U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 1

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows, effective as noted below:

1. The last two paragraphs of the Section entitled **Hardship Waiver** are amended to read as follows, and to be effective August 1, 2019:

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

   Surviving spouses who continue to qualify for a hardship waiver shall have the entire amount of the monthly survivor premium waived.

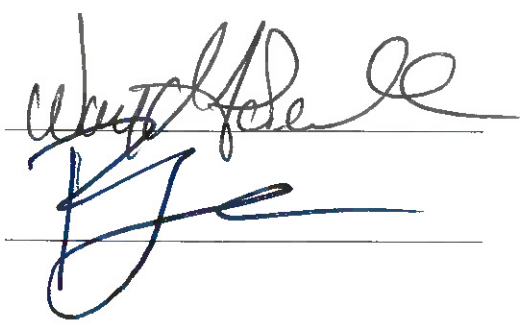
2. The final paragraph of the Section entitled **Weekly Short-Term Disability Benefit and Weekly Family Leave Benefit–Active Members Only** is amended to read as follows, and to be effective July 1, 2020:

   The Plan will pay an eligible employee a weekly benefit of $150 for up to eight (8) weeks per 12-month period if, while eligible for benefits by reason of Basic Reserve Account Credits, he or she is receiving benefits from California's Paid Family Leave Insurance Program and provides sufficient proof thereof.

Executed on December 9, 2019 at San Jose, California.

EMPLOYER TRUSTEES

UNION TRUSTEES



U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 2

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective March 16, 2020, a new paragraph is added to Plan Rule 9 Section (a) to read as follows:

   Notwithstanding the above, while California Executive Order N-25-20 remains in effect or until such earlier or later time that the Co-chair and Chair of the Plan jointly determine the emergency caused by COVID-19 to have ceased, an employee will be deemed to have satisfied Plan Rule 9 Section (a)(1) if the employee demonstrates to the satisfaction of the Trustees that he or she was unable to engage in employment because:

   > He or she was under quarantine (including self-imposed quarantine), at the instruction of a health care provider, employer, or a local, State, or Federal official, in order to prevent the spread of COVID–19; or
   >
   > He or she was engaged in caregiving for his or her child who is not ill because of the COVID–19-related closing of a school or other care facility or care program

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 3

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows, effective as noted below:

1. Effective September 16, 2019, amend Section 2 under the Section entitled **Ambulatory Surgery Centers** to read as follows:

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

2. Effective September 16, 2019, amend Section 6 under the Section entitled **Out-of-pocket Expense Limitation ("Stop-Loss Benefits")** to read as follows:

   6. Payments in excess of the $350.00 per day maximum benefit payable for out-of-network ambulatory surgery centers (excluding out-of-network providers at in-network facilities).

Pursuant to the authority granted by the Board of Trustees during their Board meeting on June 22, 2020, the Chair and Co-Chair have been granted authority to execute this Amendment.

6/25/2020
Date

Chairman

Date

Co-Chairman

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 3

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows, effective as noted below:

1. Effective September 16, 2019, amend Section 2 under the Section entitled **Ambulatory Surgery Centers** to read as follows:

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

2. Effective September 16, 2019, amend Section 6 under the Section entitled **Out-of-pocket Expense Limitation ("Stop-Loss Benefits")** to read as follows:

   6. Payments in excess of the $350.00 per day maximum benefit payable for out-of-network ambulatory surgery centers (excluding out-of-network providers at in-network facilities).

Pursuant to the authority granted by the Board of Trustees during their Board meeting on June 22, 2020, the Chair and Co-Chair have been granted authority to execute this Amendment.

_____	6/29/2020
Date	Date
_____	_____
Chairman	Co-Chairman

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 4

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows, effective as noted below:

1. Effective January 1, 2020, amend Section 4(a) under the Section entitled **Eligible Dependents** in its entirety to read as follows:

4. Dependents of eligible employees above will qualify as eligible dependents under the Plan under the following conditions, subject to the Plan's enrollment requirements:

   (a) A lawful spouse (if not legally separated from the employee) or registered Domestic Partner is covered whenever the employee is covered. If you are legally separated or divorced from your spouse, your spouse is no longer an eligible dependent as of the effective date of the legal separation or divorce. Domestic Partner shall be defined pursuant to section 297 of the California Family Code and shall include only Domestic Partners who are registered with the California Secretary of State.

   Notwithstanding any other provision of the Plan, domestic partners and their children are eligible for benefits under the Plan on the same basis as other qualified dependents.

Pursuant to the authority granted by the Board of Trustees during their Board meeting on June 22, 2020, the Chair and Co-Chair have been granted authority to execute this Amendment.

6/25/2020
Date

Chairman

Date

Co-Chairman

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 4

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows, effective as noted below:

1. Effective January 1, 2020, amend Section 4(a) under the Section entitled **Eligible Dependents** in its entirety to read as follows:

4. Dependents of eligible employees above will qualify as eligible dependents under the Plan under the following conditions, subject to the Plan's enrollment requirements:

   (a) A lawful spouse (if not legally separated from the employee) or registered Domestic Partner is covered whenever the employee is covered. If you are legally separated or divorced from your spouse, your spouse is no longer an eligible dependent as of the effective date of the legal separation or divorce. Domestic Partner shall be defined pursuant to section 297 of the California Family Code and shall include only Domestic Partners who are registered with the California Secretary of State.

   Notwithstanding any other provision of the Plan, domestic partners and their children are eligible for benefits under the Plan on the same basis as other qualified dependents.

Pursuant to the authority granted by the Board of Trustees during their Board meeting on June 22, 2020, the Chair and Co-Chair have been granted authority to execute this Amendment.

_____	6/29/2020
Date	Date
_____	_____
Chairman	Co-Chairman

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 5

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective January 1, 2020, amend Plan Rule 5, Section (b)(1) in its entirety to read as follows:

   The expense must have been for medical care as defined in Internal Revenue Code §213(d), including premiums for other medical insurance coverage. Expenses incurred between January 1, 2011 and December 31, 2019 for medicines or drugs will be reimbursed only if the medicine or drug (1) requires a prescription or (2) is available without a prescription (an over-the-counter medicine or drug) and the individual obtains a prescription or (3) is insulin. Expenses incurred on or after January 1, 2020 for menstrual care products as defined in the Internal Revenue Code shall be reimbursed and treated as incurred for medical care and medicine or drugs shall be reimbursed with or without a prescription. Pursuant to Internal Revenue Service Notice 2013-54 and U.S. Department of Labor Frequently Asked Question Guidance (Part XXII) issued on November 16, 2014, extended reserve contributions made on or after January 1, 2014 cannot be used to reimburse the premiums of individual health insurance policies.

Pursuant to the authority granted by the Board of Trustees during their Board meeting on June 22, 2020, the Chair and Co-Chair have been granted authority to execute this Amendment.

6/25/2026
Date

Chairman

Date

Co-Chairman

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 5

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective January 1, 2020, amend Plan Rule 5, Section (b)(1) in its entirety to read as follows:

   The expense must have been for medical care as defined in Internal Revenue Code §213(d), including premiums for other medical insurance coverage. Expenses incurred between January 1, 2011 and December 31, 2019 for medicines or drugs will be reimbursed only if the medicine or drug (1) requires a prescription or (2) is available without a prescription (an over-the-counter medicine or drug) and the individual obtains a prescription or (3) is insulin. Expenses incurred on or after January 1, 2020 for menstrual care products as defined in the Internal Revenue Code shall be reimbursed and treated as incurred for medical care and medicine or drugs shall be reimbursed with or without a prescription. Pursuant to Internal Revenue Service Notice 2013-54 and U.S. Department of Labor Frequently Asked Question Guidance (Part XXII) issued on November 16, 2014, extended reserve contributions made on or after January 1, 2014 cannot be used to reimburse the premiums of individual health insurance policies.

Pursuant to the authority granted by the Board of Trustees during their Board meeting on June 22, 2020, the Chair and Co-Chair have been granted authority to execute this Amendment.

_____	6/29/2020
Date	Date
_____	_____
Chairman	Co-Chairman

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 6

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective March 16, 2020, amend Section 19, Section titled "Rules Affecting Residential Employees, Service Tradesmen and Provisional Journeyman Service Plumbers under the UA National Plumbing Service Agreement," subsection titled "Disability" in its entirety to state as follows:

The short-term disability benefit is for active Residential Employees, Service Tradesmen, and Provisional Journeyman Service Plumbers (Levels I 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; notwithstanding the foregoing sentence, if the participant's one-week waiting period for California State Disability Insurance is waived pursuant to California Executive Order N-25-20 for an illness, benefits shall begin as of the first day of that illness 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.

2. Effective March 16, 2020, amend Disability Benefits Section, the subsection titled "Weekly Short-Term Disability Benefit-Active Members Only" in its entirety to state as follows:

Weekly Short-Term Disability Benefit and Weekly Family Leave Benefit - Active Members Only

The Plan will pay an eligible employee a weekly benefit of $150 if, while eligible for benefits by reason of Basic Reserve Account credits, he or she is disabled as a result of

accident or illness such that he or she cannot perform his or her regular work. This benefit will be paid in addition to any benefit to which the employee is entitled under State Disability Insurance, workers' compensation, or any similar law. An employee does not have to be confined to his or her home to be eligible, but he or she must be under the care of a physician. Individual Employers, office clerical employees, and dependents are not eligible for this benefit.

Benefits will commence with the first day of disability due to an accident, or the 8th consecutive day of disability due to illness. ; notwithstanding the foregoing sentence, if the participant's one-week waiting period for California State Disability Insurance is waived pursuant to California Executive Order N-25-20 for an illness, benefits shall begin as of the first day of disability due that illness If the employee is not covered for a full week, one-seventh of his or her weekly benefit will be paid for each day he or she is covered.

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

1. Except as provided in paragraph 2, an employee may receive the Weekly Disability Benefit for up to 52 weeks based on any single disability. If an employee returns to work but is later unable to continue to work because of the recurrence of a disability for which he or she already received Weekly Disability benefits, his or her benefits shall be limited to the remainder of the 52 weeks payable based on that disability.

2. If an employee has performed 26 weeks of covered employment after the first Weekly Disability Benefit payment based on a particular disability, then he or she shall be eligible for a new period of 52 weeks of benefits upon the recurrence of that disability. There is no limit to the number of times an employee may qualify for new 52-week periods of benefits based on the recurrence of the same disability or related disabilities, provided that the employee has performed 26 weeks of covered employment after the first payment of each successive period of 52 weeks of benefits.

For disabilities occurring on or before December 31, 2009, the weekly disability benefit was $200 and the maximum disability period was 26 weeks.

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 California's Paid Family Leave Insurance Program and provides sufficient proof thereof.

Executed on _____, 2020 at San Jose, California.

EMPLOYER TRUSTEES	UNION TRUSTEES
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Executed on _____, 2020 at San Jose, California.

EMPLOYER TRUSTEES	UNION TRUSTEES
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Executed on _____, 2020 at San Jose, California.

EMPLOYER TRUSTEES	UNION TRUSTEES
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Amendment 6

Executed on _____, 2020 at San Jose, California.

EMPLOYER TRUSTEES	UNION TRUSTEES
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Amendment 6

Executed on _____, 2020 at San Jose, California.

EMPLOYER TRUSTEES	UNION TRUSTEES
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Executed on _____, 2020 at San Jose, California.

EMPLOYER TRUSTEES	UNION TRUSTEES
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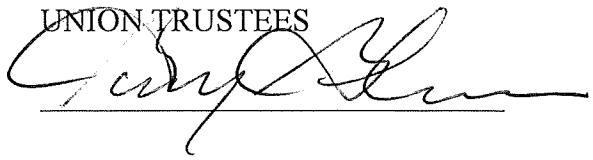
Amendment 6

Executed on July 30, 2020 at San Jose, California.

EMPLOYER TRUSTEES

UNION TRUSTEES



Amendment 6

Executed on _____, 2020 at San Jose, California.

EMPLOYER TRUSTEES	UNION TRUSTEES
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Amendment 6

Executed on _____, 2020 at San Jose, California.

EMPLOYER TRUSTEES	UNION TRUSTEES
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Executed on _____, 2020 at San Jose, California.

EMPLOYER TRUSTEES

UNION TRUSTEES

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 7

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective September 1, 2020, the following three sections are added to the Section titled "Conditions and Limitations for Particular Benefits"

CONDITIONS AND LIMITATIONS FOR PARTICULAR BENEFITS

Applied Behavioral Analysis ("ABA") Therapy

Pre-authorization by the Plan and a diagnosis of autism is required for coverage of ABA Therapy. After the deductible, the Plan pays 90% of the applicable contracted Preferred Provider rate (or 60% of the Usual Customary and Reasonable Charge for non-PPO) for ABA Therapy.

Cochlear Implants

A written recommendation from an otolaryngologist or state-certified audiologist is required for coverage. After the deductible, the Plan pays 90% of the applicable contracted Preferred Provider rate (or 60% of the Usual Customary and Reasonable Charge for non-PPO) for Cochlear Implants.

Long-Term Acute Hospital Benefits

After the deductible, the Plan pays 90% of the applicable contracted Preferred Provider rate (or 60% of the Usual Customary and Reasonable Charge for non-PPO) for long-term acute hospital benefits.

Pursuant to the authority granted by the Board of Trustees during their Board meeting on June 22, 2020, the Chair and Co-Chair have been granted authority to execute this Amendment.

6/25/2026
Date

Chairman

Date

Co-Chairman

Amendment 7

Pursuant to the authority granted by the Board of Trustees during their Board meeting on June 22, 2020, the Chair and Co-Chair have been granted authority to execute this Amendment.

_____	6/29/2020
Date	Date
_____	_____
Chairman	Co-Chairman

Amendment 7

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 8

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective March 18, 2020, the following benefits are added to the Section titled "Conditions and Limitations for Particular Benefits":

CONDITIONS AND LIMITATIONS FOR PARTICULAR BENEFITS

COVID-19 Screening, Testing and Treatment

COVID-19 Screening and Testing: All cost-sharing, copays, and deductibles on COVID-19 diagnostic tests and screenings for PPO providers are waived. All cost-sharing, copays, and deductibles on COVID-19 diagnostic tests and screenings for non-PPO providers are waived, and the Plan will pay the non-PPO Provider's cash price as publicly published or as negotiated between the Plan and the non-PPO Provider. If the non-PPO Provider does not provide a cash price, then the claim will be paid at 100% of the Usual, Customary and Reasonable charge.

COVID-19 Treatment: Effective until May 31, 2020, the Plan will cover 100% of the PPO provider rate for in-network treatment of COVID-19.

Telehealth Services

2. For the duration of the California State of Emergency (which was effective March 4, 2020) with regard to COVID-19, participants and eligible dependents are eligible to use telehealth and online services for doctor's visits. The Plan will pay 100% of online, video, telehealth visits with a PPO provider and non-PPO provider with no deductible. Effective March 4, 2020, the benefit entitled LiveHealth Online in the Section entitled Conditions and Limitations for Particular Benefits is amended in its entirety as follows:

LiveHealth Online

Participants and eligible dependents are eligible to use LiveHealth Online for doctors' visits. There is a $20 copayment for each visit. This benefit is not subject to the annual deductible. This Co-pay is waived through the duration of the California State of Emergency (which was effective March 4, 2020) with regard to COVID-19.

Pursuant to the authority granted by the Board of Trustees during their Board meeting on June 22, 2020, the Chair and Co-Chair have been granted authority to execute this Amendment.

6/25/2020
Date

Steve Flores
Chairman

Date

Co-Chairman

Amendment 8

LiveHealth Online

Participants and eligible dependents are eligible to use LiveHealth Online for doctors' visits. There is a $20 copayment for each visit. This benefit is not subject to the annual deductible. This Co-pay is waived through the duration of the California State of Emergency (which was effective March 4, 2020) with regard to COVID-19.

Pursuant to the authority granted by the Board of Trustees during their Board meeting on June 22, 2020, the Chair and Co-Chair have been granted authority to execute this Amendment.

_____	6/22/2020
Date	Date
_____	_____
Chairman	Co-Chairman

Amendment 8

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 9

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective October 1, 2020, amend the "Note" subsection under Rule 13, Section titled "Retiree Self-Payment Amounts" in its entirety to state as follows:

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. Your "Percent Paid by Member" is based on your age at retirement & your Career Hours.. Career Hours for determining the Percent Paid by Member shall mean an hour of employment for which contributions were made to this Plan, except as follows. If you worked under a collective bargaining agreement other than the Master Labor Agreement, the number of Career Hours with which you shall be credited shall be adjusted proportionally to reflect the difference between the contribution rates of the two agreements.

.

4. To determine your cost - multiply the plan cost x your applicable "Percent Paid by Member."

5. The "Percent paid by Member" remains fixed throughout retirement.

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.

Pursuant to the authority granted by the Board of Trustees during their Board meeting on September 21, 2020, the Chair and Co-Chair have been granted authority to execute this Amendment.

09/23/2020
Date

Steve Flores
Chairman

9/24/2020
Date

Co-Chairman

Amendment 9

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 10

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective June 22, 2020, amend Plan Rule 13, Section (b)(2)(B) in its entirety to state as follows:

> (B) A retiree, eligible dependent spouse or child who deferred or suspended coverage under this rule may reenroll in this Plan only if the group health coverage is no longer available to the retiree, eligible dependent spouse or child. For purposes of this rule, coverage will be deemed no longer available only if one of the following applies:
>
> (i) The person who was the eligible employee under the other group health plan (i.e., the retiree or the retiree's spouse, as the case may be) is no longer eligible to be a covered employee under a group health plan of the person's employer; or
>
> (ii) If the retiree, eligible dependent spouse or child was an eligible dependent under the other group health plan, there is no longer an option available for dependent coverage; or
>
> (iii) The person who was the eligible employee under the other group health plan (i.e. the retiree or the retiree's spouse, as the case may be) has retired and coverage under the other group health plan has changed because of retirement. A person may only reenroll under this subsection (iii) once.
>
> Coverage will not be deemed "no longer available" if the reason that retiree is no longer covered under the other group health plan is the failure of the retiree, or the retiree's spouse, to continue to elect or to pay for coverage of the retiree or the retiree's spouse or

children, even if the cost of that other coverage has increased significantly.

Pursuant to the authority granted by the Board of Trustees during their Board meeting on September 21, 2020, the Chair and Co-Chair have been granted authority to execute this Amendment.

11/20/2020
Date

Steve Flores
Chairman

11/23/2020
Date

Co-Chairman

Amendment 10

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 11

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective September 1, 2020, amend the Section titled "Conditions and Limitations for Particular Benefits", subsection titled "Physical Therapy/Occupational Therapy" in its entirety to state as follows:

Physical Therapy/Occupational Therapy

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

Pursuant to the authority granted by the Board of Trustees, the Chair and Co-Chair have been granted authority to execute this Amendment.

10/20/2020	
Date	Date
Chairman	Co-Chairman

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 11

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective September 1, 2020, amend the Section titled "Conditions and Limitations for Particular Benefits", subsection titled "Physical Therapy/Occupational Therapy" in its entirety to state as follows:

Physical Therapy/Occupational Therapy

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

Pursuant to the authority granted by the Board of Trustees, the Chair and Co-Chair have been granted authority to execute this Amendment.

_____
Date

_____
Chairman

10/20/2020
Date

Co-Chairman

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 12

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective March 18, 2020, amend the Section titled "Conditions and Limitations for Particular Benefits," Subsection titled "COVID-19 Screening, Testing and Treatment" in its entirety to state as follows:

COVID-19 Screening, Testing and Treatment

COVID-19 Screening and Testing: All cost-sharing, copays, and deductibles on COVID-19 diagnostic tests and screenings for PPO providers are waived. All cost-sharing, copays, and deductibles on COVID-19 diagnostic tests and screenings for non-PPO providers are waived, and the Plan will pay the non-PPO Provider's cash price as publicly published or as negotiated between the Plan and the non-PPO Provider. If the non-PPO Provider does not provide a cash price, then the claim will be paid at 100% of the Usual, Customary and Reasonable charge.

COVID-19 Antibody Treatment: All cost-sharing for treatment of COVID-19 with the administration of Monoclonal Antibodies by in-network PPO providers is waived.

COVID-19 Treatment: Effective until May 31, 2020, the Plan will cover 100% of the PPO provider rate for in-network treatment of COVID-19.

Pursuant to the authority granted by the Board of Trustees, the Chair and Co-Chair have been granted authority to execute this Amendment.

06/14/2021
Date

Chairman

6/11/2021
Date

Co-Chairman

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 13

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective October 1, 2020, amend the "Note" subsection under Rule 13, Section titled "Retiree Self-Payment Amounts" in its entirety to state as follows:

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. Your "Percent Paid by Member" is based on your age at retirement & your career hours in Local 393. "Career hours" shall be equivalent to Benefit Credit Hours under the U.A. Local 393 Defined Benefit Pension Plan.

4. To determine your cost - multiply the plan cost x your applicable "Percent Paid by Member."

5. The "Percent paid by Member" remains fixed throughout retirement.

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.

Pursuant to the authority granted by the Board of Trustees during their Board meeting on March 15, 2021, the Chair and Co-Chair have been granted authority to execute this Amendment.

3/19/21
Date
Chairman

3/22/21
Date
Co-Chairman

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 14

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective July 1, 2021, amend the Section "Conditions and Limitations for Particular Benefits", subsection titled "Prescription Drug Benefits" in its entirety to state as follows:

Prescription Drug Benefits

The Board of Trustees has contracted with a pharmacy benefits manager to provide prescription drug benefits to eligible employees and dependents who are covered under the PPO and Medicare Supplemental Plans. No prescription drug benefits are provided, except when the purchase is made through a participating retail pharmacy of the pharmacy benefits manager, or through the pharmacy benefits manager's mail order program. Benefits will be paid in accordance with the following table:

34-Day Retail Co-Payments		**90 Day Mail Order Co-payments**	
Generics	10% with a minimum of $10* and a $50 maximum	**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 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	**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
*If full price of your prescription drug is less than $10, your co-payment for that prescription drug is the full price			

Benefits for any purchase of prescription drugs are subject to the exclusions and limitations of the pharmacy benefit manager's plan in effect at the time of the purchase, but not the Plan deductible. The Board of Trustees has delegated to the pharmacy benefit

manager the responsibility for appeals of all determinations concerning prescriptions drug benefits (other than general eligibility for benefits under the Plan).

When you use the Plan's pharmacy benefit provider your prescription will be filled with a generic drug if available. If a generic is not available, the prescription will be filled with a brand-name drug. In either case, you will pay 10% of the drug cost with a minimum payment of $10 and a maximum payment of $50. 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

Erectile dysfunction drugs will be covered if pre-authorized by the Plan's designated pharmacy benefit manager. Such prescription treatment shall be limited to six tablets per 30 days.

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

Pursuant to the authority granted by the Board of Trustees during their Board meeting on June 21, 2021, the Chair and Co-Chair have been granted authority to execute this Amendment.

06/28/2021
Date

Steve Flores
Chairman

Date

Co-Chairman

Amendment 14

manager the responsibility for appeals of all determinations concerning prescriptions drug benefits (other than general eligibility for benefits under the Plan).

When you use the Plan's pharmacy benefit provider your prescription will be filled with a generic drug if available. If a generic is not available, the prescription will be filled with a brand-name drug. In either case, you will pay 10% of the drug cost with a minimum payment of $10 and a maximum payment of $50. 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

Erectile dysfunction drugs will be covered if pre-authorized by the Plan's designated pharmacy benefit manager. Such prescription treatment shall be limited to six tablets per 30 days.

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

Pursuant to the authority granted by the Board of Trustees during their Board meeting on June 21, 2021, the Chair and Co-Chair have been granted authority to execute this Amendment.

_____
Date

_____
Chairman

6/27/2021
Date

Co-Chairman

Amendment 14

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 15

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective January 1, 2022 add a new Section titled "Death Benefits" after the end of the Section titled "Disability Benefits" but before the start of the Section titled "Miscellaneous Rules" to state as follows:

Death Benefit

Death Benefit for Active Employees

1. Eligibility:

A covered active employee under the Plan (including employees receiving coverage under their Basic Reserve Account, employees who are self-paying under Formal Plan Rule 9, and disabled employees receiving coverage under Formal Plan Rules 10 and 11) shall be entitled to death benefits as detailed in subsection 2. below, payable to his or her designated beneficiary upon the death of the employee, if all of the following requirements are met at the time of the employee's death:

(a) The employee was an active employee covered by the Plan
(b) The employee earned his or her coverage under the Plan through (1) covered employment as a building trades apprentice, journeyperson or foreperson under the U.A. Local 393 Master Labor Agreement or the U.A. National Plumbing Service Agreement; or (2) through employment with U.A. Local No. 393 or a related entity, but such an employee shall only be eligible if he or she previously worked in covered employment under the U.A. Local 393 Master Labor Agreement or the U.A. National Plumbing Service Agreement.
(c) The employee had not yet retired; and
(d) The employee had not reached age 65.

An employee shall not be considered to be a covered active employee under the Plan if he or she or his or her dependents are receiving coverage exclusively under COBRA.

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

2. Death Benefits

Lump Sum Death Benefit:

If an employee satisfies the requirements of subsection 1. above, the employee shall be entitled to a Lump Sum Death Benefit payable to his or her designated beneficiary. The Lump Sum Death payment is equal to $50,000.

Additional Benefit:

In addition to the Lump Sum Death Benefit, if an employee satisfies the requirements of subsection 1. above, the employee may also be entitled to an Additional Benefit payable to his or her designated beneficiary. This Additional Benefit is equal to $2,000 times the number of years of Benefit Credit under the U.A. Local 393 Defined Benefit Plan earned on after January 1, 2022.

3. Payable to Designated Beneficiary

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

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

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

4. Taxability of Death Benefits

The death benefit issued from the UA Local 393 Health and Welfare Plan is a self-insured taxable benefit paid directly from the assets of the Plan.

Instructions to Form 1099 clearly indicate that the Form 1099-R is used to report death benefit payments paid by a qualified or nonqualified plan to an estate, or to another person, who has acquired the right to receive the payments solely because of the employee's death.

5. Exclusions

No death benefits will be paid if:

(1) The employee dies while committing or attempting to commit a felony or other illegal activity, or
(2) The employee dies as a result of war, whether declared or undeclared, or insurrection; or
(3) The employee or his or her dependents are receiving coverage exclusively under COBRA at the time of his or her death; or
(4) Since first becoming a participant in this Plan, the employee has worked as an employee or in a managerial, supervisory, proprietary or any other capacity or as a self-employed person in the plumbing and pipefitting industry anywhere in the United States or Canada for an employer who is not signatory to a collective bargaining agreement with U.A. Local No. 393 or another local union affiliated with the United Association; or
(5) The employee at the time of his death was an owner, officer or shareholder in an employer who was delinquent in its contribution payments to this Plan.

Pursuant to the authority granted by the Board of Trustees during their Board meeting on September 20, 2021, the Chair and Co-Chair have been granted authority to execute this Amendment.

9/29/21
Date

Steve Flores
Chairman

9/24/2021
Date

Co-Chairman

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 16

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective September 20, 2021, amend Plan Rule 5, Section (a)(2) in its entirety to state as follows:

(2) The use of an Extended Reserve Account for the Self-Payment Program, for COBRA Continuation Coverage or for retiree coverage shall be at the option of the employee or retiree. However, if a retiree fails to timely make a full or partial monthly payment for retiree coverage necessary to maintain eligibility under this Plan, then the Administration Office shall automatically deduct such monthly payment from the retiree's Extended Reserve Account, if available. An election to use Extended Reserve Accounts for Self-Payments, COBRA Coverage, or retiree coverage shall be made in writing, and shall apply until the period of Self-Payments COBRA Coverage, or retiree coverage ends, unless the employee or retiree cancels his or her election in writing. If an employee elects not to use, or elects to discontinue the use of his or her Extended Reserve Account during a period of Self-Payments or COBRA coverage, he or she may not elect later to use the Extended Reserve Account for any of the remainder of that entire period.

Executed on February 14, 2022 at San Jose, California.

Employer Trustee

Union Trustee

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 17

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective January 1, 2022, amend the Section titled "Conditions and Limitations" for particular benefits subsection titled "Alcohol and Substance Abuse Care"

Detoxification: After the annual deductible is paid, Detoxification is covered at 90% of the contracted Preferred Provider Rate for Anthem PPO Providers or 60% of UCR rate for detoxification provided by non-PPO providers. Detoxification benefits are required to be pre-approved by the Plan's PPO provider Anthem.

Residential Treatment and Outpatient Care (the Plan's PPO providers for Residential Treatment and Outpatient Care are Anthem and the Organization Beat It!):

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 an Anthem PPO Provider 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 Anthem PPO Provider or 60% of the UCR rate for residential treatment or outpatient care provided by non-PPO providers

Payments made to non-PPO providers are not counted toward the Plan's Out-of-Pocket Expense Limitation.

2. Effective January 1, 2022, amend the Section titled "Conditions and Limitations for Particular Benefits," to add a new subsection entitled "Air Ambulances"

Air Ambulances
Where an eligible participant or eligible dependent receives medical transport by a rotary-wing or fixed wing ambulance, the Plan pays in accordance with the No

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

1. PPO Provider: 90% of the applicable contracted rate, counting the eligible participant's or eligible dependent's cost-sharing amount toward the Out-of-Pocket Expense Limitation.

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

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

2. Effective January 1, 2022, amend the Section titled "Conditions and Limitations for Particular Benefits," subsection titled "Emergency Care and Emergency Room Treatment" in its entirety to state as follows:

Emergency Services for Treatment of an Emergency Medical Condition:

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

1. Emergency Services for Treatment of an Emergency Medical Condition:

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

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

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

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

(a) An appropriate medical screening examination that is within the capability of an emergency room of a hospital or independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition;

(b) Such further medical examination and treatment as are required to stabilize the patient within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable (regardless of the department of the hospital in which such further examination or treatment is furnished); and

(c) Post-stabilization services furnished by out-of-network providers or out-of-network facilities as part of outpatient observation or an inpatient/outpatient stay related to the emergency medical condition (regardless of the department of the hospital in which such further examination or treatment is furnished), until: (1) the treating provider or facility determines that the individual is able to travel using non-medical transportation or non-emergency medical transportation; and (2) the individual is provided with appropriate written notice to consent to out-of-network treatment and gives informed consent to such out-of-network treatment.

Amendment 17

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

(a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part.

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

4. Effective January 1, 2022, amend Section titled "Conditions and Limitations for Particular Benefits" to add a new subsection entitled "No Surprises Act"

NO SURPRISES ACT

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

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

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

5. Effective January 1, 2022, amend Section titled "Out-of-Pocket Expense Limitation ("Stop-Loss Benefits") to state as follows:

Out-of-pocket Expense Limitation ("Stop-Loss Benefits")

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

1. Charges in excess of the applicable contracted Preferred Provider or UCR rates;

2. If you request a brand-name drug when a generic is available, you will pay the normal 10% payment (with a minimum of $10), plus the difference in cost between the brand-name and the generic drug. The excess charge and the $10% copayment are not counted toward your out-of-pocket maximum.

3. Benefits provided through other organizations, such as organ transplants provided through a separate insurance contract; and

4. All charges paid to a non-PPO provider (excluding services covered by the No Surprises Act, which include: (a) Emergency Services for Emergency Medical Conditions provided by a Non-PPO provider or Non-PPO facility (unless the eligible participant or eligible dependent received proper notice and consented to the out-of-network billing rates for certain post-stabilization services as allowed under the No Surprises Act); (b) non-Emergency Services by a Non-PPO provider at a PPO facility (unless the eligible participant or eligible dependent received proper notice and consented to the out-of-network billing rates as allowed under the No Surprises Act); and (c) Non-PPO air ambulance services); and

5. Payments in excess of the $350.00 per day maximum benefit payable for out-of-network ambulatory surgery centers (excluding out-of-network providers at in-network facilities which shall be counted toward the Out-of-Pocket Expense Limitation in accordance with the No Surprises Act unless the eligible participant or eligible dependent has received notice and consented to an out-of-network billing rate as allowed under the No Surprises Act).

Then for the remainder of the calendar year only, covered expenses will be reimbursed at 100% of the applicable contracted rate, for all covered expenses except the following:

1. The 10% copayment and excess charge if you request a brand-name drug when a generic is available;

2. Charges in excess of the applicable contracted Preferred Provider or UCR rates;

3. Benefits provided through other organizations, such as organ transplants provided through a separate insurance contract; and

4. All charges paid to a non-PPO provider (excluding services covered by the No Surprises Act, which include: (a) Emergency Services for an Emergency Medical Condition by a Non-PPO Provider or Non-PPO emergency facility (unless the eligible participant or eligible dependent received proper notice and consented to the out-of-network billing rates for certain post-stabilization services asas allowed under the No Surprises Act); (b) non-Emergency Services by a Non-PPO provider at a PPO facility (unless the eligible participant or eligible dependent received proper notice and consented to the out-of-network billing rates as allowed under the No Surprises Act); and (c) Non-PPO air ambulance services).

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

Notwithstanding anything in the Plan to the contrary, the out-of-pocket expense limitation shall never exceed the limitations provided for under section 1302(c)(1) of the Affordable Care Act.

5. Effective January 1, 2022, amend the Section titled "Medical Benefits – PPO Plan General Rules For Payments of Benefits" to add the following sentence before the start of the Subsection titled "Priority of Rules"

MEDICAL BENEFITS - PPO PLAN

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GENERAL RULES FOR PAYMENT OF BENEFITS

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

Priority of Rules

6. Effective January 1, 2022, amend the Section titled "Qualified Non-PPO Physicians" in its entirety to state as follows:

Qualified Non-PPO Physicians

Charges by a licensed physician which are payable under this Plan shall be covered at the applicable general rate, except for services covered by the No Surprises Act as follows:
(1) An eligible participant or eligible dependent receives Emergency Services for treatment of an Emergency Medical Condition from a Non-PPO Provider or Non-PPO emergency facility (unless he or she consents to out-of-network billing rates for certain post-stabilization services as allowed under the No Surprises Act)
(2) An eligible participant or eligible dependent receives non-emergency services from a Non-PPO provider at a PPO facility (unless he or she consents to out-of-network billing rates as allowed under the No Surprises Act)
(3) An eligible participant or eligible dependent receives Non-PPO air ambulance services.

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

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

7. Effective January 1, 2022, amend the Section titled "Conditions and Limitations for Particular Benefits" to add a new subsection after "Cochlear Implants" and before "COVID-19 Screening, Testing and Treatment", titled "Continuity of Care" to state as follows:

Continuity of Care

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

8. Effective January 1, 2022, amend paragraph 2 in the Section entitled "Standard Payment and Rates and Usual, Customary and Reasonable Charges" to state in its entirety as follows:

Anthem maintains a provider directory. Anthem updates its provider directory every ninety (90) days and will respond to inquiries about the network status of a provider or facility within one business day. If an eligible participant or eligible dependent receives inaccurate information from Anthem or the Benesys Administrators about a provider or facility's network status, the individual will be liable only for in-network coinsurance for the services underlying the inquiry. It is the eligible participant or eligible dependent's responsibility to confirm that the provider or facility selected is in-network at the time the individual receives services.

9. Effective January 1, 2022, amend Appendix A, Section 1(e) in its entirety to state as follows:

(e) Provisions Under the Affordable Care Act

Effective January 1, 2012, in addition to the claims and appeal provisions above, the following provisions under the Patient Protection and Affordable Care Act (the "Act") are applicable to the Plan:

(1) An adverse benefit determination eligible for internal claims and appeals includes a rescission of coverage. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect. An adverse benefit determination eligible for internal claims and appeals also includes compliance with the surprise billing protections under the No Surprises Act.

(2) The Plan is required to provide you (free of charge) with new or additional evidence considered, relied upon, or generated by (or at the direction of) the Plan in connection with your claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for you to respond to such new evidence or rationale.

(3) The Plan must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to an individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

(4) Notices must be provided in a culturally and linguistically appropriate manner and must include the additional requirements provided under the Act, including: (i) information sufficient to identify the claim involved; (ii) the diagnosis code and its corresponding meaning 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.

(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 minimis violations.

(6) Certain adverse benefit determinations including those involving medical judgment (including but not limited to, those based on the plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; the Trustees' determination that a treatment is experimental or investigational; the Trustees' determination whether the plan is complying with the non-quantitative treatment limitation provisions of ERISA section 712 and § 2590.712), a rescission of coverage, and compliance with the surprise billing and cost-sharing protections under the No Surprises Act, are entitled to an external review. The Plan is required to pay the cost of an independent review organization (IRO) to conduct the external review. You are entitled to request an external review after receipt of an adverse benefit determination, in accordance with applicable regulations under the Act, as described below:

Standard External Review

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

(b) Preliminary Review: Within five business days following the date of receipt of the external review request, the Administration Office will complete a preliminary review of the request to determine whether: (i) You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the

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

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

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

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

(ii) The assigned IRO will timely notify you of your claim's acceptance for external review. You will be given ten business days to submit additional information to the IRO and the IRO will consider that information in making a determination on your appeal. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

(iii) Within five business days after the date of assignment of the IRO, the Plan will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination.

Within one business day after making the decision, the IRO will notify you and the Plan.

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

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

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

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

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

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

Expedited External Review

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

(b) Preliminary Review: Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request is eligible for external review and will immediately send you a notice regarding whether the claim is eligible for external review.

(c) Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO for review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination of final internal adverse benefit determination to the assigned IRO electronically or by telephone or by facsimile or by any other expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decision or conclusion reached during the Plan's internal claims and appeal process.

(d) Notice of final external review decision. The assigned IRO will provide notice of the final external review decision, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to you and the Plan.

Executed on February 14, 2022 at San Jose, California.

Employer Trustee

Union Trustee

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 18

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective March 1, 2022, amend the Section titled "Conditions and Limitations for Particular Benefits," to add a new subsection titled "Wigs and Artificial Hairpieces" to state as follows:

   Prosthetic Hair Replacement Devices (Wigs and Artificial Hair Pieces)

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

Pursuant to the authority granted by the Board of Trustees during their Board meeting on June 20, 2022, the Chair and Co-Chair have been granted authority to execute this Amendment.

6/28/2022 | 8:45 PM EDT	6/22/2022 | 11:49 AM EDT
Date	Date
DocuSigned by: Eric Mussynski ACC7ECE658B544B...	DocuSigned by: Alex Hall 7E4A8773AE51405...
Chairman	Co-Chairman

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 19

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective March 1, 2022, amend the Section titled "Conditions and Limitations for Particular Benefits," subsection titled "Hearing Aids" in its entirety to state as follows:

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

2. Effective March 1, 2022, amend the Section titled "Rules Affecting Residential Employees, Service Tradesmen and Provisional Journeyman Service Plumbers under the UA National Plumbing Service Agreement", subsection titled "Dental" in its entirety to state as follows:

Please refer to the Dental Care Plan Section.

3. Effective March 1, 2022, amend the Section titled "Dental Care Plan" in its entirety to state:

DENTAL CARE PLAN

Eligible Residential Employees Service Tradesmen, and Provisional Journeyman Service Plumbers

Active and Retired Employees and their Eligible Dependents:

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

Service	Coinsurance (Plan Pays)	
	PPO Provider	Premier and Non-Contracted Provider
Diagnostic and Preventive (adults and children)	100%	70%
Basic Services (adults and children)	80%	70%
Major Services (adults and children)	50%	50%
Antibiotic ARESTIN (minocycline HCl) Microspheres, 1 mg in conjunction with periodontal treatment	100%	100%

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

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

For Eligible Dependent Children under age 19:

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

Active and Retiree Group

Service	Coinsurance (Plan Pays)	
	PPO Provider	Premier and Non-Contracted Provider
Diagnostic and Preventive (adults)	100%	70%
Diagnostic and Preventive (children)	100%	70%
Basic and Major Services (adults)	80%	70%
Basic and Major Services (children)	100%	70%
Antibiotic ARESTIN (minocycline HCl) Microspheres, 1 mg in conjunction with periodontal treatment	100%	100%

Other Information

Retired Employee Cost
Any participant retiring after January 1, 1993, has a one-time election to self-pay for dental coverage set at an amount established by the Board of Trustees. That election shall

be made at the time of retirement, or if the retiree defers enrollment at retirement because he or she has other group health coverage, that election shall be made when the retiree enrolls in this Plan as a retiree for the first time. If, at any time, a retiree declines, or fails to make a required payment for, dental coverage, that retiree shall not be able to elect dental coverage at any later date.

Provider Network
Coverage is provided through a contract with Delta Dental Plan of California (Delta Dental), and Delta Dental provides a separate Benefits Highlights sheet and Evidence of Coverage booklet describing in more detail the benefits available through the Plan.

There are three tiers of dental providers in the Delta Dental network, and the Plan's coinsurance is dependent on which tier the dentist or provider participates:

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

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

4. Effective March 21, 2022, amend the Formal Eligibility Rules, Section titled "Eligible Dependents", the first paragraph of subsection 4(e) in its entirety to state as follows:

   (e) Surviving dependents of a deceased eligible employee and surviving dependents of a deceased eligible retiree are eligible for free coverage for the six-month period following the date of death of the employee or retiree. If a deceased eligible employee or a deceased eligible retiree has a Basic Reserve Account remaining upon his or her death, then the surviving spouse of the deceased eligible employee or deceased eligible retiree may first use any hours remaining in the Basic Reserve Account for coverage before using the six-months of free coverage. Thereafter, surviving dependents may continue to maintain eligibility as follows:

5. Effective July 1, 2022 amend subsection 1 of the Section titled "Death Benefits" in its entirety to state the following:

Death Benefit

Death Benefit for Active Employees

1. Eligibility:

A covered active employee under the Plan (including employees receiving coverage under their Basic Reserve Account, employees who are self-paying under Formal Plan Rule 9, and disabled employees receiving coverage under Formal Plan Rules 10 and 11) shall be entitled to death benefits as detailed in subsection 2 below, payable to his or her designated beneficiary upon the death of the employee, if all of the following requirements are met at the time of the employee's death:

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

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

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

6. Effective July 1, 2022, amend Section 5 titled "Extended Reserve Accounts" to add a new subsection (h) to state as follows:

(h) Participants covered under the PPO Plan (excluding participants and Eligible Dependents enrolled in the Medicare Supplemental Plan) are eligible for a credit to their Extended Reserve Account pursuant to the schedule stated below when he or she uses the Global 1 network of ambulatory surgical centers for a covered surgery. Based on the cost of the surgery performed, if a participant or an eligible dependent receives the covered surgery at one of the ambulatory surgical centers in the Global 1 network, then the credit for the individual's surgery will be deposited into the participant's Extended Reserve Account.

Bundled Global 1 Surgery Cost	Extended Reserve Account Credit to Participant
up to $10,000	$500
up to $20,000	$1,000
up to $30,000	$1,500
up to $40,000	$2,000
above $40,000	$3,000

7. Effective July 1, 2022, amend the Section titled "Conditions and Limitations for Particular Benefits," subsection titled "Ambulatory Surgery Centers" to state as follows:

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

1. PPO Provider: 90% of the applicable contracted rate; and
2. Non-PPO Provider: 60% of the UCR charges up to a maximum of $350 per day. Such maximum shall apply to all fees incurred, including but not limited to the costs of the facility and the surgeon, except for out-of-network providers at an in-network facility; and
3. Global 1 Network Provider: 100% of the bundled cost billed by Global 1. In addition, all cost-sharing (deductible and co-insurance) for this benefit is waived.

Pursuant to the authority granted by the Board of Trustees during their Board meeting on June 20, 2022, the Chair and Co-Chair have been granted authority to execute this Amendment.

7/1/2022 | 5:26 PM EDT
Date

DocuSigned by:
Eric Mussynski
ACC7ECE858B54B...
Chairman

7/5/2022 | 10:52 AM EDT
Date

DocuSigned by:
Alex Hall
7E4A873AE51405...
Co-Chairman

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 20

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective September 1, 2022, amend the Section "Conditions and Limitations for Particular Benefits", subsection titled "Prescription Drug Benefits" in its entirety to state as follows:

Prescription Drug Benefits

The Board of Trustees has contracted with a pharmacy benefits manager ("Pharmacy Benefits Manager") to provide prescription drug benefits to eligible employees and dependents who are covered under the PPO Plan. No prescription drug benefits are provided, except when the purchase is made through a participating retail pharmacy of the Pharmacy Benefits Manager, or through the Pharmacy Benefits Manager's mail order program. PPO benefits will be paid in accordance with the following table:

34-Day Retail Co-Payments		**90 Day Mail Order Co-payments**	
Generics	10% with a minimum of $10* and a $50 maximum	**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 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	**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
*If full price of your prescription drug is less than $10, your co-payment for that prescription drug is the full price			

Benefits for any purchase of prescription drugs are subject to the exclusions and limitations of the Pharmacy Benefit Manager's plan in effect at the time of the purchase, but not the Plan deductible. The Board of Trustees has delegated to the Pharmacy

Benefit Manager the responsibility for appeals of all determinations concerning prescriptions drug benefits (other than general eligibility for benefits under the Plan).

When you use the Plan's pharmacy benefit provider your prescription will be filled with a generic drug if available. If a generic is not available, the prescription will be filled with a brand-name drug. In either case, you will pay 10% of the drug cost with a minimum payment of $10 and a maximum payment of $50. 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

Erectile dysfunction drugs will be covered if pre-authorized by the Plan's designated Pharmacy Benefit Manager. Such prescription treatment shall be limited to six tablets per 30 days.

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

Manufacturer Copay Assistance

Effective September 1, 2022, you must enroll in the copay savings program for certain medications that have manufacturer copay assistance available. Once you enroll in the copay savings assistance program, you will pay the amount determined by the manufacturer copay assistance program, which may vary based on the medication. Only the amount you have paid out-of-pocket will apply to your annual out-of-pocket maximum (except that, as described above, if you request a brand-name drug when a generic is available, your payment will not count toward your out-of-pocket maximum). Manufacturer copay assistance will not be considered an out-of-pocket cost and will not apply to your out-of-pocket maximum.

Part D Prescription Drug Plan (PDP) – effective January 1, 2023

As of January 1, 2023, the pharmacy benefits for Medicare-eligible retirees is administered by the Pharmacy Benefits Manager. The Plan requires the retiree to be enrolled in Medicare Part D. Plan details are described in the Evidence of Coverage (EOC) and Summary of Benefits provided by the Pharmacy Benefits Manager. The

Board of Trustees has delegated to the Pharmacy Benefits Manager the responsibility for claims and appeals of all determinations concerning prescription drug benefits (other than for general eligibility under the Plan).

2. Effective January 1, 2023, amend the Section titled "Medicare Supplement Plan" in its entirety to state as follows:

MEDICARE SUPPLEMENTAL PLAN

Medicare Enrollment Requirements

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

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

Medicare Supplemental Schedule of Benefits

The following schedule of benefits applies to retired employees (including eligible disabled retired employees) and dependents who are entitled to Medicare, and who have taken Part B of Medicare, except with respect to Medicare-eligible individuals for whom the Plan is required to be primary under the Medicare as Secondary Payer Act, 42 U.S.C. 1395y(b).

This Plan elects to be secondary for all Medicare-eligible persons for whom the Plan may be secondary, including active employees of employers of less than 20 persons.

Any Medicare-eligible retired employee or dependent for whom the Plan is required to be primary shall be entitled to benefits under the Schedule of Benefits for Active Employees and Dependents as if he or she were not yet eligible for Medicare.

If a person is eligible under the Medicare Supplemental Schedule of Benefits, then the Plan will pay the following amounts:

1. Hospital:

   (a) 100% of Medicare deductible.

   (b) 100% of the member's coinsurance amount after Medicare has paid.

Amendment 20

2. Medical:

   (a) A Medicare calendar year deductible applies to each person. The Plan will not pay this amount.

   (b) After the participant has paid the entire calendar year deductible, the Plan will pay 100% of the participant's obligation under the Medicare rules for the doctor or supplier's bill if the participant receives services from a provider who accepts Medicare-assignment.

   (c) 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 Medicare and the Plan will still pay based on the Medicare amount as shown in (b) above and the remainder will be the member's responsibility.

   (d) Doctors can ask patients to sign a contract not to use Medicare. If a member signs such a contract, Medicare Part B will pay nothing, and the Plan will pay 12.3% of the lesser amount of the doctor's actual charge or the PPO contract rate, after the annual deductible has been paid.

3. Prescription Drugs and Medical Supplies

   On or before December 31, 2022, if the retiree has declined Medicare Part D, prescription drugs and medical supplies are covered at the same rates, and under the same rules, as provided in the Schedule of Benefits generally applicable under the PPO Plan.

   Effective January 1, 2023, the Medicare Supplemental Plan will no longer cover Medicare Part D prescription drugs and medical supplies. Medicare-eligible retirees will be required to enroll in Medicare Part D for coverage of prescription drugs and medical supplies, and their pharmacy benefits will be administered by the Pharmacy Benefit Manager. The Schedule of Benefits can be found in the Evidence of Coverage and Summary of Benefit Coverage provided by the Pharmacy Benefit Manager for Medicare-eligible retirees. The Board of Trustees has delegated to the Pharmacy Benefits Manager the responsibility for claims and appeals of all determinations concerning prescription drug benefits (other than for general eligibility under the Plan).

4. Out-Of-Pocket Expense Limitation:

   Same as for active employees.

5. Dependents:

   (a) A spouse or Eligible Dependent child who is eligible for Medicare, is eligible for the schedule of benefits listed above.

   (b) A spouse or Eligible Dependent child who is not eligible for Medicare is eligible for benefits under the regular PPO Plan schedule of benefits.

3. Effective March 16, 2020, amend Disability Benefits Section, the subsection titled "Weekly Short-Term Disability Benefit-Active Members Only" in its entirety to state as follows:

Weekly Short-Term Disability Benefit and Weekly Family Leave Benefit - Active Members Only

The Plan will pay an eligible employee a weekly benefit of $150 if, while eligible for benefits by reason of Basic Reserve Account credits, he or she is disabled as a result of accident or illness such that he or she cannot perform his or her regular work. This benefit will be paid in addition to any benefit to which the employee is entitled under State Disability Insurance, workers' compensation, or any similar law. An employee does not have to be confined to his or her home to be eligible, but he or she must be under the care of a physician. Individual Employers, office clerical employees, and dependents are not eligible for this benefit.

Benefits will commence with the first day of disability due to an accident, or the 8th consecutive day of disability due to illness; notwithstanding the foregoing sentence, if the participant's one-week waiting period for California State Disability Insurance is waived pursuant to California Executive Order N-25-20 for an illness, benefits shall begin as of the first day of disability due that illness. If the employee is not covered for a full week, one-seventh of his or her weekly benefit will be paid for each day he or she is covered.

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

1. Except as provided in paragraph 2, an employee may receive the Weekly Disability Benefit for up to 52 weeks based on any single disability. If an employee returns to work but is later unable to continue to work because of the recurrence of a disability for which he or she already received Weekly Disability benefits, his or her benefits shall be limited to the remainder of the 52 weeks payable based on that disability.

2. If an employee has performed 26 weeks of covered employment after the first Weekly Disability Benefit payment based on a particular disability, then he or she shall be eligible for a new period of 52 weeks of benefits upon the recurrence of that disability. There is no limit to the number of times an employee may qualify for new 52-week periods of benefits based on the recurrence of the same disability or related disabilities, provided that the employee has performed 26 weeks of covered employment after the first payment of each successive period of 52 weeks of benefits.

For disabilities occurring on or before December 31, 2009, the weekly disability benefit was $200 and the maximum disability period was 26 weeks.

The Plan will pay an eligible employee a weekly benefit of $150 for up to eight (8) weeks per 12-month period if, while eligible for benefits by reason of Basic Reserve Account Credits, he or she is receiving benefits from California's Paid Family Leave Insurance Program and provides sufficient proof thereof.

Pursuant to the authority granted by the Board of Trustees during their Board meeting on September 19, 2022, the Chair and Co-Chair have been granted authority to execute this Amendment.

9/28/2022 | 1:23 PM EDT	9/21/2022 | 12:29 PM EDT
Date	Date
DocuSigned by: Eric Mussynski ACC7ECE638B5448...	DocuSigned by: Alex Hall 7E4A877SAE31403...
Chairman	Co-Chairman

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 21

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective March 20, 2023, amend the Formal Eligibility Rules Plan Rule 5 (b)(2) in its entirety to state as follows:

   (2) Credit to an employee's Extended Reserve Account will only be made if the employee is eligible under this Plan and is actually enrolled in the medical coverage provided under this Plan.

2. Effective March 20, 2023, amend the Formal Eligibility Rules, Plan Rule 5(b)(3) in its entirety to state as follows:

   (3) An employee will not receive credit to his or her Extended Reserve while building his or her Basic Reserve Account to meet the initial eligibility requirements. Once an employee is eligible under this Plan and is actually enrolled in this Plan, an employee shall receive a one-time credit to his or her Extended Reserve Account in an amount equal to the credit the employee would have received had he or she been eligible and enrolled while building his or her Basic Reserve Account.

3. Effective March 1, 2023, amend the Formal Eligibility Rules, Plan Rule 5, Section (h) in its entirety to state as follows:

(h) Participants covered under the PPO Plan are eligible for a credit to their Extended Reserve Account pursuant to the schedule stated below when he or she uses the Global 1 network of ambulatory surgical centers for a covered surgery. Based on the cost of the surgery performed, if a participant or an eligible dependent receives the covered surgery at one of the ambulatory surgical centers in the Global 1 network, then the credit for the individual's surgery will be deposited into the participant's Extended Reserve Account.

Bundled Global 1 Surgery Cost	**Extended Reserve Account Credit to Participant**
up to $10,000	$500
up to $20,000	$1,000
up to $30,000	$1,500

up to $40,000	$2,000
above $40,000	$3,000

4. Effective March 20, 2023, amend the Formal Eligibility Rules, Plan Rule 5 to add a new Section (i) to state as follows:

   (i) Account Forfeiture: If an employee has never established initial eligibility under the U.A. Local 393 Health and Welfare Plan, then any available Extended Reserve Account will be forfeited.

5. Effective March 1, 2023, amend the Formal Eligibility Rules, Plan Rule 15, Section (l)(5) in its entirety to state as follows:

   (l) (5) Individual Employers and their eligible dependents are only eligible for retirement coverage through Kaiser. If the Individual Employer resides outside of the Kaiser coverage area, or the Individual Employer enrolled in this plan for the first time on or before March 31, 2009, then the Individual Employer and their dependents may enroll for retiree coverage under (1) the Aetna Medicare Advantage Plan if eligible for Medicare or (2) the PPO Plan if ineligible for Medicare, if such coverage is approved by the Board of Trustees.

6. Effective March 1, 2023, amend the section "Formal Eligibility Rules" Plan Rule 13, Section (a)(1)(C) in its entirety to state as follows:

   (C) If he or she fails to meet the above activity test and is otherwise eligible for retiree coverage, he or she may nonetheless qualify for retiree coverage under Aetna Medicare Advantage Plan or the Kaiser Permanente Senior Advantage Plan if he or she has at least thirty-five (35) years of Benefit Credit under the U.A. Local No. 393 Pension Plan and is eligible for Medicare.

7. Effective March 1, 2023, amend the Formal Eligibility Rules, Plan Rule 13, Section (c) in its entirety to state as follows:

   (c) A non-Medicare eligible participant or surviving spouse covered under this Rule 13 may elect coverage in the PPO or HMO, however, coverage under any fully insured plan is subject to the rules of those plans.

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

8. Effective March 1, 2023 amend subsection 4(a) of the section entitled "Covered Medical Charges" to state as follows:

   (a) Drugs or medicines which are administered by a physician, or which are ordered in writing, and provided through the Plan's pharmacy benefits manager;

9. Effective March 1, 2023, subsection 8(c)(1) of the Section entitled "Covered Medical Charges" is deleted in its entirety, and all subsequent sub-subsections are renumbered accordingly.

10. Effective March 1, 2023 the subsection "Organ Transplants" of the section entitled "Conditions and Limitations for Particular Benefits" is amended as follows:

    Organ Transplants

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

11. Effective March 1, 2023 amend subsection 9 of the section entitled "Exclusions" as follows:

    9. Any prescription drugs (or other items covered under the prescription drug program) provided by anyone other than a physician or a hospital during the patient's confinement, unless provided through the Plan's designated pharmacy benefits manager.

12. Effective March 1, 2023, delete subsection 14 of the section entitled "Exclusions" and renumber the subsequent subsections accordingly.

13. The section "Medicare Supplemental Plan" is replaced in its entirety with the following:

    RETIREE COVERAGE AND RULES FOR MEDICARE-ELIGIBLE INDIVIDUALS

    MEDICARE REQUIREMENTS

No retired employee or dependent regardless of age, who is eligible for Medicare, will be eligible for ANY benefits under this Health and Welfare Plan unless he or she has applied for and established coverage for both Parts A and B of Medicare. Disabled retirees who became disabled prior to retirement, having established eligibility for Medicare, will be reimbursed for the cost of the Medicare Part B premium, (providing their retirement date is prior to January 1, 1995).

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

RETIREE COVERAGE

As of March 1, 2023, the medical and pharmacy benefits for Medicare-eligible retirees is administered by the Kaiser Senior Advantage Plan, the Aetna Medicare Advantage Plan and the Pharmacy Benefit Manager. The Plans require the retiree to be enrolled in Medicare Parts A, B, and D. Plan details are described in the Evidence of Coverages (EOCs).

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

Aetna Medicare Advantage

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

Pharmacy Benefit Manager

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

Kaiser Senior Advantage

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

Pursuant to the authority granted by the Board of Trustees during their Board meeting on June 26, 2023 , the Chair and Co-Chair have been granted authority to execute this Amendment.

Date 6/27/2023 | 11:01 AM PDT

Chairman Eric Mussynski

Date 7/2/2023 | 9:35 PM EDT

Co-Chairman Alex Hall

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 22

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective May 12, 2023, amend the Section titled "Conditions and Limitations for Particular Benefits," Subsection titled "COVID-19 Screening, Testing and Treatment" in its entirety to state as follows:

COVID-19 Screening, Testing, Treatment, and Vaccines

COVID-19 Screening and Testing is covered at 90% of the contracted Preferred Provider Rate (or 60% of the UCR charges for non-PPO providers) after the annual deductible is paid.

Effective May 12, 2023 through November 11, 2023, over-the-counter COVID-19 tests are covered up to $12 for up to 8 tests per covered person per month.
COVID-19 Antibody Treatment: All cost-sharing for treatment of COVID-19 with the administration of Monoclonal Antibodies by in-network PPO providers is waived.

COVID-19 vaccines are covered in accordance with the Wellness Program.

2. Effective March 1, 2023, amend the Section titled "Conditions and Limitations for Particular Benefits," Subsection titled "Telehealth Services" in its entirety to state as follows:

Telehealth Services

Participants and eligible dependents are eligible to use telehealth, video and online services for provider visits. Telehealth, video, and online visits are covered at 90% of the contracted Preferred Provider Rate (or 60% of the UCR charges for non-PPO providers) after the annual deductible is paid.

3. Effective March 1, 2023, amend the Section titled "Conditions and Limitations for Particular Benefits," Subsection titled "LiveHealth Online" in its entirety to state as follows:

LiveHealth Online

Participants and eligible dependents are eligible to use LiveHealth Online for doctors' visits. There is a $20 copayment for each visit. This benefit is not subject to the annual deductible.

4. Effective June 26, 2023, amend the Section titled "Conditions and Limitations for Particular Benefits," Subsection titled "COVID-19 Screening, Testing, Treatment and Vaccines" in its entirety to state as follows:

COVID-19 Screening, Testing, Treatment, and Vaccines

COVID-19 Screening and Testing is covered at 90% of the contracted Preferred Provider Rate (or 60% of the UCR charges for non-PPO providers) subject to the annual deductible.

Effective May 12, 2023 through November 11, 2023, over-the-counter COVID-19 tests are covered up to $12 for up to 8 tests per covered person per month.

Treatment of COVID-19 with the administration of Monoclonal Antibodies is covered at 90% of the contracted Preferred Provider Rate (or 60% of the UCR charges for non-PPO providers) after the annual deductible is paid.

COVID-19 vaccines are covered in accordance with the Wellness Program.

Pursuant to the authority granted by the Board of Trustees during their Board meeting on June 26, 2023, the Chair and Co-Chair have been granted authority to execute this Amendment.

Date: 6/27/2023 | 11:01 AM PDT

Eric Mussynski

Chairman

Date: 7/2/2023 | 9:35 PM EDT

Alex Hall

Co-Chairman

Amendment 22

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 23

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective September 20, 2023, amend the Formal Eligibility Rules Plan Rule 3(b) in its entirety to state as follows:

(b) (1) Notwithstanding the above, a new employee who becomes enrolled in the Plan because of organizing by the Union shall be granted an advance of a Basic Reserve Account credit equal to the initial eligibility amount, in accordance with the following rules. An employee shall be eligible for a Basic Reserve Account advance upon notice to the Trust Fund by the Union that, as a part of an organizing effort by the Union:

(A) The employee left employment with a non-contributing employer for employment by a contributing employer, or the employee's employer is newly contributing; and

(B) The employee is employed by a contributing employer.

(2) An employee who qualifies for an advance shall be covered under the Plan and such advance shall be applied effective the first of the month of the month the employee is employed by a contributing employer,

(3) An employee may use an advanced Basic Reserve Account on the same basis as a regular Basic Reserve Account, except as follows:

(A) No further Basic Reserve Account may be accrued until the Basic Reserve Account accrued for contributions actually received on behalf of the employee is equal to the amount advanced to the employee's Basic Reserve Account; and

(B) The advanced Basic Reserve Account amount shall be revoked immediately if the employee ceases to work in, or to be available for, covered employment before contributions equal to the advanced Basic Reserve Account amount are received.

Pursuant to the authority granted by the Board of Trustees during their Board meeting on December 11, 2023, the Chair and Co-Chair have been granted authority to execute this Amendment.

Date: 12/22/2023 | 11:45 AM PST

Eric Mussynski

Chairman

Date: 12/19/2023 | 12:53 PM EST

Alex Hall

Co-Chairman

Amendment 23

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 24

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective January 1, 2023, amend the Section titled "Conditions and Limitations for Particular Benefits", subsection titled "Prescription Drug Benefits", sub-subsection titled "Part D Prescription Drug Plan (PDP) – effective January 1, 2023" in its entirety to state as follows:

Part D Prescription Drug Plan (PDP) – effective January 1, 2023
As of January 1, 2023, the pharmacy benefits for Medicare-eligible retirees is administered by the Pharmacy Benefits Manager. The Plan requires the retiree to be enrolled in Medicare Part D. Plan details are described in the Evidence of Coverage (EOC) and Summary of Benefits provided by the Pharmacy Benefits Manager. The Board of Trustees has delegated to the Pharmacy Benefits Manager the responsibility for claims and appeals of all determinations concerning prescription drug benefits (other than for general eligibility under the Plan).

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

2. Effective January 1, 2023, amend the Section titled "Retiree Coverage and Rules for Medicare-Eligible Individuals" in its entirety to state as follows:

RETIREE COVERAGE AND RULES FOR MEDICARE-ELIGIBLE INDIVIDUALS

MEDICARE REQUIREMENTS

No retired employee or dependent regardless of age, who is eligible for Medicare, will be eligible for ANY benefits under this Health and Welfare Plan unless he or she has applied

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

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

RETIREE COVERAGE

As of March 1, 2023, the medical and pharmacy benefits for Medicare-eligible retirees is administered by the Kaiser Senior Advantage Plan, the Aetna Medicare Advantage Plan and the Pharmacy Benefit Manager. The Plans require the retiree to be enrolled in Medicare Parts A, B, and D. Plan details are described in the Evidence of Coverages (EOCs).

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

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

Aetna Medicare Advantage

- Participants must be enrolled in Medicare Parts A and B and enrolled in the U.A. Local No. 393 Navitus MedicareRx Prescription Drug Plan (PDP) to participate in this plan.
- Participants can use any willing Medicare provider, regardless of if the provider is in or out of the Aetna Medicare Network.
- No referrals are needed for all Medicare covered Medical Services.
- Further plan rules can be found in the Aetna Evidence of Coverage (EOC) Manual located at https://retireefirst.com/local393/

- Retiree Advocates at Retiree First are available to answer any participant questions about the Aetna Medicare Advantage Plan at 408-215-1207 (TTY 711) or Toll-Free 855-460-7487 (TTY 711)

Pharmacy Benefit Manager

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

Kaiser Senior Advantage

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

Pursuant to the authority granted by the Board of Trustees during their Board meeting on December 11, 2023, the Chair and Co-Chair have been granted authority to execute this Amendment.

Date: 12/22/2023 | 11:45 AM PST

Eric Mussynski
Chairman

Date: 12/19/2023 | 12:53 PM EST

Alex Hall
Co-Chairman

Amendment 24

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 25

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective January 1, 2024, amend Rules 15 (l)(2) and (3) of the section entitled "Eligibility Rules for Individual Employers" in their entirety as follows:

(2) The Individual Employer was at least 60 years of age at the time of retirement, or was eligible for an unreduced early retirement from the U.A. Local No. 393 Defined Benefit Plan;

(3) The Individual Employer continues to make timely payment of such premium as the Board of Trustees determines applies to that person's coverage; Individual Employers who are eligible for an unreduced early retirement from the U.A. Local No. 393 Defined Benefit Plan shall pay a premium equivalent to the "Retiree Self-Pay Amounts:" as calculated under the "Local 393 – Retiree Health and Welfare Subsidy Schedule" of Plan Rule 13; and

Pursuant to the authority granted by the Board of Trustees during their Board meeting on March 25, 2024, the Chair and Co-Chair have been granted authority to execute this Amendment.

Date: 4/8/2024 | 10:48 AM PDT

Eric Mussynski
Chairman

Date: 3/27/2024 | 1:28 PM EDT

Alex Hall
Co-Chairman

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 26

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective September 1, 2023, amend Section titled "Conditions and Limitations for Particular Benefits", subsection titled "Speech Therapy" in its entity to state as follows:

Speech Therapy

After the annual deductible is paid, speech therapy is covered at 90% of the contracted Preferred Provider Rate (or 60% UCR for non-PPO providers). There is a limit of up to 20 visits per year. Additional visits may be approved if determined by the Plan's independent medical consultant to be medically necessary.

Pursuant to the authority granted by the Board of Trustees during their Board meeting on June 17, 2024, the Chair and Co-Chair have been granted authority to execute this Amendment.

Date: 7/23/2024 | 1:16 PM PDT

Eric Mussynski
Chairman

Date: 6/19/2024 | 1:38 PM EDT

Alex Hall
Co-Chairman

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 27

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective March 25, 2024, amend Section titled "Subrogation, Reimbursement and Third Party Liability in its entirety to state as follows:

Subrogation, Reimbursement and Third Party Liability

1. The Plan does not cover illnesses, injuries or other conditions which are incurred on the job or arise out of or are connected in any way with the employment of the employee or dependent and are compensable under the Workers' Compensation or Employer's Liability Law or under any other similar law, state or federal. The Fund reserves the right to be reimbursed by an employee or dependent out of any recovery obtained either through judgment or settlement of any claim for compensation under such law.

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

   If any service is provided or medical claims paid in connection to any injury caused by a third party, and the covered participant and/or eligible dependents receive reimbursement from or on behalf of a third party or from uninsured motorist coverage, the Plan is entitled to recover the full amount of benefits paid under the Plan for such services, up to the gross amount recovered by the covered participant and/or eligible dependents.

   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.

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

3. Notwithstanding any Plan Provision to the contrary, the Plan will not enforce its right to reimbursement with respect to the Plan's Weekly Short-Term Disability Benefit nor require a covered person to complete and sign an Agreement to Reimburse with respect to the Plan's Weekly Short-Term Disability Benefit.

4. The Board of Trustees reserves the right to be reimbursed for any benefits and/or premiums which it paid to, or on behalf of, an individual who was not entitled to have such benefits and/or premiums paid. The Board of Trustees reserves the right to seek recovery of such excess payments, by any legal or equitable means available to it, including restitution from the individual and/or from the participant through whom the individual claimed eligibility and/or offset of some or all of future benefit payments to, or on behalf of, either the individual or the participant through whom the individual claimed eligibility for benefits.

Pursuant to the authority granted by the Board of Trustees during their Board meeting on June 17, 2024, the Chair and Co-Chair have been granted authority to execute this Amendment.

Date: 7/23/2024 | 1:16 PM PDT

Eric Mussynski

Chairman

Date: 6/19/2024 | 1:38 PM EDT

Alex Hall

Co-Chairman

Amendment 27

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 28

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective August 1, 2024, amend the Formal Eligibility Rules Plan Rule 3(b) in its entirety to state as follows:

(b) (1) Notwithstanding the above, a new employee who becomes enrolled in the Plan because of organizing by the Union shall be granted an advance of a Basic Reserve Account credit equal to the initial eligibility amount, in accordance with the following rules. An employee shall be eligible for a Basic Reserve Account advance upon notice to the Trust Fund by the Union that, as a part of an organizing effort by the Union:

(A) The employee left employment with a non-contributing employer for employment by a contributing employer, or the employee's employer is newly contributing; and

(B) The employee is employed by a contributing employer.

(2) An employee who qualifies for an advance shall be covered under the Plan and such advance shall be applied effective the first of the month of the month the employee is employed by a contributing employer.

(3) An employee may use an advanced Basic Reserve Account on the same basis as a regular Basic Reserve Account, except as follows:

(A) Any hours that an employee works in covered employment for which contributions are actually received that are in excess of 110 hours per month, shall be applied toward repaying the amount advanced to the employee's Basic Reserve Account. An employee has twenty-four consecutive months from the date he or she first receives the Basic Reserve Advance to repay the amount advanced to the employee's Basic Reserve Account through such excess hours of covered work; thereafter he or she shall be required to self-pay the entire remaining balance at a rate set from time-to-time by the Trustees; and

(B) The advanced Basic Reserve Account amount shall be revoked immediately if the employee ceases to work in, or to be available for, covered employment before contributions equal to the advanced Basic Reserve Account amount are received.

Pursuant to the authority granted by the Board of Trustees during their Board meeting on September 16, 2024, the Chair and Co-Chair have been granted authority to execute this Amendment.

Date: 10/8/2024 | 12:11 PM PDT

Eric Muszynski

Chairman

Date: 9/19/2024 | 8:45 PM EDT

Alex Hall

Co-Chairman

Amendment 28

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 29

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective June 17, 2024, amend the "Note" subsection under Rule 13, Section titled "Retiree Self-Payment Amounts" in its entirety to state as follows:

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. Your "Percent Paid by Member" is based on your age at retirement & your Career Hours in Local 393. "Career Hours" shall be equivalent to all Benefit Credit Hours under the U.A. Local No. 393 Defined Benefit Pension Plan, including any Career Hours accrued after retirement. "Age at retirement" as used in this Retiree Self-Payment Amounts Section is fixed at your age at initial retirement and cannot be changed, regardless of whether you return to work and resume retirement at a later date.

3. To determine your cost - multiply the plan cost x your applicable "Percent Paid by Member."

4. The "Percent paid by Member" is initially fixed at retirement, but may decrease if you accrue additional Career Hours after retirement. In such situations, your Percent paid by Member may be recalculated at either of the following times: (a) when you resume retirement under the U.A. Local No. 393 Defined Benefit Pension Plan or (b) annually, if you are accruing additional Career Hours and your pension under the U.A. Local No. 393 Defined Benefit Pension Plan had not been suspended during that calendar year. .

5. 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.

2. Effective June 1, 2024, amend Section titled "Eligibility Rules for Individual Employers", Rule 15(l)(5) in its entirety to state as follows:

(5) Individual Employers and their eligible dependents are eligible for retirement coverage through either the PPO Plan, Kaiser, or if eligible for Medicare, the Kaiser Senior Advantage Plan or the Aetna Medicare Advantage Plan.

3. Effective June 17, 2024, amend Section titled "Eligibility Rules for Individual Employers", Rule 15(e) in its entirety to state as follows:

(e) All Individual Employers, office clerical employees and their eligible dependents who enroll in this plan shall be eligible for PPO or HMO coverage.

4. Effective June 17, 2024, amend Section 4(a) titled "Eligible Dependents" in its entirety to state as follows:

(a) A lawful spouse (if not legally separated from the employee) or registered Domestic Partner is covered whenever the employee is covered. Domestic Partner shall be defined pursuant to section 297 of the California Family Code and shall include only Domestic Partners who are registered with the California Secretary of State.

Notwithstanding any other provision of the Plan, Domestic Partners and their children are eligible for benefits under the Plan on the same basis as other qualified dependents.

5. Effective June 17, 2024, amend Section titled "Termination of Eligibility", Rule 6 in its entirety to state as follows:

6. Eligibility under this Plan for an employee and for his or her dependents will terminate at the following times:

(a) On the day the Plan is terminated;

(b) At the end of the month in which his or her Basic Reserve Account has less than the Basic Monthly Charge-Off, unless the employee or dependent qualifies for, elects, and pays for, any form of continuation coverage provided under the Plan;

(c) In the case of a spouse of an eligible employee, at the end of the month in which a court issues a decree or judgment of legal separation or final dissolution of the employee and spouse's marriage, or when the employee's coverage terminates;

(d) In the case of a dependent child, at the end of the month in which he or she attains maximum age, or when the employee's coverage terminates, or

(e) In the case of an employee entering military service, upon the employee's entering full-time military service, exclusive of temporary training periods. For additional information regarding employees in active military service, see Rule 18 below.

(f) A Domestic Partner and any children of the Domestic Partner cease to be eligible at the end of the month in which the Domestic Partnership is terminated.

Amendment 29

6. Effective June 17, 2024, amend Section titled "Eligible Dependents", Rule 4(e) in its entirety to state as follows:

(e) Surviving dependents of a deceased eligible employee and surviving dependents of a deceased eligible retiree are eligible for free coverage for the six-month period following the date of death of the employee or retiree. If a deceased eligible employee or a deceased eligible retiree has a Basic Reserve Account remaining upon his or her death, then the surviving spouse of the deceased eligible employee or deceased eligible retiree may first use any hours remaining in the Basic Reserve Account for coverage before using the six-months of free coverage. Thereafter, surviving dependents may continue to maintain eligibility as follows:

(1) The surviving spouse and/or surviving eligible dependent children of an eligible retiree may continue to maintain eligibility indefinitely, by paying the monthly charge determined from time to time by the Board of Trustees.

(2) (A) The surviving spouse and/or surviving eligible dependent children of an active employee may continue to maintain eligibility for the period of the employee's active participation in the Plan, by paying the amount determined from time to time by the Board of Trustees. For purposes of this subsection (2), the period of active participation includes the entire period from the employee's last enrollment as a new employee, including time during which the employee was not eligible for benefits, but was eligible for reinstatement under Rule 8.

(B) Thereafter, the surviving spouse may continue coverage indefinitely, subject to payment of the applicable monthly charge as determined from time to time by the Board of Trustees, if either of the following is true:

(i) At the time of his or her death, the employee was eligible for retirement under the U. A. Local No. 393 Defined Benefit Pension Plan; or

(ii) Before the end of the period of coverage under subsection (a), the employee would have attained an age which would have made him or her eligible for retirement under the U. A. Local No. 393 Defined Benefit Pension Plan, based on his or her actual Credited Service accrued as of his or her death.

(3) Notwithstanding the above, coverage under this rule (f) shall terminate as follows:

(A) For the surviving spouse: when he or she remarries;

(B) For eligible dependent children: when they cease to qualify as eligible dependents; and

(C) For any individual covered under this rule (f): when the individual becomes covered under other group health coverage.

(4) If the coverage for an individual terminates under this rule (e), and any of his or her original 36-month COBRA coverage period has not elapsed (measured from the participant's date of death), he or she may elect COBRA coverage for the remainder of that 36-month period.

7. Effective June 17, 2024, amend Section titled "Coverage for Retired Employees and their Dependents", Rule 13(a)(1)(C) in its entirety to state as follows:

(C) If the employee fails to meet the above activity test and is otherwise eligible for retiree coverage, the employee may nonetheless qualify for retiree coverage if:
i) the employee first started working under the U.A. Local No. 393 Defined Benefit Pension Plan prior to May 1, 2017 and has at least twenty-five (25) years of Benefit Credit under that plan and is at least age 55; or
ii) the employee first started working under the U.A. Local No. 393 Defined Benefit Pension Plan on or after May 1, 2017 and has at least twenty-five (25) years of Benefit Credit under that plan and is at least age 60.

8. Effective September 1, 2024, amend the first paragraph of Section titled "Formal Benefit Rules", subsection titled "Election of Medical Benefits Provider" in its entirety to state as follows:

Each covered employee may elect between the self-funded indemnity plan (commonly known as the Preferred Provider Organization Plan or "the PPO Plan") and health maintenance organizations ("HMOs") selected by the Board of Trustees. Such elections may be made when first eligible for benefits, or during open enrollment periods established by the Board of Trustees. Effective with September 2024 eligibility, if an eligible employee fails to elect coverage when available to do so, he or she shall be deemed to have elected coverage under the PPO Plan. However, no benefits are payable under the PPO Plan for an otherwise eligible employee until that employee is properly enrolled. Employees have 90 days from the date they are first eligible for benefits to submit an enrollment form and supporting documentation.

9. Effective September 1, 2024, amend Section titled "Rules Affecting Residential Employees, Service Tradesmen and Provisional Journeyman Service Plumbers under the UA National Plumbing Service Agreement", Subsection titled "Benefits" in its entirety to state as follows:

Benefits Eligible Residential Employees, Service Tradesmen, and Provisional Journeyman Service Plumbers (Levels I through III) may choose medical benefits from either the PPO or HMO Plan under the applicable Evidence of Coverage Document. The HMO Benefits are contained in the applicable Evidence of Coverage Document. To the extent there is a conflict between these Formal Plan Rules and the Evidence of Coverage Document, the Evidence of Coverage Document shall govern.

10. Effective October 1, 2024, amend Section titled "Covered Medical Charges" subsection 12 in its entirety to state as follows:

12. Charges incurred for employees and dependents as a result of childbirth and pregnancy and related conditions. Charges incurred for employees and dependents for elective abortions. There is no fixed limit on the number of days of hospitalization for which hospital benefits are payable following childbirth. Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

11. Effective October 1, 2024, amend Section titled "Covered Medical Charges" to add a new subsection 16 to state as follows:

16. Charges for intrauterine insemination.

12. Effective October 1, 2024, amend Section titled "Exclusions" subsection 6 in its entirety to state as follows:

6. Those incurred for the treatment of the following conditions or for performances of the following services:

   (a) Radial Keratotomy or similar procedures.

(b) Treatment of infertility, including in vitro fertilization.EXCEPT THAT intrauterine insemination shall be covered as indicated in the Section entitled Covered Medical Charges.

(c) Biofeedback and Hypnotherapy.

(d) Myofunctional therapy (facial exercises).

(e) Behavioral training used for hyperactive children, weight counseling and similar programs aimed at changing behavior. EXCEPT THAT when the services are provided by a PPO provider the Plan shall cover, without cost sharing, screening for obesity in adults and for adult parents with a body mass index (BMI) of 30 kg/m2 or higher, intensive, multicomponent behavioral interventions for weight management as described in the Wellness Program provision of the Plan.

(f) Holistic medicine or therapeutic injections.

(g) Reversal of vasectomy or reversal of tubal ligation.

(h) Routine office visits if claimant is not sick or injured.

(i) Cosmetic surgical procedures not specifically covered under the Plan, as well as reversal of cosmetic procedures not medically necessary.

(j) Temporomandibular Joint Syndrome.

(k) Eye refraction care or the fitting of eyeglasses.

(l) Organ transplants not listed as covered.

(m) Treatment of erectile dysfunction except for such surgical and prescription treatment as specifically authorized under the terms of the Plan

(n) Chelation therapy except for toxic exposure confirmed by a Plan-approved doctor of medicine, proven by blood tests conducted by PPO labs.

(o) Growth Hormone drugs shall not be covered except for the treatment of Idiopathic Short Stature for dependent children if pre-authorized by the Board of Trustees and determined to be medically necessary by an independent medical consultant other than the treating Doctor. Such prescription drug treatment shall be limited to a one-year supply. Annual extensions may be granted at the sole and exclusive discretion of the Board of Trustees after review by the Board of Trustees and a

determination by the plan's independent medical consultant that the treatment continues to be medically necessary.

13. Effective October 1, 2024, amend Section titled "Exclusions" to add a new subsection 16 to state as follows:

16. Charges for concierge medicine, concierge care, concierge doctors or any other membership-based healthcare.

14. Effective October 1, 2024, amend Section titled "Conditions and Limitations for Particular Benefits" Subsection titled "Applied Behavioral Analysis ("ABA") Therapy" in its entirety to state as follows:

Applied Behavioral Analysis ("ABA") Therapy

After the deductible, the Plan pays 90% of the applicable contracted Preferred Provider rate (or 60% of the Usual Customary and Reasonable Charge for non-PPO) for ABA Therapy.

Pursuant to the authority granted by the Board of Trustees during their Board meeting on September 16, 2024 the Chair and Co-Chair have been granted authority to execute this Amendment.

Date: 10/8/2024 | 12:11 PM PDT

Eric Mussynski

Chairman

Date: 9/19/2024 | 8:45 PM EDT

Alex Hall

Co-Chairman

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 30

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective January 19, 2024, amend Section titled , "Conditions and Limitations for Particular Benefits", subsection titled "Podiatry" in its entirety to state as follows:

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

2. Effective September 16, 2024, amend Section titled "Covered Medical Charges" to add a new subsection 17 to state as follows:

   17. Charges for home infusion therapy. Home infusion therapy is the administration of drugs in the home using intravenous (into the bloodstream), subcutaneous (under the skin), or epidural (into the membranes surrounding the spinal cord) routes. Home infusion therapy includes intravenous delivery of parenteral nutrition when nutritional needs cannot be met by oral or enteral routes, as determined medically necessary by a licensed provider.

3. Effective January 1, 2025, amend Section titled "Hardship Waiver", Rule 14 in its entirety to state as follows:

Hardship Waiver

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

    Under the Hardship Waiver, a retiree or surviving spouse's required monthly charge will be waived if their "total income" is at or below 300% of the Federal Poverty

Level. This amount may be changed from time to time by the Board of Trustees. For purposes of this rule, "total income" includes all of the following items, counting each item of both the employee and the employee's spouse:

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

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

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

4. Effective January 1, 2025, amend Section titled "Coverage for Retired Employees and their Dependents", Rule 13, -subsection titled "Retiree Self-Payment Amounts", the first paragraph under sub-subsection titled "Retiree Self-Payment Amounts" in its entirety to state as follows:

   Your payments are due by the 15th day of the month for the following month's coverage. Retired employees with Extended Reserve Accounts may use their accounts for making retiree payments.

5. Effective January 1, 2025, amend the Section titled "Coverage for Retired Employees and their Dependents", Rule 13, subsection titled "Retiree Self-Payment Amounts", to delete sub-subsection titled "Hardship Waiver" in its entirety.

6. Effective September 16, 2024, amend the third paragraph and add a fourth paragraph to the Section titled "Election of Medical Benefits Provider" of the Formal Benefit Rules to state as follows:

   All eligible employees, even those who elect coverage through an HMO, are eligible for dental benefits, disability benefits, drug and alcohol use disorder treatment through Beat-It, Employee Assistance Plan (EAP) benefits through Health Advocate Solutions, and smoking cessation benefits. Eligible Employees who participate in the PPO Plan receive prescription drug coverage through the Plan's designated pharmacy benefits manager,

under the program approved by the Board of Trustees. PPO participants receive hearing exams and hearing aids through the PPO Plan. The non-medical benefits provided by the Plan HMO(s) are limited to those provided under the contract with the HMO. Eligible employees who elect coverage through Kaiser receive vision care, hearing care and hearing aids, and prescription drug coverage through Kaiser, and may receive alcohol and drug rehabilitation benefits through Beat-It or Kaiser.

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

7. Effective September 16, 2024, amend Section titled "Conditions and Limitations for Particular Benefits", subsection titled "Alcohol and Substance Abuse Care" in its entirety to state as follows:

Alcohol and Substance Abuse Care

Detoxification: After the annual deductible is paid, Detoxification is covered at 90% of the contracted Preferred Provider Rate for Anthem PPO Providers or 60% of UCR rate for detoxification provided by non-PPO providers. Detoxification benefits are required to be pre-approved by the Plan's PPO provider Anthem.

Residential Treatment and Outpatient Care (the Plan's PPO providers for Residential Treatment and Outpatient Care are Anthem and the Organization Beat It!):

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 an Anthem PPO Provider 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 an Anthem PPO Provider or 60% of the UCR rate for residential treatment or outpatient care provided by non-PPO providers.

Payments made to non-PPO providers are not counted toward the Plan's Out-of-Pocket Expense Limitation.

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

Pursuant to the authority granted by the Board of Trustees during their Board meeting on December 16, 2024 the Chair and Co-Chair have been granted authority to execute this Amendment.

Date: 12/20/2024 | 11:51 AM PST

Eric Mussynski

Chairman

Date: 12/17/2024 | 12:47 PM EST

Alex Hall

Co-Chairman

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 31

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Amend the Formal Eligibility Rules Section Entitled RETIREE COVERAGE AND RULES FOR MEDICARE-ELIGIBLE_INDIVIDUALS to add a new paragraph to read as follows:

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

Date: 12/20/2024 | 11:51 AM PST

Eric Mussynski
Chairman

Date: 12/17/2024 | 12:47 PM EST

Alex Hall
Co-Chairman

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 32

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective December 23, 2024, amend Section titled "Miscellaneous Rules", Subsection titled "Disclosure of Protected Health Information to the Board of Trustees" in its entirety to state as follows:

Disclosure of Protected Health Information to the Board of Trustees

1. Definitions. Whenever used in these rules of disclosure to the Board of Trustees, the following terms shall have the respective meanings set forth below.

   (a) Plan means this U. A. Local No. 393 Health and Welfare Plan.

   (b) Board means the Board of Trustees of the U. A. Local No. 393 Health and Welfare Plan, which is the plan sponsor as defined in ERISA § 3(16)(B).

   (c) Health Information means information (whether oral or recorded in any form or medium) that is created or received by a health care provider, health plan (as defined in 45 C.F.R. § 160.103), employer, life insurer, school or university, or health care clearinghouse (as defined in 45 C.F.R. § 160.103) that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

   (d) Summary Health Information means information that summarizes the claims history, expenses, or types of claims by individuals for whom the Plan provides benefits, and from which the following information has been removed:

      (1) Names;

      (2) Geographic information more specific than state;

      (3) All elements of dates relating to the individual(s) involved (e.g., birth date) or their medical treatment (e.g., admission date) except the year; all ages for those over age 89 and all elements of dates, including the year,

indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older);

(4) Other identifying numbers, such as Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers;

(5) Facial photographs or biometric identifiers (e.g., fingerprints); and

(6) Any information the Board does not have knowledge of that could be used alone or in combination with other information to identify an individual.

(e) Protected Health Information ("PHI") means Health Information, including demographic information, that is (1) transmitted or maintained in any form or medium, (2) collected from an individual and created or received by a health care provider, health plan, employer, or health care clearinghouse, and (3) identifies the individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the individual involved.

(f) Public Health, as defined in 45 CFR § 160.103, means population-level activities to prevent disease in and promote the health of populations. Such activities include identifying, monitoring, preventing or mitigating ongoing or prospective threats to the health or safety of a population, which may involve the collection of protected health information. But such activities do not include those with any of the following purposes: (1) to conduct a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating health care; (2) to impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating health care; (3) to identify any person for any of the activities described in paragraphs (1) or (2) of this definition.

(g) Person means a natural person (meaning a human being who is born alive), trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private.

(h) Reproductive Health Care means health care, as defined in 45 CFR § 160.103, that affects the health of an individual in all matters relating to the reproductive system and to its functions and processes. This definition shall not be construed to set forth a standard of care for or regulate what constitutes clinically appropriate reproductive health care.

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

Amendment 32

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

4. Disclosure of PHI. The Plan will disclose PHI to the Board only in accordance with 45 CFR § 164.504(f) and the provisions of this section.

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

6. Certification. The adoption of this section shall constitute certification by the Board that this Plan has been amended to include the provisions required under 45 CFR § 164.504(f).

7. Obligations of the Board. In addition to the requirements stated above, the Board also agrees to:

   (a) Not use or further disclose PHI other than as permitted in this Section or as required by law;
   (b) Ensure that any of its agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Board;

   (c) Not use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan;

   (d) Report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses and disclosures in this Section;

   (e) Make PHI available to individuals in accordance with 45 CFR § 164.524;

   (f) Make PHI available for individuals' amendment and incorporate any amendments in accordance with 45 CFR § 164.526;

   (g) Make the information available that will provide individuals with an accounting of disclosures in accordance with 45 CFR § 164.528;

   (h) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services for purposes of determining the Plan's compliance with 45 CFR Part 164;

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

(j) Ensure that adequate separation between the Plan and the Board, as required by this Section and by 45 CFR § 164.504(f)(2)(iii), is established and maintained;

(k) not to use or disclose PHI, for any of the following activities: (1) To conduct a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing or facilitating Reproductive Health Care; (2) to impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing or facilitating Reproductive Health Care; and (3) to identify any person for any such purpose described in (1) or (2) of this subsection. This prohibition only applies where the relevant activity is in connection with any person seeking, obtaining, providing, or facilitating Reproductive Health Care, and the covered entity or business associate that received the request for PHI has determined that one or more of the following conditions exist: (a) the Reproductive Health Care is lawful under the law of the state in which such health care is provided under the circumstances in which it is provided; (b) the Reproductive Health Care is protected, required or authorized by Federal law, including the United States Constitution, under the circumstances in which such health care is provided, regardless of the state in which it is provided; or (c) the presumption under 45 CFR 164.502(a)(5)(iii)(C) applies; and

(l) not use or disclose PHI potentially related to Reproductive Health Care for purposes specified in 45 CFR 164.512(d), (e), (f), or (g)(1), without obtaining an attestation that is valid under 45 CFR 164.509(b)(1) from the person requesting the use or disclosure and complying with all applicable conditions of 45 CFR 164.509.

8. Disclosure Only to Designated Parties. Pursuant to this Section, the Plan will disclose PHI only to the Board, Individual Trustees, or plan providers that have executed valid business associate agreements.

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

10. Non-Compliance. If any person described in paragraph 8 does not comply with the provisions of this Section or the provisions of 45 CFR § 164.504(f), the Board shall

provide a mechanism for resolving the issue of non-compliance, which may include disciplinary sanctions.

11. Statement Required in Privacy Notice. The Plan may not disclose, and may not permit a health insurance issuer or HMO providing services to the Plan to disclose, PHI to the Board except as would be permitted by the Plan in this Section, and only if the appropriate statement is included in the privacy notice of the Plan, the insurance issuer, or the HMO, as required by 45 CFR § 164.520.

12. Disclosure of ePHI. The Board will reasonably and appropriately safeguard electronic PHI (ePHI) created, received, maintained or transmitted to or by the Board on behalf of the Plan. Specifically, the Board will:

    (a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the Plan,

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

    (c) Ensure that any agent, including a subcontractor, to whom the Board provides this information agrees to implement reasonable and appropriate security measures to protect the information, and

    (d) Report to the Plan any security incident of which it becomes aware.

Pursuant to the authority granted by the Board of Trustees during their Board meeting on December 16, 2024 the Chair and Co-Chair have been granted authority to execute this Amendment.

Date: 12/20/2024 | 11:51 AM PST

Eric Mussynski

Chairman

Date: 12/17/2024 | 12:47 PM EST

Alex Hall

Co-Chairman

Amendment 32

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 33

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective December 16, 2024 amend subsection (c) of Rule 4 "Eligible Dependents" in its entirety to state the following:

Unmarried children, age 26 or older, who are incapable of self-support because of a total and permanent disability that commenced prior to reaching age 26, are covered whenever the employee is covered. Evidence of the child's total and permanent disability must be provided in the form of a Social Security Disability Award and must be submitted within 6 months following an eligible child's 26th birthday.

2. Effective December 16, 2024 amend subsection (b) of Rule 13 "Coverage for Retired Employees and their Dependents" in its entirety to state the following:

(b) **Continued Eligibility:**

(1) Medicare-eligible retirees and Medicare-eligible dependents must remain enrolled in Medicare Parts A, B and D in order to be covered by the Plan.

(2) Continued eligibility of any retiree is not affected by his or her being covered under another group health plan, except as provided under the PPO Plan's or HMO's coordination of benefits rules.

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

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

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

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

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

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

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

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

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

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

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

(i) the termination of other medical coverage (without taking into account COBRA coverage), or
(ii) (ii) the date of the retiree's notification of termination.

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

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

3. Effective December 16, 2024 delete the paragraph entitled "Retired Employee Cost" in the section "Dental Care Plan" in its entirety.

~~**Retired Employee Cost**~~
~~Any participant retiring after January 1, 1993, has a one-time election to self-pay for dental coverage set at an amount established by the Board of Trustees. That election shall be made at the time of retirement, or if the retiree defers enrollment at retirement because he or she has other group health coverage, that election shall be made when the retiree enrolls in this Plan as a retiree for the first time. If, at any time, a retiree declines, or fails to make a required payment for, dental coverage, that retiree shall not be able to elect dental coverage at any later date.~~

4. Effective March 1, 2025 amend the Section entitled "Disability Benefits", sub-section titled "Weekly Short-Term Disability Benefit and Weekly Family Leave Benefit – Active Members Only" in its entirety to state the following:

Weekly Short-Term Disability Benefit and Weekly Family Leave Benefit - Active Members Only

The Plan will pay an eligible employee a taxable weekly benefit of $150 if, while eligible for benefits by reason of Basic Reserve Account credits, he or she is receiving benefits from California's State Disability Insurance Program, a worker's compensation plan, or any similar law for a disability and provides sufficient proof thereof. This benefit will be paid in addition to any benefit to which the employee is entitled under State Disability Insurance, workers' compensation, or any similar law. An employee does not have to be confined to his or her home

to be eligible, but he or she must be under the care of a physician. Individual Employers, office clerical employees, and dependents are not eligible for this benefit.

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

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

1. Except as provided in paragraph 2, an employee may receive the Weekly Disability Benefit for up to 52 weeks based on any single disability. If an employee returns to work but is later unable to continue to work because of the recurrence of a disability for which he or she already received Weekly Disability benefits, his or her benefits shall be limited to the remainder of the 52 weeks payable based on that disability.

2. If an employee has performed 26 weeks of covered employment after the first Weekly Disability Benefit payment based on a particular disability, then he or she shall be eligible for a new period of 52 weeks of benefits upon the recurrence of that disability. There is no limit to the number of times an employee may qualify for new 52-week periods of benefits based on the recurrence of the same disability or related disabilities, provided that the employee has performed 26 weeks of covered employment after the first payment of each successive period of 52 weeks of benefits.

If an employee is unable to show proof the he or she is receiving benefits under California's State Disability Insurance Program, a worker's compensation plan, or any similar law solely because he or she has exhausted the benefits thereunder, but the employee is otherwise eligible for Weekly Short-Term Disability Benefit, the employee may continue eligibility for the Weekly Short-Term Disability Benefit by submitting sufficient proof that he or she continues to be unable to perform his or her regular work because of an accident or illness and is under the care of a physician.

The Plan will pay an eligible employee a taxable weekly benefit of $150 for up to eight (8) weeks per 12-month period if, while eligible for benefits by reason of Basic Reserve Account Credits, he or she is receiving benefits from California's Paid Family Leave Insurance Program and provides sufficient proof thereof.

Pursuant to the authority granted by the Board of Trustees during their Board meeting on March 24, 2025, the Chair and Co-Chair have been granted authority to execute this Amendment.

4/7/2025 | 10:46 AM PDT	3/26/2025 | 4:33 PM EDT
Date	Date
Eric Mussynski	Alex Hall
Chairman	Co-Chairman

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 34

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective January 1, 2025, amend Section titled "Rules Affecting Residential Employees, Service Tradesmen and Provisional Journeyman Service Plumbers under the UA National Plumbing Service Agreement" in its entity to state as follows:

Rules Affecting Residential Employees and Service Tradesmen

Employees who have earned eligibility from hours worked in residential plumbing as service tradesmen working under the Northern California & Northern Nevada Refrigeration and Air Conditioning and Food Store Addendum shall not be eligible for benefits except as provided in this Section:

Initial Eligibility
To become eligible for benefits as a residential employee or service tradesmen you must complete 480 hours of covered residential plumbing, or service tradesmen 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 or service tradesmen 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 or service tradesmen 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 or service tradesmen 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

Eligible Residential Employees and Service Tradesmen may choose medical benefits from either the PPO Plan or HMO Plan under the applicable Evidence of Coverage Document. The HMO Benefits are contained in the applicable Evidence of Coverage Document. To the extent there is a conflict between these Formal Plan Rules and the Evidence of Coverage Document, the Evidence of Coverage Document shall govern.

Dental
Please refer to the Dental Care Plan Section.

Substance Abuse
Residential Employees and Service Tradesmen and their enrolled dependents are eligible for alcohol, drug, and chemical dependency treatment through BEAT IT!

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.

Disability
The short-term disability benefit is for active Residential Employees and Service Tradesmen 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 and Service Tradesmen must pay for the full cost of their coverage at retirement and are not eligible to receive supplemental unemployment benefits except as indicated in the U.A. Local 393 Supplemental Unemployment Plan. Please see the U.A. Local No. 393 Supplemental Unemployment Rules for more information.

Amendment 34

Provisional Journeyman Service Plumbers (Levels I through III) and Journeyman Service Plumbers under the UA National Plumbing Service Agreement shall be eligible for all benefits under the same terms as employees working under the U.A. Local 393 Master Agreement so long as they meet the employee eligibility requirements.

The Trustees have authority to determine whether work performed under a collective bargaining agreement constitutes residential plumbing, service tradesman, or provisional journeymen service work.

Pursuant to the authority granted by the Board of Trustees during their Board meeting on June 16, 2025, the Chair and Co-Chair have been granted authority to execute this Amendment.

Date: 7/25/2025 | 2:09 PM PDT

Eric Mussynski

Chairman

Date: 7/20/2025 | 4:47 PM EDT

Alex Hall

Co-Chairman

Amendment 34

U.A. Local No. 393 Health and Welfare Plan
Formal Plan Rules
(As revised November 1, 2019)

Amendment 35

Pursuant to the authority set forth in Article V of the U.A. Local No. 393 Health and Welfare Trust Fund Third Amended Agreement, the Trustees hereby amend the Formal Plan Rules as follows:

1. Effective January 1, 2026, amend Rule 16, Section titled "Coverage During a Leave Under the Family and Medical Leave Act" in its entity to state as follows:

Coverage During a Leave Under the Family and Medical Leave Act

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

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

    For example, for journeyman:
    Basic Monthly Charge to Hour Bank X Journeyman Contribution Rate.

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

    (b) The employee's employer must report the number of hours of FMLA leave and make the required contributions with its regular monthly reports. The employer must also certify in a form satisfactory to the Trustees that the leave is one for which contributions to this Plan are required by the FMLA.

    (c) The employee's Hour Bank will not be charged for any period of coverage for which payment is made under these rules. All other Plan rules concerning Hour Bank remain in effect during FMLA leave.

    (d) Crediting of hours for the employee, and the employer's obligation to contribute ends upon termination of FMLA leave. The employer must inform the Administration Office in writing when the employee's FMLA leave terminates.

    (e) If the employee does not return to work for the employer at the termination of FMLA leave, the employee is eligible for COBRA coverage as provided in Appendix C, with the termination of FMLA leave deemed the qualifying event as a termination of employment.

Pursuant to the authority granted by the Board of Trustees during their Board meeting on June 16, 2025, the Chair and Co-Chair have been granted authority to execute this Amendment.

Date: 7/25/2025 | 2:09 PM PDT

Eric Mussynski

Chairman

Date: 7/20/2025 | 4:47 PM EDT

Alex Hall

Co-Chairman