured under the Social Security Program. Contact your local Social Security Office to find out if you or your spouse are currently or fully insured. Generally, Medicare entitlement begins at the fourth month of dialysis treatments, but the waiting period can be shorter if you are receiving a kidney transplant. If you are entitled to Medicare because you have ESRD, there is a 30-month coordination period in which the Health and Welfare Plan will remain your primary medical coverage.

Turning Age 65 While Still Working

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

Turning Age 65 While Retired

If you are retired or the spouse of a retiree, you are no longer eligible to participate in PPO or HMO when you reach age 65 and become eligible for Medicare. However, you or your spouse may be eligible to elect the PPO Medicare Supplemental Plan or the HMO Medicare-Risk program of Kaiser Permanente, called Senior Advantage. You and your spouse must be in the same Plan.

If you elect the Medicare Supplemental Plan, Medicare pays benefits first. You must provide BeneSys Administrators with a copy of Medicare's benefit statement, after which the Plan will either pay your provider directly or will reimburse you for amounts you paid your provider, up to the Plan's limits. If you elect Kaiser Permanente Senior Advantage, you surrender your Medicare card to Kaiser, and just pay Senior Advantage co-payments at Kaiser for all your medical care. If you fail to surrender your Medicare Card to Kaiser, you and your spouse will be transferred to the Medicare PPO Supplemental Plan and your right to enroll in the Kaiser Senior Advantage Program may be forfeited.

Retirement Before Age 65

If you retire before age 65 and continue making contributions toward Health and Welfare Plan participation, you and your spouse remain participants in PPO or HMO, as though you were an active employee.

When you reach age 65 and become eligible for Medicare Parts A and B, coverage for you and your spouse in PPO or HMO is limited to the Medicare Supplemental Plan or Kaiser Permanente Senior Advantage.

For details on eligibility and costs of coverage in the Health and Welfare Plan when retired, see "Enrollment When Retired" in Section 5 of this booklet.

Enrolling for Medicare

You **must** enroll for Medicare within three months prior to your 65th birthday to be assured of coverage. If you do not, Medicare may delay approval of your application.

It is your responsibility to consult with your local Social Security office and to obtain details regarding Medicare's costs, coverage levels, and availability.

It is also **mandatory** that you enroll in both Parts A and B of Medicare, even though Part B requires contributions on your part.

In order to receive benefits from the PPO Medicare Supplemental Plan (described next) or Kaiser Permanente Senior Advantage, you **must** be enrolled in both Parts A and B of Medicare.

Medicare Benefit Chart 2019

Part A Hospital Insurance – Covered Services (Part A deductibles and coinsurance amounts change each year. The numbers shown in this chart are effective for 2019).

Services	Benefits	Medicare Pays	You Pay (Medicare Supplemental Plan or Kaiser Permanente Senior Advantage may pay all or part)
Hospitalization Semiprivate room, general nursing and other hospital services and supplies	First 60 days 61st to 90th day 91st to 150th day *(can be used once)* Beyond 150 days	All but $ 1,364 All but $341.00 per day All but $ 682.00 per day Nothing	$ 1,364 $ 341.00 per day $ 682.00 per day All costs
Skilled Nursing Facility Care Semiprivate room, skilled nursing and rehab services and other services and supplies	First 20 days 21st to 100th day Beyond 100 days	100% of approved All but $ 170.50 per day Nothing	Nothing if approved $ 170.50 per day All costs
Home Health Care Part-time or intermittent skilled care, home health aide services, durable medical equipment, and other supplies and services	Unlimited as long as you meet Medicare requirements for home health care benefits.	100% of approved; 80% for durable medical equipment	Nothing if approved 20% for durable medical equipment
Hospice Care Pain relief, symptom management, and support services for terminally ill	As long as doctor certifies need	All but limited costs for drugs & respite care	Limited costs for drugs & respite care
Blood When furnished by a hospital or skilled nursing facility during a covered stay	Unlimited during a benefit period if medically necessary	All but first 3 pints per calendar year	First 3 pints

Part B Medical Insurance – Covered Services (Part B deductibles and coinsurance amounts change each year. The numbers shown in this chart are effective for 2019).

Services	Benefits	Medicare Pays	You Pay (Medicare Supplemental Plan or Kaiser Permanente Senior Advantage may pay all or part)
Medical Expense Physician services, inpatient and outpatient medical and surgical services and supplies, diagnostic tests, durable medical equipment and other services	Unlimited if medically necessary	80% of approved (after $ 185 deductible);	20% of approved (after $185 deductible) plus excess charges physical and speech therapy,
Clinical Laboratory Blood test, urinalysis, and more	Unlimited if medically necessary	100% of approved	Nothing if approved
Home Health Care As defined for Part A	Unlimited as long as as you meet guidelines	100% of approved	Nothing if approved
Outpatient Hospital Treatment Services for the diagnosis or treatment of an illness, injury	Unlimited if medically necessary	80% of approved (after $185 deductible)	20% of approved (after $185 deductible) plus excess charges
Blood	Unlimited if medically Necessary	80% of approved amount (after $ 185 deductible and starting with 4th pint)	First 3 pints plus 20% (after deductible) for more

• Medicare Supplemental Plan

About Medicare Supplemental Plan

If you are age 65 and making payments for retiree medical benefits (See "Enrollment After Retirement" in Section 5), you may enroll in either PPO Medicare Supplemental Plan or Kaiser Permanente Senior Advantage. The following paragraphs describe the PPO Medicare Supplemental Plan. For details about the Kaiser Permanente Senior Advantage Plan, consult the KPSA booklet.

For Local 393 Retirees Age 65 Or Older

The PPO Medicare Supplemental Plan is for eligible Local 393 retirees and dependents who have enrolled for both Parts A and B of Medicare through their local Social Security Offices.

Primary vs. Secondary Payers

If you are retired and eligible for Medicare, Medicare will be considered the primary payer, with PPO Medicare Supplemental Plan providing secondary coverage.

Use Providers Who Accept Medicare Assignment

To realize greatest savings with PPO Medicare Supplemental Plan, you should use providers who accept Medicare Assignment. While you are free to use providers who do not accept Medicare Assignment, your share of the resulting bills will be considerably higher.

Part A: Hospital Benefits

Medicare Part A is hospital insurance for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

What Medicare Part A Pays

Medicare Part A pays toward an allowable amount of actual charges, after you pay a Medicare deductible.

More About Part A Deductible

Medicare requires you to pay the first $1,364 (for 2019) when you are hospitalized. This is called the Part A deductible, and the amount can change each year. It applies to each hospitalization (benefit period).

More About Part A Schedule Of Payments

For a benefit period of less than 60 days, Medicare pays the rest of the allowable charges. For days 61-90 of the hospitalization, Medicare pays all but $ 341 per day. For days 91-150 for that same hospitalization, Medicare pays all but $682 per day. Beyond 150 days, Medicare pays nothing.

How this Medicare Supplemental Plan Affects Part A

Medicare Supplemental Plan pays 100% of your Medicare Part A deductible plus 100% of the balance of the allowable amount that Medicare does not pay.

Part B: Medical Benefits

Medicare Part B is the part of Medicare that covers doctors' services and outpatient hospital care. It also covers other medical services that Part A does not cover, like physical and occupational therapy.

What Medicare Part B Pays

For doctors' bills and medical supplies in and out of the hospital, Medicare Part B pays 80% of the Medicare Allowable Amount, after you pay a $185 annual deductible.

How this Medicare Supplemental Plan Affects Part B

After you pay an annual Medicare Part B deductible, the Medicare Supplemental Plan pays:

- For doctors who accept Medicare assignment: the Plan will pay 100% of your obligation under the Medicare rules for the doctor or supplier's bill.

- If a doctor or supplier will not accept assignment, then the doctor or supplier can bill and collect more than the Medicare-approved amount, but the Plan will still pay only 100% of your obligation under the Medicare rules. Medicare Part B pays its share, as if the doctor had accepted Medicare assignment.

- For doctors who require you to sign a private contract not to use Medicare then the Plan pays 12.3% of the lesser of the doctor's actual charge or the PPO contract rate for the covered service or supply (or if there is no PPO rate, the usual, customary and reasonable charge, as described on page 12). Medicare Part B pays nothing.

The Plan does not pay for your Medicare Part B deductible.

More About Medicare Assignment

Medicare assignment means a doctor will charge no more than the Medicare Allowable Amount.

Some doctors accept Medicare patients but reserve the right to charge more than the Medicare Allowable Amount. This leaves the patient eligible for assistance from Medicare and the Plan, but ultimately responsible for any excess charges above the Medicare assignment amount.

Other doctors decline to accept Medicare patients at all, requiring instead that patients contract privately with them for services, with the doctor

setting the charges. This leaves the patient eligible for assistance from the Plan, but not from Medicare.

Out-of-Pocket Maximum

The most a person enrolled in Medicare Supplemental Plan will pay in copayments is $1,800 per year. After that, the Plan pays 100% of covered Medicare Supplemental Plan expenses for the rest of the calendar year.

This out-of-pocket maximum works the same as described for PPO on page 9.

Prescription Drugs

If you decline to enroll in Medicare Part D, your prescription drug coverage will be provided through RxEDO. Please see page 23. Notices will be sent whenever another provider is chosen for prescription drugs or supplies.

Spouse and Dependent Child

Your spouse is covered by Medicare Supplemental Plan if he or she is eligible for Medicare (age 65 or older).

A spouse or enrolled family member who is not eligible for Medicare is eligible for benefits under PPO.

Exceptions and Limitations

The exceptions and limitations of PPO coverage apply to Medicare Supplemental Plan. For example, acupuncture is limited to $500 per year and chiropractic care is limited to $1,500 in benefits per year, and spinal decompression therapy is limited to $2,500 per lifetime. Medicare Supplemental Plan benefits are payable only for medically necessary services and supplies. Some services and supplies are not covered (see page 50).

• Benefits for Residential Employees, Service Tradesmen, and Provisional Journeyman Service Plumbers under the UA National Plumbing Service Agreement

Employees who have earned eligibility from hours worked in residential plumbing, service tradesmen working under the Northern California & Northern Nevada Refrigeration and Air Conditioning and Food Store Addendum, or as Provisional Journeyman Service Plumbers (Levels 1 through III) shall not be eligible for benefits except as provided in this Section:

Initial Eligibility

To become eligible for benefits as a residential employee service tradesman, or Provisional Journeyman Service Plumber, you must complete 480 hours of covered residential plumbing, service tradesmen, or national service agreement work within a consecutive 12-month period for an employer who pays health and welfare contributions on your behalf as required by a collective bargaining agreement.

Your eligibility starts on the first day of the second month following the month in which you have completed 480 hours of covered residential plumbing, service tradesmen, or national service agreement work during the previous consecutive 12-month period (provided your employer pays the required contributions).

Maintaining Eligibility To maintain eligibility, you must work a minimum of 120 hours of covered residential plumbing, service tradesmen, or national service agreement work per month for an employer who pays health and welfare contributions on your behalf as required by a collective bargaining agreement.

Basic Reserve Account After you complete 120 hours of covered residential plumbing, service tradesmen, or national service agreement work for an employer who makes health and welfare contributions on your behalf, additional hours are deposited into your basic reserve account up to a maximum of 720 hours (6 months) at the current contribution rate. During periods when you cannot work you can use these hours to maintain eligibility.

Benefits Residential Employees, Services Tradesmen, and Provisional Journeyman Service Plumbers (Levels 1 and III) may only receive medical benefits from the Kaiser Plan below and are not eligible to participate in the PPO Plan.

600832 U.A. LOCAL 393 (RESIDENTIAL WORKERS AND SERVICE TRADESMEN And PROVISIONAL JOURNEYMEN SERVICE PLUMBERS LEVELS I-III) Active

600832 U.A. LOCAL 393 (RESIDENTIAL WORKERS)

Principal Benefits for Kaiser Permanente Traditional HMO Plan (9/1/19—8/31/20)

Health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call our Member Service Contact Center.

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

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

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

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

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

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	$20 per procedure
Allergy injections (including allergy serum)	$3 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Covered individual health education counseling	No charge
Covered health education programs	No charge
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge
Emergency Health Coverage	**You Pay**
Emergency Department visits	$50 per visit
Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).	
Ambulance Services	**You Pay**
Ambulance Services	$50 per trip
Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy or through our mail-order service	$10 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy or through our mail-order service	$20 for up to a 100-day supply
Most specialty items at a Plan Pharmacy	$20 for up to a 30-day supply
Durable Medical Equipment (DME)	**You Pay**
DME items as described in the *EOC*	20% Coinsurance
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	$20 per visit
Group outpatient mental health treatment	$10 per visit
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	No charge
Individual outpatient substance use disorder evaluation and treatment	$20 per visit
Group outpatient substance use disorder treatment	$5 per visit
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the *EOC*	No charge
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

Dental

Eligible residential, service tradesmen, and Provisional Journeyman Service Plumbers (Levels 1 through III) employees and their enrolled dependents are covered under Delta Dental Plan of California. A dentist participating in Delta Dental Plan must provide services. The Plan pays 80% of the covered charges for basic, diagnostic and preventive care and 50% of the covered charges for crowns, restorations, prosthodontics and orthodontics (for dependent children only) up to a maximum of $2,000 per patient per calendar year. There is a $2,500 lifetime maximum on the orthodontic benefit for dependent children.

Substance Abuse

Eligible residential, service tradesmen, and Provisional Journeyman Service Plumbers (Levels 1 through III) and their eligible dependents are eligible for alcohol, drug, and chemical dependency treatment through BEAT IT! After the annual deductible is paid, benefits are payable at the following rates:

- First Course of Treatment: 100% for residential treatment or outpatient care provided by Beat It! or 60% of the UCR rate for residential treatment or outpatient care provided by non-PPO providers.

- Additional Courses of Treatment: 90% for residential treatment or outpatient care provided by Beat It! or 60% of the UCR rate for residential treatment or outpatient care provided by non-PPO providers.

Disability

The short-term disability benefit is for active residential employees, service tradesmen, or Provisional Journeymen Service Plumbers (Levels 1 through III) who are currently eligible for Health and Welfare Plan benefits through a reserve account (but not self-payment or COBRA payments). The short-term disability benefit begins as of the first day of an accident or the eighth day of illness that has you under the care of a physician and keeps you from performing your regular work. You do not have to be confined to home to receive benefits. This benefit is in addition to any payments from Workers' Compensation, State Disability Insurance or similar law. The benefit amount is $150 a week or 1/7th of $150 for each day of disability less than a full week. Payments continue for up to 52 weeks. There is no limit to the number of benefit periods for unrelated disabilities. If you have received Plan benefits, return to work and are absent again for the same cause within 52 weeks of the start of benefits, payments will begin again without a waiting period. They will continue until you receive 52 weeks of benefits. A disability occurring after you have been continuously engaged in covered work for 26 weeks after the first Plan payment for a related disability will be considered a new claim.

Miscellaneous

Residential employees, service tradesmen, and Provisional Journeyman Service Plumbers (Levels 1-III) must pay for the full cost of their coverage at retirement and are not eligible to receive supplemental unemployment benefits except for such benefits as expressly indicated in the U.A. Local 393 Supplemental Unemployment Plan.

The Trustees have authority to determine whether worked performed under a collective bargaining agreement constitutes residential plumbing,

service tradesmen or national service provisional journeymen agreement work. Journeyman Service Plumbers under the UA National Plumbing Service Agreement shall be eligible for benefits under the same terms as employees working under the U.A. Local No. 393 Master Labor Agreement.

• Definitions

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 the Local 393 Health and Welfare Plan. 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."

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 the Local 393 Health and Welfare Plan. 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. However, a brief overview of Kaiser Permanente HMO appears beginning on page 41.

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

Non-PPO Providers Any doctors, hospitals, and laboratories who are not listed in the Prudent Buyer Network booklet. PPO members are free to seek services from non-PPO providers. However, you will pay more than if you had stayed "in-network."

PPO Medicare Supplemental Plan One of two plans in which eligible Local 393 retirees may enroll after they reach age 65 and also enroll in Medicare Part A and Medicare Part B. This Plan is affiliated with PPO and is summarized on beginning on page 50.

Kaiser Permanente Senior Advantage The Medicare supplemental plan offered by the HMO. For details, consult the KPSA booklet.

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 BeneSys Administrators at (408) 588-3751. To read more about COBRA, see Section 5.

• Important Telephone Numbers

Beat It! Drug, Alcohol, Chemical Dependency Treatment	800-828-3939
Delta Dental Customer Service	888-335-8227
Prudent Buyer Network	800-688-3828
Mail-Order Prescription Program under PPO	1-800-607-6861
RXEDO (Prescriptions)	1-888-879-7336
VSP	800-877-7195
BeneSys Administrators (Questions About Plans)	408-588-3751

Section 2 Dental Benefits From Health and Welfare Plan

This section of your booklet gives a summary description of dental benefits from Local 393 Health and Welfare Plan. Coverage is provided through a contract with Delta Dental Plan of California.

It costs active members no additional contributions to be part of the Plan's dental coverage. Retirees may choose dental coverage by making monthly contributions.

Features include:

- Regular Check-Ups and Teeth Cleaning
- Fillings, Extractions
- Crowns, Dentures

• Dental Services

About Dental Services

For dental services, active Health and Welfare Plan members and their enrolled dependents are covered under Delta Dental Plan of California. A dentist participating in Delta Dental Plan must provide services. Thousands of California dentists do participate.

Retiree Dental

Retirees may have dental coverage for an extra monthly charge (See "Enrollment After Retirement" in Section 5). However, retirees have only one chance to elect coverage. If a retiree chooses to decline coverage at retirement, he or she will not be able to elect dental coverage at any later date.

You may postpone the effective date of Retiree dental coverage under this Plan if (1) you are covered under your spouse's group dental plan when you retire and (2) you apply for coverage and commence any required payments to this Plan within thirty (30) days after coverage under your spouse's plan ceases. If you do not begin making payments to this Plan at the time you retire, you will not be permitted to make such payments until your coverage under your spouse's plan ends or is substantially reduced. You will be required to submit satisfactory evidence that you were covered under your spouse's plan during the deferral period and that your coverage under that plan has ended. You and your spouse may both defer coverage under these rules. If you elect immediate coverage under this Plan, your spouse may independently choose to defer his/her effective date in accordance with these rules.

Maximum Dental Benefits

For Participants, Eligible Retirees and their Eligible Dependents age 19 or older, covered dental benefits are provided at no charge to eligible active employees or retirees and their eligible dependents up to a maximum of $3,000 per year per covered person. Diagnostics and preventive care do not

count toward this $3,000 maximum. For Eligible Dependent Children under age 19, covered dental benefits are provided at no charge with no annual limit.

The Trustees may approve advancement of annual maximums for eligible active employees, retirees and their eligible dependents, up to one (1) year, only if they determine in their sole discretion that the participant will suffer extreme detriment if the services are not provided.

Preventive Care

The Plan pays 80% of charges for adults and 100% for children (with no annual limit) for:

- Dental prophylaxis (cleaning and scaling of teeth) – four times in any 12-month period
- Fluoride treatment
- Space maintainers
- Dental diagnostic procedures – to assist the dentist in determining what dental treatment is required
- X-rays
- Bitewing x-rays – twice every 12 months when requested by the dentist
- Full mouth x-rays – once every three years unless special need is shown

Dental Treatment

The Plan pays 80% of charges for adults (up to a maximum of $3,000 per year) and 100% for children (with no annual limit) for:

- Extractions
- Oral surgery
- Anesthetics administered in connection with a covered oral surgery procedure
- Fillings (silver or plastic) for treatment of tooth decay
- Crowns, jackets, inlays, onlays, and cast restorations, when fillings will not suffice. Replacement of such items is covered after five years.
- Sealants for the purpose of preventing dental decay in children under age 16
- Endodontic treatment of tooth pulp
- Periodontic treatment of gums and bones supporting the teeth
- Prosthodontic services for construction or repair of fixed bridges, partial dentures, or complete dentures. Replacement is covered after five years, unless Delta Dental approves earlier replacement. Approval is based on whether extensive loss of remaining teeth or change in supporting tissues renders the existing appliance impossible to satisfy. Replacement of appliances not provided under the Delta Dental program is covered if the appliances cannot be made satisfactory. Partial or complete dentures and related procedures are paid at 80% of the customary charge for a standard prosthodontic appliance, up to a maximum fee allowance

Orthodontics

Orthodontics are not covered for adults. For dependent children under age 19, orthodontics are covered up to a maximum of $2,500 per lifetime.

Substitutions

You may select a more expensive plan of treatment than is customary. For example: Crowns, when a silver or plastic restoration could restore the tooth; or, implants or their surgical removal, when complete or partial

dentures will suffice. In those cases, the Plan will pay the cost of standard treatment or appliances (up to a maximum of $3,000 per year) and you will pay the balance. If an allowance toward the cost of implants is approved, Delta Dental will not pay for any replacement appliance for five years.

Deductible

You pay a one-time deductible of $50 per person or $200 per family. To satisfy the deductible, these individuals pay the first $50 ($200 family) in covered dental expenses. After that, the Plan pays 80% of the balance of covered charges for adults (up to a maximum of $3,000 per participant per year) and 100% for children. Charges for preventive and diagnostic care, and orthodontics are not applied toward the $3,000 maximum.

Example
Plan Pays 80% For Adult Care

An adult's initial visits to the dentist result in these services and fees. The Plan pays 80% of the fee, after the deductible.

Dental Service	Fee
Oral examination	$ 50
x-rays	100
cleaning & scaling	40
4 regular fillings	160
	$350 total expenses
	- 50 adult's deductible payment
	$300 eligible for Plan payment
	x 80%
	$240 Plan benefit

For these visits to the dentist the Plan paid $240. The member paid $110 ($50 one-time deductible + $60 not paid by Plan).

On Your First Visit To Delta Dentist

On the first visit to the dentist, you and your dependents must provide the following identification numbers in order for benefits to begin:

- For Active Members: Delta Dental Group No. 117-0003
- For Retired Members: Delta Dental Group No. 117-0004
- Member's Social Security Number (Both you and your dependents should refer to your Social Security Number).
- If you are a member of another dental insurance program, let the dentist know. For questions about dual coverage, contact the Delta Dental Benefit Services Department.

Treatment Plan

On your first visit, the dentist will:

- Perform an oral examination, and
- Submit a treatment plan form to Delta Dental.

The plan form will be used by Delta Dental to verify your eligibility as an active employee and to determine how much of the dentist's bill the Plan will pay.

Most dentists in California have treatment planning forms on hand and are familiar with Delta Dental. However, if your dentist does not have the Delta Dental forms or has questions, he or she should contact:

Delta Dental
P.O. Box 7736
San Francisco, CA 94120
Telephone: 888-335-8227
Website: deltadentalca.org

Before treatment is started, be sure to discuss with the dentist the total amount of his or her fee and the portion that will be your responsibility. Usually there is no claim form for you to complete. The treatment plan form the dentist submits is all that is necessary. Simply sign the form to indicate that you are in agreement with the treatment your dentist has decided upon. The dentist submits the treatment plan form to Delta Dental.

Predetermination Of Benefits

Your plan includes a "predetermination of benefits" feature that allows you to obtain an estimate in advance of how much of your dental bill will be paid by Delta Dental. It offers you and your dentist the ability to have Delta Dental review the proposed services and charges to determine the Payment that will be made by the Plan.

To take advantage of this feature, your dentist must complete the Attending Dentist's Statement and submit it to Delta Dental. Your dentist will be notified by Delta Dental of the estimated benefits that are payable. You and your dentist should discuss the findings of Delta Dental. If you agree to the treatment plan, your dentist returns the statement to Delta Dental for payment when treatment has been completed.

Payment Of Benefits

Delta Dental pays its benefits to the dentist. Or, if the services were performed by a non-Delta Dental dentist, benefits will be paid directly to you. The amount paid will be based on what the majority of Delta Dental dentists would have received.

In the event Delta Dental fails to pay the participating dentist, you will not be liable to the dentist for any sums owed by Delta Dental. However, if Delta fails to pay a non-participating dentist, you may be liable to the dentist for that portion of the cost.

All dentists must submit their Attending Dentist's Statements to Delta Dental within six months after the services were provided. Otherwise, Delta Dental may deny payment. If the late claim of a participating dentist is denied, you will not be liable for the sum that was denied.

Appeal of Denied Claim for Benefits

Delta Dental will notify you if any services are denied, in whole or in part, stating the reasons for the denial. A copy of the Attending Dentist's Statement will be sent to you, and you will be advised of your right to a review of the denied claim and the procedures you should follow to request a review.

Within 60 days after receiving the notice described above, you may make a written request for review of the denial by writing to Delta Dental, stating the reason(s) you are requesting a review of the denied claim. Address the request to:

Delta Dental
P.O. Box 7736
San Francisco, CA 94120
Attention: Member Services Department

The telephone number of the department is 888-335-8227 (toll-free). The Website is: www.deltadentalca.org

Delta Dental will make a full and fair review of your request for a re-evaluation. It may require additional documents if these are necessary or desirable in making the review.

Certain reviews may be referred to one of Delta Dentist's regional consultants, to a peer review committee of the dental society in your area, or to Delta Dental. Delta Dental agrees to be bound by the decision of the respective review committee.

Unless the claim is referred to a review committee or other unusual circumstances arise, you should receive a decision on your request for review, in writing, within 30 days. In no case will the written decision arrive in more than 120 days after Delta Dental receives your request.

Any dispute not settled by this claim review procedure is subject to arbitration by a single arbitrator selected by the parties, in accordance with the terms of the Group Dental Agreement with Delta Dental.

Delta Dental cooperates with the grievance process of the California Department of Corrections. If you feel your grievance has not been satisfactorily resolved after 60 days, you may file a complaint with the department at the toll-free number of 1-800-400-0815.

Dental Expenses Not Covered

Delta Dental Plan does not pay toward:

- Prosthetic device or any single procedure started prior to the date you or your dependents became eligible for service under the Plan
- Services or supplies for which there is no charge or for which the charge is paid by a government agency, such as the military, a veterans' hospital, workers' compensation, Medicare, or Medicaid, except as provided in Section 12532.5 of the California Government Code (Medi-Cal)
- Services or supplies to correct a congenital (hereditary) or developmental (following birth) malformation, or cosmetic surgery or dentistry for purely cosmetic reasons. Examples of excluded surgeries or services include for cleft palate, upper and lower jaw malformations, lack of enamel development, discoloration of the teeth, and congenitally missing teeth.
- Services to stabilize or create equilibrium for the teeth, such as splinting, or to restore tooth structure lost from wear
- Appliances to increase the vertical dimension of the mouth or restore occlusion
- Prescription drugs, premedication, or analgesia (except as provided under the prescription drug benefit of the Health and Welfare Plan)
- Experimental procedures

- All hospital costs and any additional fees charged by the dentist for hospital treatment
- Charges for anesthesia, other than general anesthesia administered by a licensed dentist in connection with covered oral surgery services
- Extra-oral grafts (grafting of tissues from outside the mouth to oral tissues)
- Orthodontic services for adults
- Temporomandibular joint syndrome (TMJ)

Section 3 Disability Benefits From Health and Welfare Plan

This section of your summary plan description covers disability benefits from Local 393 Health and Welfare Plan. These benefits are available only to working members with Reserve Accounts.

- Weekly Short-Term Disability Benefit
- Supplemental Long-Term Disability Benefit

• Weekly Short-Term Disability Benefits (52 Weeks)

For Active Members with Reserve Accounts

The short-term disability benefit is for active members who are currently eligible for Health and Welfare Plan benefits through a Reserve Account (but not self-payment or COBRA payments).

Individual employers, office clerical employees, and dependents are not eligible for this benefit.

Day 1 of Accident; Day 8 of Illness

The short-term disability benefit begins as of the first day of an accident or the eighth day of an illness that has you under the care of a physician and keeps you from performing your *regular work*. You do not have to be confined to home to receive benefits.

This benefit is in addition to any payments from Workers' Compensation, State Disability Insurance, or similar law. A participant who is receiving Supplemental Unemployment Benefits from the Local 393 Supplemental Unemployment Plan is not eligible for the Short-term Disability Benefit.

Weekly Benefit

Currently the benefit amount is $150 a week or 1/7 of $150 for each day of disability less than a full week. Payments continue for up to 52 weeks. *This amount is set by the Health and Welfare Board of Trustees and is subject to change from time to time.*

Unrelated Disabilities: There is no limit to the number of benefit periods for unrelated disabilities.

Recurring Disabilities: If you have received Plan benefits, return to work, and are absent again for the same cause within 52 weeks of the start of benefits, payments will begin again without a waiting period. They will continue until you receive 52 weeks of benefits.

A disability occurring after you have been continuously engaged in covered work for 26 weeks after the first Plan payment for a related disability will be considered a new absence.

Family Leave Benefit (Active Members Only): The Plan will pay an eligible employee a weekly benefit of $150 for up to six (6) weeks per 12-month period if, while eligible for benefits by reason of Basic Reserve Account Credits, he or she is receiving benefits from the California's Paid Family Leave Insurance Program and provides sufficient proof thereof.

• Supplemental Long-Term Disability Benefit

Total and Permanent Disability Before Age 55

Supplemental Long-Term Disability benefits are designed to provide income, as though you were retired, while you are totally and permanently disabled before age 55.

Eligibility

Eligibility for benefits includes:

- Awarded Social Security disability benefits
- 10 years of vesting credit in Defined Benefit Pension Plan
- Actively enrolled in Health and Welfare Plan for 5 of the last 7 years, including 60 or the last 84 months prior to the start of disability
- Under age 55
- Not receiving a pension from the U.A. 393 Defined Benefit Plan

Pending Determination for Social Security Disability Benefits: If you would otherwise be eligible for the Supplemental Long-Term Disability Benefit except that you have not received a Social Security Disability Award, you will nonetheless be eligible for up to twenty-four (24) months of Supplemental Long-Term Disability if all of the following criteria are met:

- You have applied for a Social Security Disability Benefits award and the determination is pending, including the determination on appeal
- You are certified by the Plan's Independent Medical Examiner to be totally and permanently disabled; and
- You furnish proof satisfactory to the Trustees that you are not gainfully employed

The twenty-four (24) months of benefits payable under this provision will not be paid on a retroactive basis.
You must inform the Plan as soon as you receive a determination on your application for Social Security benefits and/or when you receive a determination on the appeal of the Social Security Administration's initial determination.
If your application for Social Security disability benefits is granted, your Supplemental Long-Term Disability benefits will continue as long as you remain eligible under the provisions listed above.
If your application for Social Security is denied, and if applicable, your appeal through the Social Security Administration, has been denied, Supplemental Long-Term Disability benefits will terminate.

Deliberately failing to notify the Administration Office of a denial of Social Security Benefits, including a Denial on Appeal, may result in the termination of all long-term disability benefits and will be considered a fraud on the Plan and the Trustees may take any appropriate action to remediate the fraud in accordance with Plan Rules.

Benefit Amount

Your benefit from Long-Term Disability will be an annual amount equivalent to the annual benefit you would have begun receiving from the Defined Benefit Pension Plan had you been eligible for a disability retirement at the onset of disability.

Payments from Long-Term Disability continue as long as you are disabled, up to age 55. Then, benefits become payable from the Pension Plans.

You will receive 75% of your annual Long-Term Disability amount in monthly installments. The rest will be paid at the end of the year, subject to availability of funds for this purpose.

If there are not sufficient funds in the Plan to pay full benefits to all participants, participants will receive a proportionate amount of the money available for that year.

Long-Term Disability benefits are in addition to any other disability benefits from State Disability Insurance Law or Workers' Compensation. You are not eligible for Weekly Short-Term Disability from the Health and Welfare Plan while you are receiving Long-Term Disability payments.

Payment of benefits for any eligible employee will be retroactive to the date of the disability, as indicated in the Social Security Disability Award, up to a maximum of 36 monthly installment payments. Note that benefits will not be paid on a retroactive basis if you do not have a Social Security Award.

Death Benefit

If you die while receiving benefits from Long-Term Disability, your spouse will receive the balance of payments for the year of your death.

Claims for Benefits

Complete and file a Disability Application Form, along with proof of disability, with the Plan's Administration Office as soon as possible after the onset of disability. You or your representative may present any written comments, documents, records, or other information relating to your claim. You must provide the Plan's Administration Office with proof of your Social Security Disability Benefit and proof annually of the disability thereafter. You will be provided with access to or copies of Plan documents, records, and other information relevant to your claim upon request and free of charge.

To appeal a denied claim for short-term or supplemental disability benefits, follow the Plan's appeals rules, which are summarized beginning in Section 1, page 34.

Termination of Benefits

Your Long-Term Disability benefits will cease when any of the following events occur:

- Attainment of Age 55
- Termination of your Social Security Disability Benefit

- Two months after you have returned to covered employment, even if you continue receiving Social Security Disability Benefits
- You begin receiving a monthly pension benefit from the UA 393 Defined Benefit Plan

If you attempt to return to covered employment while receiving Social Security Disability Benefits and find that you are unable to perform such work, then the Supplemental Long-Term Disability Plan shall start again once you end covered employment and submit a new application.

Section 4 Enrolling in Local 393 Health and Welfare Plan

You Cannot Receive Benefits from the Plan Until You are Properly Enrolled!

Your *Spouse and Dependent Children* Cannot Receive Benefits from the Plan Until You Properly Enroll Them!

Participation in the U.A. Local 393 Health and Welfare Plan can't start until you enroll. Your family members can't receive medical benefits until you enroll them.

Delay can mean loss of benefits. When you or your spouse or child become eligible to enroll, submit a new enrollment form for that person *within 31 days*. The benefits and rights that you and your dependent spouse, domestic partner or child have under this plan cannot be assigned to others. .A direction to pay a provider is not an assignment or any right under this Plan or of any legal or equitable right to institute any court or arbitration proceeding.

To obtain an enrollment form and assistance in filling it out, contact:

BeneSys Administrators
P.O. Box 2460
San Jose, CA 95109
(408) 588-3751

• When To Enroll in Health and Welfare Plan

Initial Enrollment You may enroll in the Plan when you have completed the minimum 440 hours of work necessary to qualify for Plan participation.

Open Enrollment The Plan maintains a "rolling" Open Enrollment. You have the opportunity to change from PPO to HMO (or vice versa) anytime during the year, as long as you have not changed plans in the last consecutive twelve (12) months. This means you must wait twelve (12) months after your initial enrollment to change medical plans. The only exception to this rule will be if you move out of the Kaiser service area (in which case you must enroll in PPO) or a change is approved by the Board of Trustees. If you become eligible for Medicare and you are covered under Kaiser, you **must** enroll in the Kaiser Permanente Senior Advantage Plan. Any changes in plan(s) will be effective on the first day of the second calendar month following the date the enrollment form is received by the Administration

Office. When a change is made, an anniversary date for that plan is established. The anniversary date will be used to determine when future changes may be allowed. Please remember that your eligible dependents will be enrolled in the same plan as you. Details on the different plans will be mailed to you upon request.

If you switch back to PPO after having been enrolled in HMO, prior benefit usage under PPO will be taken into account in calculating the maximum benefits available.

When To Enroll Spouse, Domestic Partner, or Children

On the initial enrollment form that you complete for yourself, list the name, age, and Social Security Number of your husband/wife, domestic partner, and each dependent son/daughter. Enrolling your dependents costs you nothing, no matter how many eligible dependents you have.

Once enrolled, your spouse, domestic partner, and dependents qualify for medical and dental benefits, just like you. However, no coverage is provided for a dependent while the dependent is in fulltime military service.

When a Change in the Family Takes Place

After initial enrollment, if a change occurs in the family as the result of marriage, divorce, remarriage, or additional children, ***submit a new enrollment form within 31 days of the change.*** If you do not submit a new enrollment form within 31 days, coverage for a new dependent (other than a newborn child) will not begin until the calendar month following the month the new enrollment form and supporting documentation are received. Claims for newborn children will be held by the Administration Office and will not be paid until a new enrollment form and a birth certificate for the child are received.

Special Enrollment

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 toward your other coverage have ended. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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 Trust Fund Office within sixty (60) days of your Eligible Dependents 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 State Sponsored Children's Health Insurance Plan.

Definition of Spouse

Spouse means your lawful spouse, unless legally separated. "Common law" spouses are not covered. If you get divorced or legally separated, your spouse loses coverage immediately, but may purchase COBRA coverage.

Definition of

Two adults who have established a domestic partnership in California by

Domestic Partner filing a Declaration of Domestic Partnership with the Secretary of State.

Definition of Dependent Child

A dependent son/daughter means your child (including legally adopted children (or a child placed with you for adoption), stepchildren, foster children, and children of an eligible domestic partner) who has not reached his or her 26th birthday.

Your unmarried child who is age 26 or older and who is incapable of self-support because of a permanent or total disability that began prior to reaching age 19 is covered whenever you are covered. In order to extend coverage for your unmarried, disabled child after age 26, you would need to provide evidence of the total and permanent disability in the form of a Social Security Disability Award within 6 months following his or her 26th birthday.

Important: When a spouse or child ceases to qualify as a dependent, contact BeneSys Administrators immediately. The dependent will be eligible, if he or she acts within 60 days, to elect continued coverage for up to 36 months by paying the premium plus an administrative fee (See Continuing Enrollment Under COBRA).

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Is Your Enrollment Up-To-Date?

Have you moved? Divorced? Changed your name? Changed your phone number? Acquired a new dependent? If so, contact BeneSys Administrators so that your enrollment forms can be updated. ***New dependents (other than newborns) must be enrolled within 31 days*** of the date they become your dependents in order to receive medical benefits without delay. Claims for dependent newborns will be held and not paid until an enrollment form and birth certificate are received by the Administration office.

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• How To Enroll Yourself, Spouse, And Dependent Children in Health and Welfare Plan

1. Complete the U.A. Local 393 Health and Welfare Plan form. Attach copies of:
   - Marriage Certificate
   - Birth Certificate for yourself and each dependent
   - Legal adoption/guardianship documents, if applicable
   - Medical child support orders, if applicable

2. If you are not enrolling in HMO, complete an enrollment form for PPO. If you do not complete an enrollment form, you will automatically be enrolled in HMO.

Anytime you change anything regarding your Health and Welfare Plan enrollment, you must complete a new enrollment form, attach the appropriate documents to the form, and send them to BeneSys Administrators. Those having difficulty obtaining documents should contact BeneSys Administrators or the Members' Advocate.

Documents Needed On File

Always keep up-to-date copies of the following certificates on file at BeneSys Administrators:

- Marriage Certificate
- Birth certificates for you, your spouse, and all dependents
- Divorce documents, including qualified domestic relations orders (QDRO) and medical child support orders

Upon the death of a member or dependent, a copy of the death certificate must be provided to the Union and to BeneSys Administrators.

If you move or change telephone numbers, contact BeneSys Administrators so that benefits and benefits information will reach you in a timely manner.

Coordination of Medical And Dental Benefits

The Health and Welfare Plan contains a provision that enables anyone covered under more than one group plan or government plan to get coverage up to 100% of his or her eligible charges -- but no more than that. For example, you may choose to be covered for medical benefits under this Plan plus under your spouse's group plan wherever he or she works. If so, the benefits paid by each Plan will be coordinated.

Section 5 Using Basic Reserve Account And Other Options To Retain Eligibility For Health and Welfare Plan

This section of your summary plan description covers all the methods of getting in and staying in the Local 393 Health and Welfare Plan, from new hire through retirement, termination, or death.

- Working 440 Hours within 12 Months To Qualify for Enrollment
- Working 110 Hours Per Month To Stay Enrolled Month-to-Month
- Building up a Basic Reserve Account
- Self-Payment If Your Basic Reserve Account Runs Out
- Qualifying for an Extended Reserve Account
- Continuing Enrollment During
  - Disability
  - Retirement
  - Qualified Marriage and Family Leave
  - Military Leave
- Continuing Coverage After Termination (COBRA)

• New Hire

Hours of Work For Membership

Membership in the U.A. Local 393 Health and Welfare Plan is based on current or accumulated Basic Reserve credits, which you receive for hours of work. The following rules apply as of October 1, 2009.

New Member

As a new U.A. Local 393 member, when you complete 440 hours of union covered work within a 12-month period, you will become eligible to enroll in the Health & Welfare Plan.

In a typical case, someone who starts work in January 1 and works 20 hours per week, will accumulate 440 hours 22 weeks later, on May 31. In June, the employer reports the hours to the Plan administrator. The new member's enrollment will be processed, and at the start of the next month, July 1, Plan membership begins.

If the person in the example above did not complete the required number of hours by December 31 (the end of the initial 12-month eligibility period), the eligibility period would continue. The new member would

become eligible to enroll as soon as he or she had completed the required hours of work within 12 months in a row. (See Example 1).

Once you become eligible for coverage you will automatically be placed in the HMO Plan (see page 1). You have 90 days to submit an enrollment form and switch to PPO (see page 1).

Employees Not Covered By a Collective Bargaining Agreement

These Basic Reserve Account Rules shall apply to any Employee 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, which allows contributions on behalf of the employee. These 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 Eligibility Rules for Individual Employers unless that person is an officer/shareholder and Employer meet all of the following requirements:

- The Employer is incorporated; and
- The Employer is signatory to a collective bargaining agreement with U.A. Local 393; and
- The Employer signs a participation agreement requiring the Employer to make hourly contributions on behalf of the officer/shareholder at the journeyperson rate; and
- The officer/shareholder's participation is approved by the Trustees or a designated committee of Trustees; and
- The officer/shareholder has at least 10 (ten) Vesting Credits in the U.A. Local No. 393 Defined Benefit Plan; and
- The participation is otherwise in accordance with law.

• Basic Reserve Account

Once your Basic Reserve Account reaches 440 hours, Plan membership begins (provided you complete your enrollment documents promptly).

The Plan needs your enrollment application, all accompanying documents, and your choice of medical plans before you can be enrolled.

See Example 1.

Hour of work means an hour of covered employment under a collective bargaining agreement of U.A. Local 393.

However, if you have reciprocity in effect, so that contributions made on your behalf are transferred to another U.A. Trust Fund, your hours are counted only under the plan of the other Trust Fund. Likewise, if you have contributions transferred here from another Trust Fund, your work in the other area is treated as covered hours, except that they are adjusted proportionally to reflect the difference in contribution rates.

Basic Reserve Account Advance

A Basic Reserve Account will be opened immediately for an employee who joins Local 393 as a result of organizing activities.

The employee who qualifies will be one who left employment with a non-contributing employer or whose employer is newly-contributing.

The employee's Basic Reserve Account will be advanced sufficient credit (440 hours) to enable the new hire to enroll in the Health and Welfare Plan. The employee will make up for the advance with his or her first 440 hours of covered work.

This advance Basic Reserve Account will be revoked immediately if the employee stops working in or is no longer available to work for a contributing employer before contributions equal to the advanced Basic Reserve Account amount are received.

• Termination of Eligibility

When your Eligibility is Terminated

You or your dependents eligibility under the Plan will terminate at any of the following times:

1. On the day the Plan terminates.

2. At the end of the month that your Basic Reserve Account has less than the Basic Monthly Charge-Off unless you or your dependent qualify for, elect, and pay for any form of continuation coverage provided under the Plan.

3. In the case of your spouse, when your coverage terminates or when a court issues a decree or judgment of legal separation or final dissolution of your marriage, or when your coverage terminates.

4. When your dependent child attains a maximum age, or when your coverage terminates.

5. When your Domestic Partnership ends, then your partner and his or her children cease to be eligible for coverage.

6. Upon your entering full-time military service, exclusive of temporary training periods.

• Losing Coverage Because of Misconduct

How You Lose Plan Coverage

Regardless of how much you have in your Basic Reserve Account, you will lose coverage under the Plan immediately if you do any of the following:

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.

If any of these apply to you, you and your family lose coverage as soon as possible. This means immediate loss of all benefits except for benefits prepaid for that month (such as Kaiser coverage), which terminate at the end of the month. In addition, your Basic Reserve Account is lost, and you will not be eligible for any regular coverage unless and until you requalify as a new employee. The only coverage for which you may be eligible is COBRA coverage, but that is only available if you had a qualifying event under COBRA. For example, if 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 less than the full contract rate, there is no qualifying event.

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Example 1

Plan Eligibility = Basic Reserve Account Balance of 440 Hours of Work Within 12 Months

	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8
	Hours	Hours	Hours	Hours	Hours	Hours	Hours	Hours
Employee A	**40**	**80**	**80**	**80**	**90**	**80**	**Skip***	**Enroll**
Employee B	**40**	**40**	**40**	**40**	**40**	**40**	**30**	**30**

	Month 9	Month 10	Month 11	Month 12	Month 13	Month 14	Month 15
	Hours	Hours	Hours	Hours	Hours	Hours	Hours
Employee B	**30**	**30**	**30**	**40**	**40**	**Skip***	**Enroll**

Employee A has more than 440 hours by the end of the sixth month of work. Month 7 is the "skip" month. On the first day of Month 8, Employee A's Plan membership starts.

Employee B doesn't finish 440 hours within a period of 12 months in a row until the end of the thirteenth month of work. Month 14 is the "skip" month. On the first day of Month 15, Employee B's Plan membership starts.

*Note about "Skip Month Accounting:" Hours accumulated for Plan eligibility are reported by the employer the month following the date of accumulation. They do not enter the employee's Basic Reserve Account system in the Health and Welfare Plan until the first day of the second month after they were accumulated. For example, the 440 hours accumulated by June are reported by the employer in July, then are used for coverage beginning August 1. July is the "skip" month for June's hours.

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• Staying Enrolled Month-to-Month

Satisfying Contribution Requirement

Once you become a Plan member, you need 110 hours of work to *stay enrolled* in the Plan. You satisfy this requirement in one of the following ways:

(1) Working at least 110 hours per month at the current base contribution rate, or
(2) Drawing on reserves, if any, in your Basic Reserve Account or,
(3) As a last resort, if eligible, making a monthly premium payment (see Self-Payment When Basic Reserve Account Runs Out).

Current Work

A member working 110 hours per month will satisfy the continuing enrollment requirement through current hours. Should current hours dip below 110, Basic Reserve Account reserves may be drawn on.

• When Low on Hours, Draw on Basic Reserve Account Reserves

About Basic Reserve Account Reserves

Basic Reserve Account reserves are made up of work hours credited to your Basic Reserve Account in excess of the 110 hours being deducted for a month's continuing enrollment. A maximum of 660 hours may be reserved.

See Example 2.

For example, a member working 130 hours per month will use 110 hours to pay for continuing enrollment, and save 20 hours in reserve. At that rate, after 33 months, the member will have accumulated the maximum 660 reserve hours (20 hours x 33 months = 660 hours).

Altogether, the Basic Reserve Account reserves provide about six months' continuing enrollment during times when you are out-of-work.

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How Basic Reserve Account Reserves Are Used

Reserves may be used to satisfy part or all of the continuing enrollment requirement. For example, a member working 100 hours per month will draw 10 hours of reserves. A member working 0 hours per month will draw on 110 hours of reserves. After your Basic Reserve Account is used up, other alternatives may be available to continue enrollment from month-to-month (See Self-Payment When Your Basic Reserve Account Runs Out).

A member who leaves covered employment to work as a public safety officer may request in writing that his or her Basic Reserve Account be frozen for up to one year during the period he or she is serving as a public safety officer. The member and his or her dependents will not be eligible to participate in the Plan while the Basic Reserve Account is frozen.

If the member returns to covered employment within one year, notifies the Trust Fund in writing of his or her return, and provides adequate proof of his or her service as a public safety officer, the Basic Reserve Account will be unfrozen and used to satisfy part or all of the continuing enrollment requirement.

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Example 2
Sample Activity in the Basic Reserve Account of a New Enrollee

Assume a member joins the Plan with 440 hours in his or her Basic Reserve Account as of June 1. Also assume that the member works 150 hours per month, 40 hours more than the minimum needed to fund continued participation in the Health and Welfare Plan. The additional hours are credited to the Basic Reserve Account and the Basic Reserve Account grows by 40 hours per month. By the following March 1, the member's Basic Reserve Account reaches the maximum 660 hours. From that point, additions to the Basic Reserve Account and deductions for one month's continuing enrollment begin to offset each other, and the Basic Reserve Account remains at the maximum.

Date	Addition To Basic Reserve Account	Deduction for One Month's Continuing Enrollment	Basic Reserve Account
Beginning Basic Reserve Acct.			440 hours
June 1	0 (June is the "skip"* month for May hours)	110 hours for June's coverage	330 hours
July 1	150 for May Hours	110 hours for July's coverage	370 hours
August 1	150 for June hours	110 hours for August's coverage	410 hours
September 1	150 for July hours	110 hours for September's coverage	450 hours
October 1	150 for Aug. hours	110 hours for October's coverage	490 hours
November 1	150 for Sep. hours	110 hours for November's coverage	530 hours
December 1	150 for Oct. hours	110 hours for December's coverage	570 hours
January 1	150 for Nov. hours	110 hours for January's coverage	610 hours
February 1	150 for Dec. hours	110 hours for February's coverage	650 hours
March 1	Only 120 hours for Jan. hrs. (Basic Reserve Account has reached max.)	110 hours for March's coverage	660 hours
April 1	Only 110 hours for Feb. hrs.	110 hours for April's coverage	660 hours

*Note about "Skip Month Accounting:" Hours worked in one month are reported by the employer the following month. They are not used to buy coverage or added to Basic Reserves until the first day of the second month after they were earned. For example, a member's work hours for May are reported by the employer in June, then are converted to Basic Reserve Account additions for the member's continuing enrollment in the Health and Welfare Plan on July 1. June is the "skip" month for May's hours.

Keep Your Pay Stubs As a Record of Your Hours Worked

To inquire about the hours in your Basic Reserve Account at any time, contact the Trust Fund Office. Also, please retain pay stubs. They provide evidence of hours worked. In months when work hours are low, contact the office to review your Basic Reserve Account reserves. Inquire about the availability of the self-payment option (see Self-Payment When Your Basic Reserve Account Runs Out).

When Your Reserve Account Runs Low

Should your Basic Reserve Account sink to less than 110 hours, your continuing enrollment is at risk. You will receive a notice in the mail from the Trust Fund Office. You will have until the end of the month in which you receive the notice to make a self-payment, if eligible, to continue

enrollment for the following month. If self-payment is not an option, enrollment will cease at the end of the current month. It may be reinstated if work hours resume within a reasonable time and the Basic Reserve Account again accumulates 110 hours (See Reinstated Enrollment).

Example of Low Hours

In June, a member receives a notice from the Trust Fund revealing that his or her Basic Reserve Account has a remaining reserve of, say, only 48 hours. This is less than the total hours (110) necessary to continue enrollment for *July*. Here are the member's choices:

1. Self-payment. If the member qualifies for self-payment, he or she will have until the 20th day of *June* to make a payment of 62 hours at the current contribution rate to bring the total hours to 110, in order to continue enrollment in *July*. Then, on a month-to-month basis, the member may continue to make self-payments (See Self-Payment When Your Basic Reserve Account Runs Out) to extend enrollment for up to 11 more months. Monthly payments after the initial payment are due on the 15th of each month.

   OR

2. No self-payment. If the member does not qualify for self-payment or does not wish to make self-payment, enrollment will be suspended at the end of *June*. It may be reinstated if the member goes back to work within a reasonable time and a total of at least 110 hours accumulates in the member's Basic Reserve Account. (See Reinstated Enrollment).

• Self-Payment When Your Basic Reserve Account Runs Out

About Self-Payment

Self-payment is the valuable option that allows an eligible member to continue enrollment for certain benefits for up to one year after his or her Basic Reserve Account has run out.

Members eligible for self-payment are:

- Active members who are on the Union's out-of-work list and actually available for dispatch,
- Disabled members who became disabled from working in the trade while eligible for continuing enrollment (See Continuing Enrollment When Disabled), and
- Apprentice employees who are dispatched to an employer who is not signatory to a U.A. Local No. 393 collective bargaining agreement and who do not receive contributions to this Plan during the period of employment.

You make self-payments for both medical and dental coverage, or select medical coverage only. Self-payment means that cash temporarily replaces hours of work as the means for continuing enrollment. The Trust Fund

Office will advise you of the amount and the deadline for monthly payments. The self-payment amount will be less than if you were purchasing coverage through COBRA (See Continuing Enrollment Under COBRA).

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Example 3
Sample Activity in Basic Reserve Account That Is Running Out

Assume a member has been down to 0 hours of work and has been drawing on Basic Reserve Account reserves to continue enrollment from month-to-month. Assume the Basic Reserve Account has been reduced to 118 hours. Here's how activity proceeds from that point.

Date	Addition To Basic Reserve Account	Deduction for One Month's Continuing Enrollment	Net Basic Reserve Account
Beginning Basic Reserve Acct.			118 hours
June 1	0 hours for April	110 hours for June's coverage. Trust Fund Office sends alert notice to the member letting him or her know that his/her Basic Reserve Account has fallen below 110 hours. If the member is eligible for self-payment, he or she can send a payment for 102 hours at the current contribution rate by June 20 to bring the total hours to 110 in order to continue enrollment for July.	8 hours
July 1	0 hours for May	A self-payment for 102 hours sent at the end of June brings the total hours to 110 and buys July's coverage. If no self-payment was sent, coverage ends at the end of June.	0 hours
August 1	0 hours for June	Member, if eligible, self-pays for August coverage by July 15. If not, any coverage in effect for July as a result of earlier self-payment ceases at the end of July.	0 hours
September 1 through June 1 of the next year	0 hours for July-April	Member, if eligible, self-pays for coverage in each of these 10 months. Enrollment ceases at the end of June. The member may re-qualify for enrollment as though he or she were a new employee. Otherwise, the member may apply for continuing enrollment through COBRA (See Continuing Enrollment Under COBRA).	0 hours

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Reinstated Enrollment

An active member whose Basic Reserve Account has run out wants to end self-payment as soon as possible and be able to rely once again on his or her Basic Reserve Account to provide continuing enrollment in the Plan. The Plan's reinstatement rules are designed to do just that.

Immediate Reinstatement Within 12 Months: Under the Plan's rules, a Basic Reserve Account that falls to zero will be left open for the next 12 months to receive any additions based on hours of work the member may complete during that time. If, at the start of any month, the Basic Reserve Account again shows a balance of 110 hours, enrollment will resume for that month. After that, each additional 110 hours accumulated will result in one month's continuing enrollment.

See Example 4.

Delayed Reinstatement After 12 Months: If a member is unable to complete enough hours of work within 12 months to build up a Basic Reserve Account of 110 hours after his or her Basic Reserve Account falls to zero, he or she may still qualify for delayed reinstatement. The member will follow the rules for a new employee and be reinstated after accumulating a new Basic Reserve Account of 440 hours within a 12-month period. Otherwise, the member may apply for continuing enrollment under COBRA. (See Continuing Enrollment Under COBRA.)

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Example 4 - Reinstated Enrollment Within 12 Months

Assume a member's Basic Reserve Account had dropped to 0 hours on June 1, and his or her work hours are up and down for several months after that. In this example, the member's enrollment will be reinstated two months later, in August, because the total hours worked equal at least 110 in 12 months.

Date	Addition To Basic Reserve Account	Deduction for One Month's Continuing Enrollment	Net Basic Reserve Account
Beginning Reserve Acct.			0 hours
June 1	0 for April hours	0 (Not eligible for June's coverage except by self-payment)	0 hours
July 1	80 May hours	0 (Not eligible for July's coverage except by self-payment)	80 hours
August 1	40 June hours	110 hours for August's coverage	10 hours
September 1	120 July hours	110 hours for September's coverage	20 hours
October 1	120 Aug. hours	110 hours for October's coverage	30 hours

November 1	140 Sept. hours	110 hours for November's coverage	60 hours
December 1	120 Oct. hours	110 hours for December's coverage	70 hours

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• Continuing Enrollment When Disabled

First 12 Months Enrollment Free

If you become disabled from working in the trade while eligible for continuing enrollment in the Plan, your Basic Reserve Account will be frozen. For the next 12 months of disability, enrollment will continue with no deductions from your Basic Reserve Account.

After that, your Basic Reserve Account will be unfrozen, and you may draw on it, for as long as it lasts, to continue enrollment month-to-month. After that, you may be eligible for one of the following additional periods:

Requirements	**Additional Coverage**
1. If Disabled from Trade Only (No Social Security Disability Award):	
Not Covered as an active employee during 9 of last 10 years, including 80 of the last 120 months immediately prior to the month of the onset of disability.	Eligible for 12 months of disability at no charge, then exhaustion of the Basic Reserve Account, and then self-payments for the remainder of 36 months. Note that if you have applied for a Social Security Disability Award, but have not yet received a determination (including, if applicable a determination on appeal): the Basic Reserve Account Run Out will be charged at fifty percent (50%) of the required monthly charge for coverage. Note that you must immediately inform the Administrative Office when Social Security makes a determination (including any determination on appeal, if applicable) and that if you intentionally fail to do so your benefits may be suspended for fraud.
Covered as an active employee during, 9 of the last 10 years, including 80 of	Eligible for 12 months of disability at no charge, then

the last 120 months immediately prior to the month of the onset of disability	exhaustion of the Basic Reserve Account, and then coverage for the remainder of the 36-month period for an amount equal to one-half the current active employee self-payment rate. Note that if you have applied for a Social Security Disability Award, but have not yet received a determination (including, if applicable, a determination on appeal) the Basic Reserve Account Run Out will be charged at fifty (50%) of the required monthly charge for coverage. Note that you must immediately inform the Administrative Office when Social Security makes a determination (including, if applicable, a determination on appeal) and that if you intentionally fail to do so your benefits may be suspended for fraud.

OR

2. If Receiving Social Security Disability Award:

Less than 10 Years of Vesting Credit, or not covered for 5 of last 7 years and 60 of last 84 months	First 12 months of benefits at no charge, then exhaustion of Basic Reserve Account, and then self-payments until the period of coverage equals total number of months of eligibility before onset of disability.
10 or more Years of Vesting Credit, and covered for 5 of last 7 years and 60 of last 84 months	First 12 months of benefits at no charge; then exhaustion of Basic Reserve Account; and then coverage until period of coverage equals number of months of eligibility before onset of disability, for an amount equal to one-half the current active employee self-payment rate.

Please note that all forms of Disability Coverage apply to you only if you remain disabled. You may be requested to provide proof of continuing disability any time while on Disability Coverage. In addition, all eligibility for Disability Coverage terminates when you become eligible for retirement benefits and Health and Welfare benefits as a retiree, or earlier if you actually retire before that under the Defined Benefit Pension Plan.

If your Disability Coverage terminates, and you have any months remaining in your original COBRA Continuation Coverage period (less any period of coverage you received at the same cost or at a lower cost), you or your dependents may elect COBRA coverage for the remaining months (see page 96).

• Continuing Enrollment When Terminally Ill

If you have been diagnosed with a terminal illness and have been given less than six months to live, you may remain eligible for benefits for up to thirty-six months at no charge, including any months of coverage for disability, so long as you are:

1. Under the age of 55;
2. Provide written certification from three different doctors regarding your terminal illness and that you have less than six months to live; and
3. You were an active employee in the Plan for at least ten years (120 months) **and** you had at least twelve (12) consecutive months of coverage as an active employee within the eighteen (18) months before you were diagnosed as terminally ill.

Terminally ill coverage includes any months of coverage you may receive for disability, and cannot exceed thirty-six months combined.

• Help Yourself With an Extended Reserve Account

About Extended Reserve Account

While Working: Funds in your Extended Reserve Account can be used - to pay for co- payments, self-payments, COBRA payments, deductibles, and for reimbursement of qualified health expenses which are not covered by this Plan.

At Retirement: When you retire, you must draw on your Extended Reserve Account to pay for the monthly premiums for Health and Welfare Plan medical coverage or Medicare supplemental coverage from PPO or HMO, or to pay the premiums for other medical insurance coverage (only contributions received on or before December 31, 2013 can be used to pay for individual coverage). You may also use the funds in your Extended Reserve Account to pay for co-payments, self-payments, deductibles, and for reimbursement of qualified health expenses which are not covered by this Plan. You and your spouse will still be permitted to use your Extended Reserve Account for reimbursement of qualified medical expenses if you opt out of retiree coverage because you are covered under another group health plan. However, you will permanently forfeit your extended reserve account if you become employed in industry service (as defined on page 91) 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.

Upon Your Death: In the event of your death, the Extended Reserve Account will be used to provide coverage for your spouse and eligible dependent children. The Funds in the Extended Reserve Account may also be used to pay for their co-payments, deductibles and for reimbursement of their qualified health expenses and to pay the premiums for other medical insurance coverage (only contributions received on or before December 31, 2013 can be used to pay for individual coverage).

W*hen You Leave the Plan:* Even when you are no longer eligible for coverage under this health and welfare plan, you may still draw on your Extended Reserve Account to pay for the qualified health expenses (as defined in the subsection uses for Extended Reserve Account on page 73, (including premiums for other medical insurance coverage) of you and your eligible dependents (only contributions received on or before December 31, 2013 can be used to pay for individual coverage). However, you will permanently forfeit your extended reserve account if you become employed in industry service (as defined on page 91) 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.

Health Expense Reimbursements: Effective January 1, 2006, you and/or your covered dependents, while active or retired or after your death, may also elect to use any part of an Extended Reserve Account for reimbursement of qualified health expenses which are not otherwise covered by the Plan.

Growth and Earnings Tax-Free: Funds deposited in your Extended Reserve Account are tax-exempt. The funds are invested, and the growth and earnings are added to the account.

Credit to Your Extended Reserve Account: Effective January 1, 2014, credit to your Extended Reserve Account will only be made if you are eligible under this Plan and are enrolled in the medical coverage provided under this Plan, or another employer sponsored group medical coverage that provides minimum value, as defined in Internal Revenue Code § 36B(c)(2)(C)(ii). You are not eligible for credit to be added to your Extended Reserve Account credit if you are enrolled in medical coverage purchased on the individual market. In addition, you will not receive credit to your Extended Reserve Account while building your Basic Reserve Account to meet the initial eligibility requirements. Once you are eligible under the Plan and are actually enrolled in this Plan or other group medical coverage that meets the requirements discussed above, you will receive a one-time credit to your Extended Reserve Account in an amount equal to the credit you would have received had you been eligible and enrolled while building your Basic Reserve Account.

Optional Bonus Amount at the Discretion of the Trustees

The Board of Trustees may, from time to time, provide for the crediting of the Extended Reserve Accounts 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 and subject to terms within their exclusive discretion. Eligible Participants and Beneficiaries will be notified if the Board approves such a bonus.

Uses For Extended Reserve Account

You may use funds in your Extended Reserve Account in the following ways:

- For self-payment when your Basic Reserve Account has dipped below 110 hours
- When you qualify for self-payment, you may authorize the Trust Fund Office to use funds in your Extended Reserve Account to cover your payments. Any election to use your Extended Reserve Account must be made in writing. You may cancel your election if you later decide to make cash payments. Once cancelled, an election may not be reinstated for that period of self-payment.
- Purchase monthly coverage in the Health and Welfare Plan after you have retired from Local 393 Defined Benefit Pension Plan (see page 87).
- Earn investment income. The Extended Reserve Accounts of all participants are invested for growth and earnings. At the end of any year in which you have a balance in your Extended Reserve Account, your account will be updated to reflect your share of gains (or losses) on the Plan's investments.
- Purchase COBRA coverage (see page 96) after Union employment has terminated.
- Provide survivor benefits. If you die with any credits remaining in your Extended Reserve Account, your surviving enrolled family members may use these funds to continue their enrollment in the Health and Welfare Plan after your death. It may also be used to pay for their co-payments, deductibles and for reimbursement of their qualified health expenses or toward the premiums of other medical insurance coverage (only contributions received on or before December 31, 2013 can be used to pay for individual coverage).
- Reimbursement of health expenses. The Extended Reserve Account can be used to pay for medical, dental, vision or similar expenses you pay that are either in excess of Plan limits, or not covered by the Plan Effective January 1, 2011, expenses for medicines or drugs may be reimbursed only if you have a prescription (true even for over-the-counter medicines or drugs), or if the expense is for insulin. Under governing law, some things are not reimbursable – the Plan office will advise you whether an expense is reimbursable.

Examples of permitted reimbursable expenses:
- All non-cosmetic dental work
- All vision correction devices and services
- Co-pays and deductibles

Examples of non-reimbursable expenses:
- Teeth whitening
- Strictly cosmetic surgical procedures
- Vitamins

If you die without dependents eligible for continued coverage, or if the dependents decline the coverage, the balance remaining in the Extended Reserve Account will be forfeited to the general assets of the Health and Welfare Plan.

Upon termination of participation in the Plan, you are permitted to permanently forfeit reimbursement from the Extended Reserve Account.

What size Extended Reserve Account do I need?
If you intend to use your account for reimbursement of health expenses while active and/or retired, you need to plan for those amounts. All of us hope to enjoy a long and healthful retirement. A good question to ask yourself is: What will be my total premium expense if I know my date of retirement? Then, if I am building my account now, at what rate should I be doing so?

Benny Prepaid Card

The Board of Trustees is providing you with a convenient way to access your Extended Reserve Account (ERA) money.

Your Benny™ Prepaid Card will be loaded with the available balance of your ERA (less any amounts you have already spent) and is updated regularly. The Card is used, instead of cash, to pay for qualified health care expenses. So, no more claims forms! Use your Card to pay for items such as:
- Covered prescription co-pays
- Lasik surgery and eyeglasses
- Health plan co-insurance
- Orthodontics
- Health plan deductibles
- Out-of-pocket dentist fees
- Doctor and emergency room co-pays

• Enrollment After Retirement

About Retiree Enrollment

As an eligible retiree of U.A. Local 393, you have the option of continuing enrollment in the Plan by paying monthly enrollment premiums.

Eligible retiree means:

- At the time of your retirement, you were covered as an active employee during at least nine of the last ten years prior to the month of retirement, provided that:

    - Your service in 2009 may be disregarded if your hours that year would make you ineligible and you were signed on the U.A. 393 Building and Trades Joint Hiring Hall out of work list; and

    - Service for an approved general contractor who is not signatory to U.A. Local No. 393 Collective Bargaining Agreement, but is signatory to another collective bargaining agreement for another building trade, may be disregarded under this rule and your years covered as an active employee will be frozen until you return to work for a contributing employer and resume accruing years covered as an active employee; and

- Unless you defer retiree coverage because you are covered under another group plan, you enroll in retiree coverage at the earlier of: (A) commencement of your 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

- You are a member of U.A. Local 393. U.A. Local 393 will notify you if your union dues are overdue and you will be given an opportunity to pay the overdue amount. If you fall 6 or more months behind in the payment of union dues, you will not be eligible for coverage under this Plan until the overdue amount is paid and membership in U.A. Local 393 is reestablished; and

- You satisfy one of the following:

    - You are 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

    - You are receiving monthly installments under the U. A. Local No. 393 Defined Contribution Plan under Article 6, Section 1(b)(4).

If you have twenty (20) Years of Benefit Credit under the U.A. Local No. 393 Defined Benefit Pension Plan and you work for a municipality in Industry Service in the jurisdiction of U.A. Local No. 393, you are not required to satisfy the service requirement under this rule, provided you are working either for such municipality or for a contributing employer at the time of your retirement.

If you have thirty-five (35) Years of Benefit Credit under the U.A. Local No. 393 Defined Benefit Plan and you are enrolled in Medicare Parts A and B, you are not required to satisfy the service requirement under this rule.

If you are otherwise eligible for this coverage and you engage in any covered employment for an employer that is not signatory to a U.A. Local Union having jurisdiction over the respective geographical area, or engage in business for yourself without being party to such an agreement, your right to retiree medical coverage for you and your dependents will be forfeited.

If you are under age 65, your retiree medical benefits will be received from PPO or HMO, whichever you elect.

If you are age 65 or otherwise eligible for Medicare, your retiree medical benefits will be received from PPO Medicare Supplement Plan or Kaiser Permanente Senior Advantage (KPSA), whichever you elect, provided you are enrolled in both parts A and B of Medicare. However, you may elect Kaiser coverage only if you live in the Northern California Kaiser service area.

You may change your enrollment from PPO Medicare Supplemental Plan to Kaiser Permanente Senior Advantage at any time, but those in KPSA may change to PPO Medicare Supplement Plan only once in a twelve month period.

Dependents who were covered at the time you retired will continue to be covered while you are retired, for as long as they remain your dependents. Your spouse and eligible dependents who survive you may continue to be covered following your death, if they make monthly premium payments.

Retiree Self-Payment Amounts

Your first payment is due the first month after your Basic Reserve Account runs out. After that, your payments are due by the 15th day of the month for the following month's coverage. Retired employees with Extended Reserve Accounts must use their accounts for making retiree payments. If your total income is less than $3,390 per month, you may receive assistance in making payments through the hardship waiver provision, described next.

For retirees who enroll in the retiree medical plan on or after July 1, 2009, the retiree premium is determined in accordance with the chart below. Please note that the retiree rates are updated on a periodic (typically annual) basis by the Board of Trustees. As the chart illustrates:

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Those who retire before age 55 will pay 100% of that year's plan cost until turning age 55, whereby the rate will be adjusted to the applicable 55 year old payment percentage.

Those who retire at age 65 or older, will pay the applicable percentage based on the (64+) group.

Lastly, those who retire at pre-Medicare age (prior to age 65) will have their applicable pre-Medicare percentage value fixed throughout their retirement. However, at age 65 (Medicare-eligible) their 'fixed percentage' will be applied to the Medicare plan cost.

Local 393 – Retiree Health and Welfare Subsidy Schedule
Percent of Plan Cost **(Excluding Dental)** Paid by Member

Career Hrs in LU 393	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%

Note:

1. Those who retire at age 52-54 will pay 100% of the plan cost until said retiree turns age 55, where the percentage paid will be adjusted to match the 55 year old group.
2. The **plan cost** per member/per month is reviewed annually.
3. Your "Percent Paid by Member" is based on your age at retirement & your career hours in Local 393.
4. To determine your cost - multiply the plan cost x your applicable "Percent Paid by Member." (ex. Retire age 60 w/ 50,000 hrs. in Local 393 - 50% (Paid by Member) x (plan Cost) = your cost.
5. The "Percent paid by Member" remains fixed throughout retirement. At age 65 the plan cost is reduced to the Medicare eligible rate cost reviewed annually).
6. This chart has been approved by the Trustees of the U.A. Local 393 Health and Welfare Plan, but is subject to revision or correction at any time.

Hardship Waiver

If you or your surviving spouse's total income is less than $3,390 per month (this amount is periodically reviewed and changed by the Board of Trustees), you or your surviving spouse may apply for assistance in making self-payments for your retiree coverage from Local 393. Total income means monthly pension benefit from the Local 393 Defined Benefit Pension Plan, plus the equivalent monthly pension from the Local 393 Defined Contribution Plan, plus Social Security income, plus wages, plus investment income, and plus capital gains.

If your total income from these sources is less than $ 3,390 per month, contact the Trust Fund Office for assistance.

A retiree who qualifies for a hardship waiver shall have the entire amount of the monthly retiree premium waived.

Surviving spouses who qualify for a hardship waiver will receive hardship relief in an amount equivalent to the Self-pay Rate for Retirees who qualified for Medicare before 1993.

When To Elect Retiree Coverage

In order to continue enrollment as a retiree, you must elect it at one of the following times:

- Upon retirement, or
- Upon becoming eligible for Medicare, or
- Within 31 days of terminating coverage under another group health plan or group dental plan in which you may have been enrolled at the time of retirement instead of in the U.A. Local 393 Health and Welfare Plan.

Once you become eligible for Medicare, you must enroll in both Parts A and B.

All retirees must continue to be members of Local 393. If your benefits under the Defined Benefit Plan become suspended for working in Industry Service during retirement, your retiree benefits under this Plan will be terminated. They will resume if you again qualify for retiree benefits.

Suspension Of Coverage for Working In Industry Service

Retiree benefits are available only to qualified persons who are retired. This means your benefits will be suspended if you do any of the following, with limited exceptions:

1. You perform any work of the type covered under the Collective Bargaining Agreements of U.A. Local 393, or
2. You do any work for which benefits may be suspended under the U.A. Local 393 Defined Benefit Pension Plan, or
3. You become an employer, or a significant shareholder of an employer, who is signatory to a Collective Bargaining Agreement with U.A. Local 393; or
4. You perform paid work for the Union or a related entity, for which work contributions are made to this Plan.

What Is Industry Service?

Industry Service includes any work for, or ownership interest in, a business in the Plumbing and Pipefitting Industry, including not only working with

the tools, but also management work of any kind, such as estimating, project management, or sales. Industry Service also includes holding a license that would allow you to perform work in the Plumbing and Pipefitting Industry, whether you are active in the Industry. However, the following positions are not considered Industry Service:

(a) Inspector for any public agency (including plumbing or mechanical inspector), in a position not involving the use of the tools of the trade, whether employed directly or indirectly by the public agency; and
(b) Employment for a retail store in a position not involving the installation of plumbing facilities.

What Happens If You Perform Industry Service

If you work for or as an employer, or become an owner of a company which does Plumbing or Pipefitting work of any kind and is not signatory to a U.A. Local 393 Collective Bargaining Agreement, your benefits will be suspended and will not be reinstated unless you requalify on the basis of nine (9) new years of coverage.

If you work under a U.A. Local 393 Collective Bargaining Agreement, or as an employer or as a significant shareholder of a corporate employer, who is signatory to such an agreement, your benefits will be suspended while you are actually working in Industry Service, but will recommence when your Industry Service ends. As an employer or significant shareholder, you may be eligible to enroll as an Individual Employer immediately.

The following groups of retirees will have their coverage suspended as retirees, but shall be eligible for coverage as active employees on the first day of the month your Basic Reserve Account equals the Basic Monthly Charge-off. And until such time, you can continue to pay the retiree self-pay for your coverage.

(a) A retiree who performs work of the type covered by the Collective Bargaining Agreement for an employer who is signatory to a Collective Bargaining Agreement with U.A. Local 393.
(b) Disability Retirees who attempt to work as part of a rehabilitation program.
(c) Retirees who work for Local 393 or a related entity in a position for which contributions are made to the Plan.

Contact BeneSys Administrators to find about your benefits before you begin working in Industry Service.

Deferring Or Suspending Coverage

You may defer or suspend coverage in this Plan if you become covered under another group health plan and provide a written request and proof satisfactory to the Board of Trustees of your other coverage.

Voluntarily

You may elect to defer medical coverage and maintain dental benefits with the Plan, but in no event may you defer dental benefits unless you are also deferring medical benefits.

You may enroll or re-enroll in this Plan's medical coverage after the other coverage is no longer available. For example, you may have ceased to be a covered employee under the other coverage, or you were an eligible

dependent under the other coverage and the other coverage dropped dependent eligibility.

Coverage will not be deemed "no longer available" if it ceased because you or your spouse elected to stop paying for your coverage, even if the cost of the other coverage had increased significantly.

When you enroll or re-enroll in this Plan's medical coverage following a deferral or suspension, if you are Medicare-eligible you will be covered under Kaiser Permanente Senior Advantage for at least 12 months. After that, you may choose either KPSA or PPO Medicare Supplement.

You may enroll or re-enroll in this Plan's dental coverage if you can demonstrate that you had the other dental coverage for at least the 60 days prior to re-enrollment in this Plan.

If you are covered under a spouse's group health plan and elect to defer enrollment at retirement, the hours in your Basic Reserve Account shall be converted to an equivalent dollar amount and deposited into your Extended Reserve account upon your retirement effective date. Once your Basic Reserve Account hours have been converted and deposited into your Extended Reserve Account, there shall be no hours remaining in your Basic Reserve Account.

Retiree Enrollment Not a Vested Right Of Retirees

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

• Continuing Enrollment For Your Surviving Dependents

About Continuing Survivor Enrollment

Local 393 provides survivor coverage in the event of your death while you are actively enrolled in the Health and Welfare Plan.

Death While an Active Employee

If you die while an active employee in the Health and Welfare Plan, Local 393 will provide continued coverage at no charge to your surviving spouse and enrolled dependent children for the first six months following your death.

After that, they may continue to have coverage by making self-payments as follows:

Your surviving spouse and surviving eligible dependent children may continue to self-pay for the period of your active participation in the Plan, by paying the amount determined from time to time by the Board of Trustees. The period of active participation includes the entire period from your last enrollment as a new employee, including time during which you were not eligible for benefits, but were eligible for immediate reinstatement of coverage as described on page 81.

Thereafter, your surviving spouse may continue coverage subject to payment of the monthly premium if at the time of your death you were eligible for retirement under the U.A. Local No. 393 Defined Benefit or would have become eligible (had you lived) during the period in which your surviving spouse was entitled to self-pay for coverage following your death.

Coverage for a surviving spouse will terminate when a surviving spouse remarries, or when the spouse becomes covered under other group health coverage. Coverage for a surviving child will terminate when a child ceases to qualify as an eligible dependent or when the child becomes covered under other group health coverage.

Surviving spouses of active employees pay the same monthly rate as a pre-Medicare retiree until they become eligible for Medicare at which time they pay the Medicare Retiree rate.

Death While Retired

If you die while retired under the Local 393 Defined Benefit Pension Plan and were enrolled for retiree health or dental coverage at your date of death, Local 393 will provide continued coverage at no charge to your surviving spouse and enrolled dependent children for the first six months following your death. After that, they may continue to have coverage by making contributions at the same rate that the participant was paying prior to his/her death. If your spouse becomes qualified for Medicare coverage, he/she will then make contributions according to the plan's Medicare coverage rates. These rates are subject to change and set from time-to-time by the Board of Trustees.

Your spouse may continue purchasing coverage until his or her death, unless he or she remarries or becomes covered under another group health plan before then. Your children may continue purchasing coverage for as long as they continue to be eligible dependents as defined by the Plan, unless they become covered under another group health plan before then.

Death With an Extended Reserve Account

If you die with any credits remaining in your Extended Reserve Account and your spouse and enrolled dependents are not eligible for further coverage in the Health and Welfare Plan, they may apply the balance in the account toward purchase of COBRA continuation coverage (see page 96). They may also use the Extended Reserve Account for qualified health expenses or to pay premiums of other medical insurance coverage. If they elect not to use your Extended Reserve Account, or if you die and there are no dependents eligible for coverage, your account will be forfeited to the general assets of the Plan.

• Continuing Enrollment While on Family or Medical Leave

About FMLA

If the Family and Medical Leave Act of 1993 (FMLA) applies to the employer for which you work, you may qualify for continued enrollment under the Health and Welfare Plan while you are on a leave under the provisions of FMLA. Check with your employer to find out whether you qualify for FMLA leave.

Where FMLA leave applies, an employee qualifies for FMLA leave after completing one year of service with the employer.

If the employer grants the leave, the employer is required to make contributions to the Trust Fund for your continuing enrollment under the Plan while you are absent from work on FMLA leave. The cost of the continuing enrollment to your employer will be the COBRA coverage rate (See Continuing Enrollment Under COBRA).

Your employer must also report the number of hours of FMLA leave with its regular monthly reports. The employer must also provide evidence, in a form satisfactory to the Trustees, that the leave is one for which contributions to this Plan are required under FMLA.

Your Basic Reserve Account and Extended Reserve Account will remain unchanged during the leave.

Reasons for FMLA Leave

Under the provisions of FMLA, a qualified employee is entitled to leave for:

- Birth of a child and to care for such child (up to 12 months after the birth of the child).
- Placement of a child for adoption or foster care (up to 12 months after the placement of the child).
- Care of your seriously ill spouse, child, or parent.
- A serious health condition that makes you unable to perform your job functions.

Length of FMLA Leave

A qualified employee is entitled to up to 12 weeks of leave in a 12-month period under FMLA. The 12-month period will be measured looking back 12 months from the date leave is used.

If You Do Not Return to Work

The employer which granted the FMLA leave must inform the Trust Fund Office in writing when your FMLA leave terminates. If you do not return to work at the end of your FMLA leave, you will be eligible for continuing enrollment under COBRA (see Continuing Enrollment Under COBRA), with the termination of the FMLA leave as the qualifying event under COBRA.

• Continuing Enrollment While in Active Military Service

Family Coverage At No Cost

If you are called to active military duty and notify your employer, Trust Fund or Local 393, your Basic Reserve Account will be frozen. Your participation in the Health and Welfare Plan will end while you are on active military duty, but your enrolled family member's coverage will continue at no cost.

This dependents' coverage will continue for up to 24 months of military service, unless a presidential order extends your period of service beyond 24 months.

If you return to covered employment through Local 393 within 90 days following discharge from active military service, your Basic Reserve Account will be unfrozen, and you will resume Plan participation for yourself and your enrolled family members under normal Plan rules.

If you serve for more than 24 months, there are options for continued coverage of your family through your Basic Reserve Account or COBRA. Contact the Trust Fund Office for more information.

• Enrollment While Serving as a Seasonal Public Safety Officer

Effective January 1, 2008, you may make a written request to the Fund Office that your Basic Reserve Account be frozen for up to one year while you are serving as a public safety officer (firefighter, law enforcement officer, or member of a rescue squad or ambulance crew). You and your eligible dependents will not be eligible to receive benefits from the Plan while your hour bank is frozen.

Your hour bank will be unfrozen and used to provide coverage for you and your eligible dependents if within a year you return to a job covered by this Plan or register on the U.A. Local 393 out of work list. You will be required to provide proof of your service as a public safety officer (for example pay stubs or a letter from your employer) before your account will be unfrozen.

• Continuing Enrollment Under COBRA

About COBRA

You and your enrolled family members may have the right to temporarily continue medical coverage and/or dental coverage through U.A. Local 393 after certain events cause you to lose coverage. Your rights are governed by a federal law, the Consolidated Omnibus Reconciliation Act (COBRA).

Medical benefits under COBRA are the same as those for active employees. However, COBRA coverage does not take effect automatically. You must elect it and pay premiums, plus an administrative fee. The rules for election are described later in this section.

Qualifying Events

18-Month Period. You and/or your dependents may elect continued medical coverage for a maximum of 18 months after you would otherwise lose coverage because:

- Your normal working hours are reduced so that you are ineligible for Plan coverage.
- You are no longer considered an active employee.
- Your employment ends for a reason other than gross misconduct.

29-Month Period. If you or a dependent is totally disabled when a qualifying event occurs, you may extend COBRA coverage for the disabled person from 18 to 29 months. (Coverage for other family members who are not disabled, however, would be limited to 18 months). The cost of the additional 11 months of COBRA coverage would be 150% of the applicable premium.

To qualify for this 11-month extension, the disabled person must receive a determination from the Social Security Administration stating that total disability existed on the date of the qualifying event. In addition, the Trust Fund's COBRA administrator must be notified within 60 days after the Social Security determination and before the end of the 18-month period.

36-Month Period. Your dependent spouse or child may choose to continue coverage for up to 36 months after he or she would otherwise lose it because:

- You and your spouse are divorced or legally separated.
- Your child ceases to be a dependent under the Plan.
- You die.

Should any of these events occur while you are on self-payments or COBRA after your termination of employment or reduction in work hours, your dependents will be eligible for a total of 36 months of continued coverage, starting from the date of your termination or reduction in hours.

Electing COBRA Coverage

Qualifying Event for MEMBERS: If you are about to lose Plan coverage because your Basic Reserve Account has run out and any extended enrollment under the self-payment option has ended, the Trust Fund Office will notify you of the qualifying event and of the right to elect COBRA coverage.

Qualifying Event for a DEPENDENT: A dependent who is about to lose coverage must notify the Trust Fund Office within 60 days of the qualifying event. Otherwise, the opportunity to elect continuing coverage under COBRA will be lost.

The Trust Fund Office will provide a written notice of the right to continue coverage and the required premium amount. If you or your dependent wants to continue coverage, you must complete and return the notice to the Trust Fund Office within 60 days of the later of: the date your coverage would otherwise end, or the date of the notice.

Premiums

You are required to pay for your COBRA continuing enrollment. The cost is generally 102% of the applicable Plan premium. However, if an 18-month COBRA period has been extended to 29 months, the cost for the additional coverage can be up to 150% of the applicable premium. You will be advised of the cost when you elect COBRA coverage.

Your first premium is due 45 days after you make an election to continue enrollment. This initial payment must include all monthly premium costs retroactive to the date coverage would have ordinarily ended under the Health and Welfare Plan. Subsequent monthly payments are due by the

25th day the month. You will not be billed unless there is an adjustment in your monthly rate.

The Board of Trustees reserves the right to adjust any individual's COBRA premium if the underlying costs to the Plan change.

When COBRA Ends

Medical coverage under COBRA will end at the expiration of the 18, 29, or 36-month period, as described earlier in this section. However, coverage will end sooner if any of the following occur:

- A premium payment is not received by the deadline.
- You become covered by a group plan which does not contain any pre-existing condition clause that would exclude or limit your coverage.
- You become entitled to Medicare.
- Your disability ends (if you are on extended COBRA).
- The Plan stops providing medical coverage for employees or retirees.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace (known as Covered California in this State), Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than Cobra continuation coverage.

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

You can learn more about many of these options at www.healthcare.gov.

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COBRA Checklist

Events that permit you, your spouse, or child to elect continuing enrollment under the federal law, COBRA:

- Termination of employment (other than gross misconduct), or
- Reduction in hours, making you ineligible for Health and Welfare Plan coverage. For example, your Basic Reserve Account has run out and you have exhausted your continuing enrollment under the less-expensive self-payment option, or
- Death of employee, or
- For your spouse, divorce or legal separation from you, or
- For a dependent child, ceasing to qualify as a dependent under the Health and Welfare Plan.

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• Additional Information About Local 393 Health and Welfare Plan

Qualified Medical Child Support Order

The Health and Welfare Plan will honor qualified medical child support court orders. If a medical child support order (MCSO) issued in a divorce or legal separation proceeding requires you to provide medical coverage to a child who is not in your custody, you must do so upon it becoming a qualified medical child support order (QMCSO).

MCSOs should be sent to the Plan Administrator. Upon receipt, the Plan Administrator will notify you and describe the Health and Welfare Plan's procedures for determining whether the order is qualified. If the order is qualified, you may cover your children under the Health and Welfare Plan. As a beneficiary covered under the Health and Welfare Plan, your child will be entitled to information that the Health and Welfare Plan provides to other beneficiaries under ERISA's reporting and disclosure rules (see page 103).

If you would like to obtain a copy of the Medical Plan's procedures governing QMCSOs, contact the Trust Fund Office. The procedures outline an appeals procedure in case the Trustees rule that the order is not qualified.

Termination or Suspension for Fraud

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

Limitations on Liability of Trust Fund

The benefits provided by the Health and Welfare Plan CAN be paid only if the Trust Fund has enough money to pay. If assets become insufficient, benefits will be prorated for payment. There is no liability on the Board of Trustees, any employers, the Union, signatory association or any other person to provide benefits if the Trust Fund does not have sufficient assets to pay for such health services.

Clerical Error

Any benefit from this Plan to which you are otherwise entitled will not be withheld or denied if there was a clerical error in reporting the hours and contributions by your employer or the Plan's Administrator, or if your employer failed to make contributions fully and on time.

Use and Disclosure Of Protected Health Information

The Health and Welfare Plan will use protected health information (PHI) in accordance with the uses and disclosures permitted by the Health Information Portability and Accountability Act of 1996 (HIPAA).

Specifically, the Plan may:

- Disclose summary health information to the Board of Trustees if the Board requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending, or terminating the Plan.

  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:

  - Names
  - Geographic information more specific than state
  - All elements of dates relating to the individuals involved (such as birth date) or their medical treatment (such as admission date) except the year
  - All ages for those over age 89
  - Other identifying numbers such as Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers
  - Facial photographs or fingerprints
  - Any information the Board does not have knowledge of that could be used alone or in combination to identify an individual

- Disclose to the Board information on whether an individual is participating in the Plan, or is enrolled in or has unenrolled from a health insurance issuer or HMO offered by the Plan.

Personal Health Information disclosed to the Board may only be used for the Plan administrative functions that the Board performs.

Personal health information means information that is created by a health care provider, health plan, or health care clearinghouse 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.

The Plan will use and disclose PHI as required by law. As a Plan Sponsor, the Board agrees to the following conditions:

- Not to use or further disclose PHI other than as permitted or required by the plan document or required by law.
- Ensure that any agents, including a subcontractor, to whom the Board provides PHI received from the health related plans, agree to the same restrictions and conditions that apply to the Board.
- Report to the Plan any inappropriate uses or disclosures of PHI.
- Make PHI available to an individual in accordance with HIPAA access requirements.
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA.
- Make available the information required to provide an accounting of disclosures.

- Make internal practices and records relating to the use and disclosure of PHI received available to the Secretary of the U.S. Department of Health and Human Services for the purpose of determining compliance with HIPAA.
- If feasible, return or destroy all PHI received that the Board still maintains in any form, and retain no copies of such when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that made the return or destruction infeasible).
- Ensure that adequate separation between the Plan and the Board be maintained.

The Plan will control access to where PHI is stored and maintained in order to assure only those employees who have a need to know will be able to obtain access. The Plan will disclose PHI only to the Board and/or to individual Trustees. If persons to whom PHI is disclosed do not comply with the privacy requirements, the Board shall provide a mechanism for resolving issues of noncompliance, including possible disciplinary action up to and including possible termination.

The Plan's insurance issuers and HMO's must include a privacy notice in their Plans and cannot disclosure PHI to the Board except for the administrative reasons described above.

• Rights

PPO Plan Reimbursement

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.

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. 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.

The Plan will not provide benefits for illnesses, injuries, or other conditions that are covered under Workers' Compensation Employer's Liability Law or other similar state or federal law.

Rights of States

The state has rights under this Plan if a participant in this Plan is also enrolled in a state plan for medical assistance approved under Title XIX of the Social Security Act. (Title XIX covers programs such as supplemental security income and medical assistance to low-income families).

The Plan will coordinate benefits with the state plan when medical services and supplies are covered under both plans. State law will determine which Plan pays first.

The Plan will not take into account a member's enrollment in a Title XIX medical plan when determining eligibility or benefit amounts from this Plan.

Right of Examination

The Trust Fund may request you or an enrolled family member who has a medical claim pending to undergo an examination at its expense.

Rights of Trustees

The Board of Trustees expects and intends to continue the Health and Welfare Plan indefinitely, but reserves the right to amend or end the Plan. The Trustees reserve the right to terminate or amend either the amount or conditions for receiving any benefit, even if such a change would affect claims in process or expenses already incurred. It may alter or postpone the method of payment of any benefit and amend any procedure for Plan administration.

Your Rights Under ERISA

As a participant in the U.A. Local 393 Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). As in the past, U.A. Local 393 fully intends to support your rights. Nevertheless, federal law requires that a statement of ERISA rights be included with this description of your plans.

As a member of the Plan, you have the following rights:

- **Receive Information About Your Plan and Benefits**

You may examine, without charge, all Plan documents -- including any insurance contracts, collective bargaining agreements, annual reports (Form 5500 Series), summary plan descriptions -- of which this is an example -- and other documents filed with the Department of Labor. These documents may be examined at the Plan administrator's office, union hall, and other specified locations.

If you want a personal copy of Plan documents or related materials, you should send a written request to the Plan administrator. You will be charged only the actual cost of reproducing these copies.

Each year, the Plan will provide Plan members with a summary of the Plan's financial reports (Form 5500 Series) as required by ERISA.

- **Continue Your Group Health Plan Coverage**

You or your enrolled dependent may elect continued coverage under the medical services of the Plan for a period of 18 or more months after eligibility would otherwise cease. You or your dependent may have to pay for such coverage. Review the enrollment section of this summary description and the documents governing the Plan for the rules describing your COBRA continuation coverage rights.

If you request a "certificate of creditable coverage" from this Plan when you lose coverage under the Plan or under the COBRA continuation period for this Plan, you may be able to reduce or eliminate any exclusionary period of coverage that a future group health plan applies to "preexisting conditions." (Some plans delay eligibility for benefits for a health condition for which a participant was receiving benefits under an old plan. Such a condition is termed a "preexisting condition").

Certificates of creditable coverage will be automatically provided by this plan, free of charge, when coverage ceases. You are entitled to ask for a "certificate of creditable coverage" when you lose eligibility for this Plan, or within 24 months after losing coverage. You would then present the certificate to your new group health plan administrator. Without such a certificate, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after enrolling in your new coverage. To request a certificate of credible coverage, please contact BeneSys Administrators:

P.O. Box 2460
San Jose, CA 95110
Telephone: (408) 588-3751

- **Prudent Actions by Plan Fiduciaries**

Under ERISA, the persons responsible for operating the Plan are called fiduciaries. These individuals have an obligation to administer the Plan prudently and to act in the interest of Plan members and their beneficiaries.

No one, including your employer, your union, or any other person may discriminate against you in any way to prevent you from receiving benefits or exercising your right under ERISA.

- **Enforce Your Rights**

When you become eligible for payments from the Plan, you should follow the appropriate steps for filing a claim. In case of a claim denial, in whole or in part, you will receive a written explanation of the reasons for the denial. Then if you wish, you may request the Plan administrator to review and reconsider your claim.

If you feel that your ERISA rights have been violated, you may file suit. However, your right to sue may be limited if you failed to use the Plan's appeal procedures. Among the violations for which you may file suit are:

- Improper denial of benefits.
- Disagreement with the Plan's decision concerning the qualified status of a medical child support order.
- Misuse of Plan funds by a fiduciary or discrimination against you for asserting your rights. In either case, you may seek assistance from the Labor Department or file suit in a federal court.
- Failure of the Plan administrator to provide materials within 30 days after receiving your written request -- unless due to reasons beyond the administrator's control. If a violation exists, the court may require the Plan administrator to provide the materials and to pay you up to $110 for each day's delay.

The court will decide who should pay court costs and legal fees. For example, if you are successful, the court may order the person you sued to pay these costs and fees. If you lose -- or if the court finds your suit to be frivolous -- you may be ordered to pay these costs and fees.

- **Assistance With Your Questions**

If you have questions about your Plan, you should contact the Plan administrator. For questions regarding this explanation of your rights or your rights under ERISA, contact the nearest Area Office of the Employee Benefit Security Administration, Department of Labor. The address of the San Francisco Regional Office is:

EBSA
90 7th Street, Suite 11300
San Francisco, CA 94103
The telephone number is (415) 625-2481

Or, you may contact:

Division of Technical Assistance and Inquiries,
Employee Benefit Security Administration
U.S. Department of Labor,
200 Constitution Avenue NW
Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

• Eligibility Rules For Individual Employers

Medical/Dental Benefits Only

Individual Employers may enroll in U.A. Local 393 Health and Welfare Plan. They are eligible for medical and dental coverage only.

Individual Employer

Individual Employer means an employer who is in business in the Plumbing and Pipefitting Industry and has signed a Collective Bargaining Agreement with U.A. Local 393.

Eligibility For Employees, Dependents

Eligibility for Plan membership extends to self-employed persons, sole proprietors, bona fide members of partnerships and other unincorporated associations, and officers, directors and shareholders of corporations who comprise the Individual Employer, and their eligible dependents.

Also eligible are fulltime employees (who work at least 20 hours per week) of the Individual Employer and their dependents, as long as the Individual Employer covers all such employees. Any employee covered by another Taft-Hartley Trust Health and Welfare Plan is not eligible.

Individual Employers who enroll in this Plan on or after April 1, 2009 are eligible for HMO coverage only.

Notwithstanding any other provision of this rule, an eligible officer/shareholder who qualifies for coverage with a Basic Reserve Account under a participation agreement with the Plan shall qualify for coverage as an active Employee and not under these rules as an Individual Employer.

Eligibility Date

An Individual Employer has until the 20th day of the month following the enactment of the Collective Bargaining Agreement to enroll for Plan coverage. The application should be made in writing to BeneSys Administrators, and include the names of all persons eligible for coverage.

Each person named in the application 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 for each person, as determined from time to time by the Board of Trustees, has been made received.

Notwithstanding the foregoing, an eligible Individual Employers receiving coverage through his or her Basic Reserve Account through work he or she performed under a Collective Bargaining Agreement shall continue to

receive coverage through that Basic Reserve Account until depleted, and then may receive coverage as an Individual Employer by submitting a proper application.

The Individual Employer must notify BeneSys Administrators to add a person to coverage within 30 days after the person becomes an eligible employee or eligible dependent.

Continuing Enrollment After Retirement

An Individual Employer may elect to continue Plan coverage after retirement for himself or herself and eligible dependents if:

- The Individual Employer had been continuously eligible for Plan Benefits for the 120 months immediately prior to retirement,
- The Individual Employer is at least age 60 at the time of retirement,
- The Individual Employer continue to make timely payment of premiums as the Board of Trustees determines applies that person's coverage, and
- If the Individual Employer or dependent is eligible for Medicare, he or she obtains and retains coverage under Medicare Part A and B.
- Individual Employers are only eligible for Retiree Coverage from HMO, unless you live outside of the HMO coverage area and the Board of Trustees approves your coverage under the PPO Plan or PPO Medicare Supplemental Plan.

Enrollment during retirement does not apply to employees of the Individual Employer or their dependents.

Continuing Enrollment After Termination Under COBRA

Individual Employers, their enrolled employees, and their enrolled dependents are eligible to temporarily continue medical coverage and/or dental coverage under the Plan after certain events, such as reduction of working hours or termination, cause them to lose coverage.

These rights are governed under the federal law, COBRA. COBRA coverage does not take effect automatically. Persons must elect it and pay premiums, plus an administrative fee. Otherwise the coverage is the same as for active employees.

Qualifying Event

COBRA coverage, as described in detail elsewhere in this booklet, applies to Individual Employers. However, "termination of employment" in the case of an Individual Employer means he or she has completely terminated connection to the participating company, or the company has ceased operations. No person is deemed to have a qualifying event if the reason his or her Plan coverage is terminated is because the Individual Employer failed to make a required payment for coverage or has ceased to qualify for the Plan.

Terminating Plan Membership

An Individual Employer may terminate Plan coverage by writing to BeneSys Administrators at least 30 days in advance of the last day of the last month in which coverage is to be provided under the Plan. Coverage ceases on the first day of the next month.

After coverage is terminated, the Individual Employer will receive a refund of any advance monthly charges (not including any reserve account of

contributions made pursuant to a Collective Bargaining Agreement), less any outstanding premiums, delinquent employer contributions, and other obligations of the Trust Funds.

U. A. Local 393 will terminate an Individual Employer's Plan membership if the Individual Employer ceases to pay premium charges. The Individual Employer's coverage and the coverage of all non-bargaining unit employees and their dependents will end as of the first day of the month for which no payment was made. Coverage will also terminate upon the occurrence of any events listed for retirees, listed above, except for the requirement to maintain union membership.

A terminated Individual Employer may reapply for membership if he or she furnishes proof of insurability satisfactory to the Board of Trustees. The application must be filed between January 15 and February 15 of any year.

• General Information And Mailing Address For the Plan

Plan Name

The name of the Plan is U.A. Local No. 393 Health and Welfare Plan.

Type of Plan

The Plan is a welfare benefit plan providing medical, dental, and disability benefits.

Plan Number

The Plan Number is 501.

Employer ID Number

The federal identification number of the Trust Fund is 94-6401544.

Plan Administrator

The Plan is administered by a joint Board of Trustees consisting of Employee Trustees appointed by U.A. Local 393 and Employer Trustees appointed by the participating employer associations. The Board of Trustees is assisted in the administration of the Trust fund by BeneSys Administrators, a contract administrator.

Address of Plan Administrator

The addresses and telephone of the Board of Trustees and the Trust Fund Office are:

Mailing:
U.A. Local 393 Health and Welfare Plan
c/o BeneSys Administrators
P.O. Box 2460
San Jose, CA 95109
Telephone: (408) 588-3751

Physical:
BeneSys Administrators Office
1731 Technology Drive
Suite 570
San Jose, CA 95110

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
Telephone: 1-800-688-3828
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 Trust Fund.

Board of Trustees

The U.A. Local 393 Health & Welfare Trust Fund Board of Trustees consists of representatives of employees from U.A. Local 393 and representatives of employers and the signatory employer associations. The current members of the Board are:

Employee Trustees

Steve Flores
U.A. Local 393
6150 Cottle Road
San Jose, CA 95123

Greg Gonzales
U.A. Local 393
6150 Cottle Road
San Jose, CA 95123

Gary Glenn
U.A. Local 393
6150 Cottle Road
San Jose, CA 95123

Karl Baumheckel
U.A. Local 393
6150 Cottle Road
San Jose, CA 95123

Ed Nichols
U.A. Local 393
6150 Cottle Road
San Jose, CA 95123

Employer Trustees

Alex Hall
Northern California Mechanical
Contractors Association
P.O. Box 159
Benicia, CA 94510

Tim Whalen
Pacific Plumbing
980 Terminal Way
San Carlos, CA 94070

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

Leroy Ginn
ACCO Engineered Systems
1133 Aladdin Avenue
San Leandro, California 94577.

Wayd LaPearle
Santa Clara Valley
Contractors' Association
400 Reed Street
Santa Clara, CA 95052

Alternate Employer Trustees

Robert Dills
Western Allied Mechanical, Inc.
1180 O'Brien Drive
Menlo Park, CA 94025

Plan Year

January 1st through December 31st

Agent for Service Of Legal Process

The agent for service of legal process is:

George Kraw
Katherine McDonough
Patricia A. McCormick
Kraw Law Group, APC
605 Ellis Street, Suite 200
Mountain View, CA 94043
(650) 314-7800

Legal process may also be served on any Trustee at his or her regular place of business or on the Administration Office.

The Trustees also employ the following firm as special legal counsel for collections:

Salzman & Johnson
1141 Harbor Bay Pkwy,
Alameda, CA 94502

Plan Consultant And Actuary

Sidney T. Kaufmann
Kaufmann & Goble Associates
160 West Santa Clara Street, Suite 1550
San Jose, CA 95113

Plan Auditor

Alex Miller/Melissa Evjenth
Eide Bailly., LLP
1900 S. Norfolk Street, Suite 225
San Mateo, California 94403

Investment Consultant

Don Grijalva
Raymond James
150 Almaden Boulevard
Suite 1375
San Jose, CA 95113

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.

U.A. Local 393 currently has collective bargaining agreements with the following employer associations:

Industrial Contractors-UMIC, Inc.
2173 Francisco Blvd., Suite 1
San Rafael, CA 94901
(415) 454-6060

Plumbing Heating Cooling
Contractors Association of
Greater Bay AREA (PHCC of GBA)
595 Price Avenue, Suite 2
Redwood City, CA 94063
(650) 364-7717

Northern California Mechanical
Contractors Association
P.O. Box 159
Benicia, CA 94510
(800) 640-5152

Santa Clara Valley
Contractors Association
400 Reed Street
Box 58032
Santa Clara, CA 95052
(408) 727-5887

A complete list of employers and employee organizations sponsoring the 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.

Section 6 SUB (Supplemental Unemployment Benefit Plan)

This section of your summary plan description covers the Supplemental Unemployment Benefit Plan. It is designed to pay $200 per week to eligible unemployed Plan members.

- Who Is Eligible for SUB Benefits
- Earning SUB Credits
- Qualifying for SUB Benefits
- Re-Qualifying After a Break in Service
- Rules for Drawing Earned Sub Benefits
- Amount of SUB Benefits
- How To Apply for SUB Benefits
- Continuing Claims
- Losing Credits Because of Misconduct
- Amending SUB Plan

• SUB Benefits

Eligibility For Benefits

Employees and former employees of employers who have signed a U.A. Local 393 Collective Bargaining Agreement and have contributed to the SUB Plan are eligible for Plan benefits. Residential plumbers who do not contribute to the SUB Plan are not eligible for Plan benefits.

Earning SUB Credits

When your employer begins making SUB contributions, a SUB account is opened in your name.

Your account may receive a maximum of two SUB credits per month: 1 SUB credit for the first 40 hours of covered employment during the month, plus 1 SUB credit for performing more than 80 hours of covered employment during the month.

No account may accrue more than a total of 26 SUB credits.

Qualifying for SUB Benefits

You qualify for SUB benefits after your account earns 26 benefit credits within a 24-month period.

Example: Member A works 40 hours a month for 24 months. The member receives one SUB credit per month for a total of 24 credits after 24 months. Having failed to accumulate the necessary 26 credits within a 24-month period, Member A's qualifying period continues until he or she has accumulated 26 credits within 24 consecutive months.

Example: Member B works 40 hours a month for 20 months and 90 hours a month for three months. The member receives one SUB credit per month for the first 20 months and two SUB credits per month for the next three months for a total of 26 credits after 23 months. Having accumulated the necessary 26 credits the member qualifies for SUB benefits at the close of month 24.

Re-Qualifying After A Break in Service

Once you qualify for Plan benefits, you remain qualified unless a break in service occurs. Break in service means your employer has ceased making contributions on your behalf for 60 months.

When a break occurs, all your benefit credits are cancelled. After your employer resumes contributions, you re-qualify for Plan benefits by earning 26 credits in 24 months.

Use of Benefit Credits

Benefit credits are used at the rate of one credit per week of SUB payments. After 26 weeks of SUB payments, all your SUB credits will have been cancelled, and a new 26-week qualifying period will begin.

Rules For Drawing Earned SUB Benefits

In order to receive SUB payments, you must satisfy all of the Rules below:

- Rule 1: Be receiving California State Unemployment benefits (UI) or satisfy the following requirements:
  - Have been laid off from your last employment, and provide a written verification of lay off from your employer; and
  - Have applied for UI and been denied solely on the ground of having insufficient earnings in your UI base contribution period, and provide a copy of such denial of your UI claim; and
  - Provide written verification from U.A. Local 393 that you are available for employment in the Plumbing and Pipefitting Industry.

- Rule 2: You must be unemployed (for reasons other than expulsion or termination from the U.A. Local No. 393 Joint Apprenticeship Training Program due to insubordination, bad behavior, or otherwise) and registered on U.A. Local 393's Building Trades Joint Hiring Hall A, B, or Apprenticeship list continuously since your last employment for which contributions were made to this Plan.

- Rule 3: You must have accumulated 26 benefit credits within a 24-month period and not have suffered a break in service or lost your credit due to misconduct and have at least one benefit credit remaining.

Employees working under the U.A. National Plumbing Service Agreement shall be eligible for supplemental unemployment benefits under Plan under the same conditions as Employees working in the building trades journeyman classification under the U.A. Local 393 collective bargaining agreement.

No SUB benefits are paid during the one-week waiting period for UI or, if you qualify under Rule 2, for the first week after the termination of your last

employment (your "SUB waiting period"). No SUB benefits are paid for partial weeks of unemployment.

You are not eligible for SUB benefits if you are receiving Social Security, Workers' Compensation, State Disability Insurance, disability benefits of any kind from the U.A. Local 393 Health and Welfare Plan, or pension benefits of any kinds from the U.A. Local 393 Pension Trust Fund.

The Board of Trustees has approved a negative credit bank for all apprentices eligible to participate in the SUB program who become unemployed between January 1, 2009 and December 31, 2010 and who have earned at least one credit, but have not established initial eligibility. Any benefit credits the apprentice subsequently earns will first be credited toward the benefits he receives under the negative credit bank program before the apprentice begins accumulating earned benefit credits.

Amount of SUB Benefits

Currently, the weekly benefit amount is $200. This amount is set by the Board of Trustees and is subject to change from time-to-time.

How To Apply For SUB Benefits

Obtain an application for SUB benefits from BeneSys Administrators or the Union Office, or call (408) 588-3751 to request that the application be mailed to you.

It is important to obtain an application promptly, because you must submit the completed application within 180 days from the end of the covered week as printed on the California State Unemployment Insurance ("UI") check stub. If you fail to submit your SUB application by that deadline, your SUB payments will be delayed until the application is received, and all benefits for the preceding period will be lost.

With your application, include a copy of your State Unemployment Insurance check with your name, address, and telephone number. Also, complete and sign an IRS Form W-4.

Filing must be in writing and mailed to BeneSys Administrators with the proper forms and check stubs.

Continuing Claims

Continuing claims for SUB benefits must be filed within 180 days from the end of the covered week as printed on the California State Unemployment Insurance check stub. A continuing claim requires only a copy of your California Unemployment Insurance check stub with your name, address, and telephone number.

If you fail to file a continuing claim within the deadline, your claim will be considered a new claim, with the starting date the date your continuing claim is received, and all benefits for the preceding period will be lost.

Losing Credits Because of Misconduct

Regardless of how many SUB credits are in your account, you will lose credits under the Plan immediately if you do any of the following:

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 U.A. Local 393 (without the approval of U.A. Local 393).

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.

If misconduct occurs, all SUB credits in your account will be cancelled, and you will be subject to a new 26-week qualifying period.

Benefits for Residential Plumber

Notwithstanding the foregoing, if an Employee working as residential plumber for an Employer signatory to a U.A. Local No. 393 Collective Bargaining Agreement becomes unemployed and has provided proof of his or her California State Unemployment Insurance benefits, he or she may receive up to twelve (12) weeks of supplemental unemployment benefits in the amount of $100 per week even if he or she has not established his or her initial eligibility, so long as he or she remains continuously unemployed and registered on the U.A. Local No. 393 Building Trades Joint Hiring Hall out-of-work list since he or she last worked for an Employer signatory to a collective bargaining agreement with U.A. Local No. 393. Notwithstanding Section 4, a residential plumber satisfying these conditions shall receive a weekly benefit amount of $100 per week for up to twelve (12) weeks.

Fraud Against The Plan

If you commit a fraud against the Plan, all your benefit credits will be cancelled. As a result, you will be permanently barred from having an account and receiving any benefits from the SUB Plan.

Fraud includes filing a false claim for SUB benefits and continuing to draw SUB Plan benefits after you start working, including working in self-employment or as an employee of another person or company, whether or not you are paid.

Amending SUB Plan

The Board of Trustees of U.A. Local 393 Health and Welfare Trust Fund reserve the right to amend any provision of the SUB program.

NOTES