# U. A. LOCAL NO. 393
# HEALTH AND WELFARE PLAN
# And
# SUPPLEMENTAL UNEMPLOYMENT PLAN
# FORMAL PLAN RULES

## (As Revised November 1, 2019)

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

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

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

# FORMAL ELIGIBILITY RULES

## Employee Eligibility

1. (a) Each employee working under a Collective Bargaining Agreement with U. A. Local No. 393, in a position for which contributions are required to be made to this Plan, or on whose behalf contributions are made, will accrue a Basic Reserve Account credit, for each hour of covered employment, in an amount determined by these rules. Credits will be added to each employee's Basic Reserve Account and become available to be applied to eligibility, effective on the first day of the second month following the month in which the hours are worked. The Basic Monthly Charge will then be deducted, effective on the first day of each month, for eligibility for coverage for that month. Notwithstanding the above, no employee may carry a Basic Reserve Account, after such deductions, in excess of the then-effective Maximum Basic Reserve Account amount.

(b) The Reserve Account rules shall also apply to any employee who is working as a non-collectively bargained employee for a participating employer, the Union, the training program, or other related entity approved by the Board of Trustees, if the employer has executed a subscriber agreement with the Board of Trustees which allows contributions on behalf of the employee. These rules do not apply to persons who are working in the trade as employers or in self-employment, who may be eligible for benefits only under Rule 15, Eligibility Rules for Individual Employers, unless that person is an officer/shareholder of an Employer, and the officer/shareholder and Employer meet all of the following requirements:

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

(c) The Reserve Account rules shall also apply to any employee who is working outside the jurisdiction of U. A. Local No. 393, and who elects to have his or her Health and Welfare Plan contributions reciprocated back to this Plan. Such contributions shall be deemed available for a month's coverage only if received by the 25th day of the prior month.

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

delinquent employer, the Trust shall be reimbursed by the employer for such payments and the Trustees shall have the authority to enforce such right of reimbursement.

2. The following rates apply to accrual and use of Basic Reserve Accounts as of July 2005 hours worked and September 2005 eligibility:

(a) Each employee's Basic Reserve Account will be credited at the lesser of: (1) the actual contribution rate; or (2) the standard Base Contribution Amount set by the applicable collective bargaining agreement with U.A. 393;

(b) An employee's Basic Reserve Account must reach 440 hours of contributions for the employee to become initially eligible for benefits under the Plan;

(c) The Maximum Basic Reserve Account an employee may accrue is 660 hours of contributions; and

(d) The Basic Monthly Charge for benefits is set by the Trustees from time to time.

3. (a) Each employee now eligible for benefits (and his or her eligible dependents) may maintain eligibility subject to these Eligibility Rules. Each employee not currently eligible will become eligible for employee and dependent benefits as of the first day of the month following any period of 12 consecutive months or less in which the employee's Basic Reserve Account has been credited with the initial eligibility amount. However, no benefits will be paid until an enrollment form has properly been completed and all documents are on file with the Administration Office.

(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 immediately 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 as if the initial eligibility amount had been credited to the employee before the first day of the month in which the employee became enrolled in the Plan, except that no benefits shall be provided for the period before the date that the employee first worked for a contributing employer in that month.

(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.

## Eligible Dependents

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. Pursuant to section 297 of the California Family Code, "domestic partners" means: two adults who have established a domestic partnership in California by filing a Declaration of Domestic Partnership with the Secretary of State. At the time of the filing, all of the following requirements must be met:

(1) Both persons have a common residence;

(2) Neither person is married to someone else or is a member of another domestic partnership;

(3) The two persons are not related by blood in a way that would prevent them from being married to each other in this state;

(4) Both persons are at least 18 years of age;

(5) Both persons are capable of consenting to the domestic partnership; and

(6) Either of the following must be true:
- Both persons are members of the same sex, or
- If they are of opposite sex, at least one of the persons is over the age of 62 and qualifies for certain Medicare or Social Security entitlement.

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.

(b) Children, until the end of the calendar month in which the child attains age 26.

The term "children" includes the Employee's natural children, legally adopted children (including children placed with the Employee for legal adoption), an Employee's legal ward, stepchildren, foster children and children of an eligible domestic partner.

(c) Unmarried children, age 26 or older, who are incapable of self-support because of a permanent or total disability that commenced prior to reaching age 19, 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.

(d) Notwithstanding the above:

(1) If a participant is enrolled in PPO Plan: No person (other than a newborn child) who is otherwise qualified to be an eligible dependent of a participant enrolled in the PPO Plan shall receive any coverage or benefits from the PPO Plan unless and until a Plan enrollment form has been completed and documents proving eligible dependent status are on file at the Administration Office. Claims for newborn children will be held and will not be paid until such time as an enrollment form and birth certificate are received by the Administration Office. Continued eligibility of a dependent is conditioned on confirmation, on request of the Administration Office, of eligible dependent status, in a manner satisfactory to the Board of Trustees.

(2) If a participant is enrolled in a Plan HMO: No person who is an eligible dependent of a participant covered under a Plan HMO shall receive medical and related benefits from the PPO Plan. No person who is an eligible dependent of a participant covered under a Plan HMO shall receive any benefits from the HMO, unless that person is enrolled in the HMO by the participant, in accordance with procedures acceptable to the HMO, at one of the following times, unless the HMO consents or unless otherwise required by law:

(A) Upon the participant's initial enrollment in the Plan;

(B) Upon the participant's initial enrollment in the HMO;

(C) Within 31 days of the person's becoming qualified as an eligible dependent if an enrollment form and supporting documentation are submitted within 31 days of eligibility; or

(D) The first day of the calendar month following the month the dependent's enrollment form (and supporting documentation) is received by the Administration Office.

(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. 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, 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.

(C) Surviving spouses and children of active participants pay the pre-Medicare rate until the spouse is eligible for Medicare, at which time the surviving spouse pays the Medicare rate.

(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 (f), 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.

(f) Except as provided in subsection 4(f) or under COBRA Continuation Coverage, if a dependent of an eligible employee is covered under another group health plan, benefits are not terminated, but are subject to the Plan's Coordination of Benefits rules.

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

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

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

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

# Extended Reserve Accounts

5. (a) Extended Eligibility

(1) If an employee exhausts his or her Basic Reserve Account, the employee's eligibility may be maintained by having the monthly cost paid from his or her Extended Reserve for any form of eligibility requiring self-payment by the employee. If an employee's Extended Reserve Account is exhausted, and the employee has any months remaining during which he or she is permitted to maintain eligibility under a Plan provision requiring self-payment, the employee may self-pay the remaining months.

(2) The use of an Extended Reserve Account for the Self-Payment Program or for COBRA Continuation Coverage shall be at the option of the employee, but for retiree coverage shall be mandatory. An election to use Extended Reserve Accounts for Self-Payments or COBRA Coverage shall be made in writing, and shall apply until the period of Self-Payments or COBRA Coverage ends, unless the employee cancels his or her election in writing. If an employee elects not to use, or elects to discontinue the use of his or her 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.

(3) The use of an Extended Reserve Account for coverage of an employee's surviving eligible dependent(s) shall be mandatory unless the surviving eligible dependent(s) have elected to decline coverage.

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

(1) 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 on or after January 1, 2011 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. 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.

(2) Effective January 1, 2014, 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 or another employer sponsored group medical coverage that provides minimum value, as defined in Internal Revenue Code § 36B(c)(2)(C)(ii). Supporting documentation of such coverage may be requested by the Plan and upon request shall be provided by the employee. If employee fails to provide such supporting documentation, no credit will be made to the employee's Extended Reserve Account until the Plan receives the supporting documentation. An employee is not eligible for credit to be added to his or her Extended Reserve Account credit if he or she is enrolled in medical coverage purchased on an individual market.

(3) An employee will not receive credit to his Extended Reserve Account while building his Basic Reserve Account to meet the initial eligibility requirements (See Employer Eligibility). Once an employee is eligible under this Plan and is actually enrolled in this Plan or other group medical coverage that meets the requirements discussed in paragraph (2), employee shall receive a one-time credit to his Extended Reserve Account in an amount equal to the credit employee would have received had he been eligible and enrolled while building his Basic Reserve Account.

(4) The expenses must have been incurred by the active, retired, or former employee, or surviving spouse or by a person was then either a covered eligible dependent of the employee (active participants) or a dependent within the meaning of Internal Revenue Code §152 (retired and former employees).

(5) The expense must have been incurred on or after January 1, 2006.

(6) A former employee who is no longer eligible for coverage under this Health and Welfare Plan may be reimbursed for his and his dependent's qualified medical expenses and for premiums for other medical insurance coverage. However, a participant's extended reserve account will be forfeited to the general reserves of the plan if he becomes employed in industry service for an employer that does not contribute to a health and welfare plan benefiting workers in the pipe trades industry under the terms of a collective bargaining agreement. 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.

(c) Procedures for Payment of Reimbursement from Extended Reserve Account Benefits:

(1) Benefits will be paid only to an employee, former employee, retiree, or eligible dependents. Benefits will be paid only after an eligible person has incurred a Qualified Expense, and submitted a claim with supporting documents. Assignment of Extended Reserve Account benefits is not allowed.

(2) Claims may be submitted at any time. Payment of claims will be subject to the regular claims payment procedure of the Plan. If an employee, retiree, or dependent is aggrieved by the action on a claim, he or she may appeal that action to the Board of Trustees, under the general appeal procedures provided in the Plan.

(d) Extended Reserve Accounts which have a year-end balance will be credited with a bonus amount annually. The bonus amount will reflect the net rate of return of the Plan's Extended Reserve Account fund for the Plan year as determined by the Board of Trustees. In addition, the Board of Trustees may, from time to time, provide for the crediting of the Extended Reserve Accounts with an additional bonus on a one-time basis, subject to any limitations in the collective bargaining agreement or Trust Agreement, but otherwise in an amount subject to terms within their exclusive discretion, with the Minutes of such actions deemed a part of this Plan.

(e) If an employee dies with any credits remaining in his or her Extended Reserve Account and other coverage is exhausted, the surviving eligible dependents may elect COBRA continuation coverage (see Appendix C for COBRA rules). The employee's Extended Reserve Account may then be used to pay COBRA continuation coverage. If the employee's Extended Reserve Account falls below the monthly charge-off prior to the ending of COBRA continuation coverage, the surviving dependent(s) will have the right to self-pay the remainder of COBRA eligibility. If an employee dies and there are no dependents eligible for coverage, his or her account shall be forfeited to the general assets of the Plan.

(f) An employee is permitted to permanently opt out of and waive future reimbursement from the Extended Reserve Account. An employee upon termination of participation in the Plan, is permitted to permanently opt out of and waive future reimbursement from the Extended Reserve Account.

(g) Interplan Transfers

If an employee has a health reimbursement account that is sponsored by another U.A. local union and that plan has executed an inter-plan transfer agreement with this Plan, then the Trustees may, upon receipt of any supporting documents required by the Trustees, order a transfer to that Plan of the employee's entire extended reserve account, regardless of amount. Once the employee's extended reserve account is transferred, the employee shall have no further right to reimbursement of medical expenses or premiums from this Plan.

# Termination of Eligibility

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, when 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, when 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 upon the first day of the month following the termination of the domestic partnership.

## Termination for Cause

7. Eligibility under this Plan for an employee and for his or her dependents will terminate under the conditions set out below, which constitute termination for cause:

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

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

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

(d) An employee's Basic Reserve Account will be cancelled when his or her coverage is terminated for cause.

(e) If an employee's coverage is terminated for cause, his or her Extended Reserve account may be used for COBRA continuation coverage (see Appendix C), if he or she qualifies for, and elects, COBRA coverage. If funds are left in the Extended Reserve Account after COBRA coverage runs out, see Extended Reserve Account rules above.

## Reinstatement of Eligibility

8. (a) An employee whose benefits have been terminated other than under Rule 7, may qualify for reinstatement within 12 months of the termination of his or her coverage under the Basic Reserve Account rules. Such an employee will be reinstated on the first day of the calendar month following any month in which the employee's Basic Reserve Account is credited with an amount equal to the Basic Monthly Charge-Off. If an employee does not reinstate his or her coverage within 12 months from the date he or she was last eligible, his or her Basic Reserve Account will be cancelled. If this occurs, he or she will be treated like a new employee and will be eligible only in accordance with Rule 3 above.

(b) An employee whose benefits have been terminated under Rule 7 will be treated like a new employee and will be eligible only in accordance with Rule 3.

(c) An employee who is covered under Rule 10 or Rule 11, who returns to covered employment, shall be reinstated the first day of the month following the month in which he or she has accrued the Basic Monthly Charge.

## Self-Payment Provisions

9. (a) An employee whose Basic Reserve Account has fallen below the Basic Monthly Charge because of unemployment or reduced hours may elect to continue to be eligible for employee and dependent benefits on a month-to-month basis for a period of up to 12 months ("the Self-Payment Program"). An employee who participates in the Self-Payment Program may elect either medical and dental coverage, or medical coverage only. This election must be made at the beginning of each period of participation in the Self-Payment Program, and shall apply to the entire period. In order to be covered through the Self-Payment Program, the employee must satisfy the following rules:

(1) The employee must be registered on the out-of-work list at, and be available for dispatch from, the U. A. Local No. 393 Hiring Hall, for employment under a collective bargaining agreement calling for payments of contributions to this Trust Fund;

(2) The employee must make a timely initial payment and timely payments every month thereafter, of the amount determined by the Board of Trustees for the coverage elected by the employee. The initial payment is timely only if, by the 20th day of the last month of coverage under the Basic Reserve Account, the employee either: 1) makes the payment for the prior month's coverage; or 2) authorizes use of his or her Extended Reserve. If the employee did not authorize use of his or her Extended Reserve or cancels that authorization, or if the Extended Reserve is exhausted, payments for any later month are timely only if received by the 15th day of the month preceding the month to be covered. For example, if your last month of coverage under your Basic Reserve Account is May, then your first payment is due by April 20th for June coverage, and your second payment is due by May 15, for July coverage, and so on.

(b) If an apprentice employee is dispatched by U.A. Local No. 393 to an employer who is not signatory to a collective bargaining agreement with U.A. Local No. 393 and

does not receive contributions to this Plan during the period of such employment, the apprentice may elect to continue to be eligible for employee and dependent benefits on a month-to-month basis through this Self-Payment Program by making monthly payments at the rate of $500.00 per month. During the time that the apprentice is Self-Paying for benefits under this rule 9(b), his or her Basic Reserve Account will be frozen and shall not be used to pay for benefits.

## Coverage for Certain Disabled Employees Before Retirement - Employees Who Are Not Social Security Disabled

10. An employee qualifies for coverage under this Rule 10 if the employee is so disabled, due to sickness or injury, that he or she is no longer able to perform work covered by a U.A. Local No. 393 Collective Bargaining Agreement, and furnishes proof satisfactory to the Trustees that the disability is continuing and that he or she is not gainfully employed at any employment, other than employment in a training program funded by the Plumbing Industry Apprenticeship Non-Profit Corporation, and satisfies all of the other requirements defined below.

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

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

(2) Basic Reserve Account Runout:

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

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

An employee must notify the Administration Office as soon as he or she learns that a determination has been made on his or her application for a Social Security Disability Award and/or on the appeal of the initial determination. If his or her application is denied, he or she shall continue

coverage under Formal Plan Rule 10(a)(2)(B) and/or 10(a)(3) if eligible. If an employee intentionally fails to inform the Administration Office that his or her application for Social Security Disability benefits has been denied and or his appeal has been denied, then his or her benefits or coverage may be terminated or suspended on the grounds of fraud in accordance with Formal Plan Rule 20.

(3) After Basic Reserve Account is Exhausted: Self-payments may be made by the employee, subject to periodic proof of continuing disability. Coverage under this Rule 10 will be available only until the total period of coverage reaches 36 months.

(4) Notwithstanding the above, eligibility for benefits under subsection 10(a)(3) shall terminate when the employee becomes eligible to retire under the U.A. Local No. 393 Defined Benefit Pension Plan. At that time, the employee may remain eligible for benefits only under the rules for retirees. In addition, if the employee recovers from his or her disability, coverage under this Rule 10 will terminate on the first day of the month following his or her recovery.

(5) An employee, dependent or former dependent whose eligibility terminates under subsection 10(a)(4) may elect COBRA continuation coverage, for any period of COBRA coverage he or she may have remaining, less the number of months during which he or she received similar coverage at the same, or a lower, monthly charge.

(b) If the employee was covered as an active employee under the U.A. Local No. 393 Health and Welfare Plan during at least 9 of the last 10 years, including 80 of the last 120 months, immediately prior to the month of the onset of disability, the employee will remain eligible for benefits for 36 months as follows:

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

(2) Basic Reserve Account Runout:

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

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

An employee must notify the Administration Office as soon as he or she learns that a determination has been made on his or her application for a Social Security Disability Award and/or on the appeal of the initial determination. If his or her application is denied, he or she shall continue coverage under Formal Plan Rule 10(b)(2)(B) and/or 10(b)(3) if eligible. If an employee intentionally fails to inform the Administration Office that his or her application for Social Security Disability benefits has been denied and/or that his appeal was denied, then his or her benefits or coverage may be terminated or suspended on the grounds of fraud in accordance with Formal Plan Rule 20.

(3) After the employee's Basic Reserve Account is Exhausted: Subject to periodic proof of continuing disability, the employee shall remain eligible for the remainder of the 36 months by making timely monthly self-payments in an amount equal to one-half the current active employee self-payment rate. Coverage under this Rule 10 will be available only until the total period of coverage reaches 36 months.

(4) Notwithstanding the above, eligibility for benefits under subsection 10(b)(3) shall terminate when the employee becomes eligible to retire under the U.A. Local No. 393 Defined Benefit Pension Plan. At that time, the employee may remain eligible for benefits only under the rules for retirees. In addition, if the employee recovers from his or her disability, coverage under this Rule 10 will terminate on the first day of the month following his or her recovery.

(5) An employee, dependent or former dependent whose eligibility terminates under subsection 10(b)(4) may elect COBRA continuation coverage, for any period of COBRA coverage he or she may have remaining, less the number of months during which he or she received similar coverage at the same, or a lower, monthly charge.

## Coverage for Certain Disabled Employees Before Retirement - Employees Who Are Social Security Disabled

11. An employee qualifies for coverage under this Rule 11 if the employee is Totally and Permanently Disabled and has received a determination from the Social Security Administration.

(a) If the employee does not have 10 years of Vesting Credit under the U.A. Local No. 393 Defined Benefit Pension Plan, or was not covered as an active employee under the U. A. Local No. 393 Health and Welfare Plan during 5 of the last 7 years, including 60 of the last 84 months, immediately prior to the month of the onset of disability, the employee will remain eligible for benefits for the total number of months that he or she was eligible for benefits before the onset of disability, subject to the following conditions and to the payment of co-payments where required:

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

(2) Basic Reserve Account Runout: After the first 12 months of coverage under this Rule, if the employee has a Basic Reserve Account which totals

more than the required monthly charge, the employee's Basic Reserve Account will be charged the required monthly charge for coverage, and coverage will be provided until the Basic Reserve Account falls below the required monthly charge.

(3) After Basic Reserve Account is Exhausted: Self-payments may be made by the employee, subject to periodic proof of continuing disability. Coverage under this Rule 11 will be available only until the total period of coverage reaches the total number of months the employee was eligible for benefits before the onset of disability.

(b) If the employee has 10 years of Vesting Credit under the U. A. Local No. 393 Defined Benefit Pension Plan and was covered under the U. A. Local No. 393 Health and Welfare Plan during 5 of the last 7 years, including 60 of the last 84 months, immediately prior to the onset of disability, the employee will remain eligible for benefits for the total number of months that he or she was eligible for benefits before the onset of disability, subject to the following conditions:

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

(2) Basic Reserve Account Runout: After the first 12 months of coverage under this Rule, if the employee has a Basic Reserve Account which totals more than the required monthly charge, the employee's Basic Reserve Account will be charged the required monthly charge for coverage, and coverage will be provided until the Basic Reserve Account falls below the required monthly charge.

(3) After the employee's Basic Reserve Account is Exhausted: Subject to periodic proof of continuing disability, the employee shall remain eligible by making timely monthly self-payments in an amount equal to one-half the current active employee self-payment rate until the total period of coverage reaches the total number of months the employee was eligible under the Plan before the onset of disability. Coverage under this Rule 11 will be available only until the total period of coverage reaches the total number of months the employee was eligible for benefits before the onset of disability.

(c) (1) Notwithstanding the above, eligibility for benefits under this Rule 11 shall terminate when the employee becomes eligible to retire under the U.A. Local No. 393 Defined Benefit Pension Plan. At that time, the employee may remain eligible for benefits only under the rules for retirees. In addition, if the employee recovers from his or her disability, coverage under this Rule 11 will terminate on the first day of the month following his or her recovery.

(2) An employee, dependent or former dependent whose eligibility under this provision terminates may elect COBRA continuation coverage, for any period of COBRA coverage he or she may have remaining, less the number of months during which he or she received similar coverage at the same, or a lower, monthly charge.

# Coverage for Certain Terminally Ill Employees Before Retirement

12. (a) An employee who has a terminal illness and less than six (6) months to live may remain eligible for benefits for up to thirty-six (36) months at no charge, including any months of coverage for disability, if the following requirements are met:

(1) Employee is under the age of 55;

(2) Employee provides written certification from three physicians attesting that employee has a terminal illness and has less than six (6) months to live;

(3) Employee was covered as an active employee under the U.A. Local No. 393 Health and Welfare Plan for at least one hundred and twenty (120) months and had at least twelve (12) consecutive months of coverage as an active employee under the U.A. Local 393 Health and Welfare Plan within the eighteen (18) months preceding the date he is first diagnosed as terminally ill.

(b) Coverage provided to eligible individuals under this Rule 12 includes months of coverage provided for disability under Rule 10 or Rule 11 and shall not exceed a total of thirty-six (36) months combined.

# Coverage for Retired Employees and their Dependents

13. (a) A retired former employee will be eligible to enroll in retiree coverage if he or she satisfies the following four conditions:

(1) At the time of his or her retirement, he or she was covered as an active employee during at least nine of the last ten years prior to the month of retirement, provided that:

(A) If he or she fails to meet the above activity test due to lack of hours in 2009, he or she must have been covered as an active employee during at least nine of the last eleven years prior to the month of retirement and must have been signed on the UA 393 Building Trades Joint Hiring Hall out of work list and available for work in 2009; and

(B) Service for an approved general contractor who is not signatory to the Collective Bargaining Agreement with U.A. Local No. 393 but is signatory to another collective bargaining agreement for another building trade, as determined at the sole discretion of the Board of Trustees, shall be disregarded for purposes of satisfying the condition under this Plan Rule 13(a)(1) and his or her years covered as an active employee shall be frozen until he or she returns to work for a contributing employer and resumes accruing years covered as an active employee; and

(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 the PPO Medicare Supplemental 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 and enrolled in Medicare Parts A and B.

(2) Except as provided in subsection (b)(2) of this Rule, he or she enrolls in retiree coverage at the earlier of: (A) commencement of his or her benefits under the U. A. Local No. 393 Defined Benefit Pension Plan; or (B) commencement of installment benefits under the U. A. Local No. 393 Defined Contribution Pension Plan; and

(3) He or she satisfies one of the following:

(A) He or she is receiving monthly benefits from the U. A. Local No. 393 Defined Benefit Pension Plan, based either on the accrual of 10 or more Years of Benefit Credit under that Plan, or on the attainment of age 65 and the tenth anniversary of his or her participation in that Plan; or

(B) He or she is receiving monthly installments under the U. A. Local No. 393 Defined Contribution Plan under Article 6, Section 1(b)(4).

(4) He or she is a member of U.A. Local 393. U.A. Local 393 will notify a retiree if his or her union dues are overdue and he or she will be given an opportunity to pay the overdue amount. If the retiree falls 6 or more months behind in the payment of union dues, he or she will not be eligible for coverage under this Plan until the overdue amount is paid and membership in U.A. Local 393 is reestablished.

Dependents who were covered at the time the participant retired will continue to be covered while the participant is covered as a retiree for as long as they remain eligible dependents.

Notwithstanding the above, a former employee who has twenty (20) Years of Benefit Credit under the U.A. Local No. 393 Defined Benefit Pension Plan and who works for a municipality in Industry Service in the jurisdiction of U.A. Local No. 393 is not required to satisfy the condition under Section 13(a)(1) in order to be eligible to enroll in retiree coverage, provided he or she is working either for such municipality or for a contributing employer at the time of his or her retirement.

Except as otherwise provided in this Rule 13(a), if an employee who is otherwise eligible, performs any employment of the type covered by a Collective Bargaining Agreement with U.A. Local No. 393 for any employer not signatory or otherwise party to a Collective Bargaining Agreement with the U.A. Local Union having jurisdiction over the respective geographical area, or engages in business for his or her own account without being party to such an agreement, the right to retiree coverage for such employee and his or her dependents shall be forfeited.

(b) (1) Continued eligibility of any Medicare-eligible retiree or of any Medicare-eligible dependent of a retiree is subject to the person's enrollment in Parts A and B of Medicare.

(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. However, 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 participation in the Plan, for as long as such coverage is in effect, under the following rules:

(A) To defer enrollment at retirement, or to suspend coverage after retirement, a retiree, eligible dependent spouse or child must make a written election to do so, and must provide information about the other coverage, in a form and at times satisfactory to the Board of Trustees. The following rules apply to elections to defer or suspend coverage:

(i) Deferral at Retirement. An election to defer enrollment at retirement shall apply to all benefits available under the Plan. Effective January 1, 2012, a retiree, eligible dependent spouse or child may elect to defer all benefits under the Plan OR may elect to defer medical coverage but maintain dental coverage 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 Basic Reserve Account converted to an equivalent dollar amount and deposited into his or her Extended Reserve Account upon the retiree's retirement effective date. Once a retiree's Basic Reserve Account hours have been converted and deposited into the retiree's Extended Reserve Account pursuant to this Formal Plan Rule 13, Section (b)(2)(A)(i), there shall be no hours remaining in the retiree's Basic Reserve Account.

(ii) Suspension after Retirement. An election to suspend coverage after retirement shall apply to all medical benefits under the Plan. However, effective September 1, 2003, such elections shall apply to dental benefits if the retiree, eligible dependent spouse or child requests suspension of dental benefits, and provides information about the other dental coverage, in a form satisfactory to the Board of Trustees. Effective January 1, 2012, a retiree, eligible dependent spouse or child may elect to suspend all benefits under the Plan OR may elect to suspend medical coverage but maintain dental coverage.

(iii) In no event may an election be made to defer or suspend dental benefits unless the retiree, eligible dependent spouse or child is also electing to defer or suspend medical benefits.

(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.

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.

(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) the retiree's notification of the termination. A retiree's or dependent spouse's or child's right to recommence coverage is subject to the retiree's providing satisfactory verification of the date of the termination or notification.

(D) When a retiree recommences coverage, the benefits available to the retiree shall be limited as follows:

(i) If the retiree or eligible dependent spouse had declined dental coverage, he or she shall not be eligible for dental coverage. If the retiree had not declined dental coverage, he or she shall be eligible for dental coverage if, and only if, he or she provides information, satisfactory to the Board of Trustees, that he or she had dental coverage through the group health plan providing medical coverage, for the last two months preceding reenrollment in this Plan.

(c) A participant or surviving spouse covered under this Rule 13 may elect coverage through the self-funded PPO Plan or any Plan HMO, or if Medicare-eligible, the self-funded Medicare Supplemental Plan, or under the Medicare-Risk program of any Plan HMO offering such a program. Coverage under the self-funded Medicare Supplemental Plan is subject to the rules for Medicare-eligible participants in this Plan. Coverage under any Plan HMO is also subject to the rules of their plans, which may limit coverage options for Medicare-eligible participants. A retiree may elect coverage through a Medicare-Risk plan of a Plan HMO at any time, but may elect coverage through the self-funded Medicare Supplemental Plan or non-Medicare risk programs of a Plan HMO, if available, only during open enrollment.

(d) Eligibility for benefits as a retiree is subject to payment of a monthly self-payment, which may be changed from time to time by the Board of Trustees. The first payment for Retiree Coverage will be due the first month after which the Retiree's active coverage ends after his Basic Reserve Account runs out. After that time, payments due under this rule must be received by the 15th day of the month preceding the month to be covered. Retired employees may use their Extended Reserve Account for all self-payments required under this Rule (see Extended Reserve Accounts Rule 5, page 6).

**RETIREE SELF-PAYMENT AMOUNTS**:

**Retiree Self-Payment Amounts**

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. If your total income is less than $3,390 per month, you may receive assistance in making payments through the hardship waiver provision, described next.

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

- Those who retire before age 55 will pay 100% of the that year's plan cost until turning age 55, whereby the rate will be adjusted to the applicable 55 year old payment percentage.
- Those who retire at age 65 or older, will pay the applicable percentage based on the (64 +) group.
- Lastly, those who retire at pre-Medicare age (prior to age 65) will have their applicable pre-Medicare percentage value fixed throughout their retirement. However, at age 65 (Medicare eligible) their 'fixed percentage' will be applied to the Medicare cost to the plan.

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

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

**Note:**

1. Those who retire at age 52-54 will pay 100% of the plan cost until said retiree turns age 55, where the percentage paid will be adjusted to match the 55 year old group.
2. Your "Percent Paid by Member" is based on your age at retirement & your career hours in Local 393.
4. To determine your cost - multiply the plan cost x your applicable "Percent Paid by Member."
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.

**Hardship Waiver**

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

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

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

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

*See Rule 14, Hardship Waiver for qualified participants.

(e) In addition to the above, a separate self-payment shall be required of retirees who elect dental coverage, as provided in Dental Care Plan, Retired Employees.

(f) Eligibility shall be suspended for any retiree who returns to work of the type covered under the Collective Bargaining Agreement, to any work for which benefits are suspendible under the U. A. Local No. 393 Defined Benefit Pension Plan, or to paid work for the Local Union or a related entity in a position for which contributions are made to this Plan. Eligibility shall be suspended, terminated and/or restored under the following rules:

(1) If the retiree works as an employer, or becomes a significant shareholder of an employer, who or which is not signatory to a Collective Bargaining Agreement with U. A. Local No. 393 or the U. A. Local Union having jurisdiction in the area of operations of the employer, or works for such an employer, then the retiree's eligibility shall be terminated immediately. Thereafter, the employee's eligibility shall not be restored at any time, unless he or she requalifies as a new Active Employee, and shall not be restored under Rule 13(a), unless the employee requalifies on the basis of nine new years of coverage.

(2) Unless a retiree qualifies under Rule (3) below, the benefits of any other retiree who works as an employee covered under, or an employer signatory to, the Collective Bargaining Agreement with U. A. Local No. 393, or performs other work for which benefits are suspendible under the U. A. Local No. 393 Defined Benefit Pension Plan, shall be suspended immediately upon the performance of such work. Thereafter, he or she shall be covered only as provided under the Eligibility Rules for Active Employees, until his or her benefits recommence under the U. A. Local No. 393 Defined Benefit Pension Plan, at which time he or she shall recommence under these eligibility rules for Retired Employees.

(3) (A) If the retiree falls into one of the following categories, then his or her benefits shall be suspended only as provided in paragraph (B) of this section (3):

(i) The retiree becomes employed on a paid basis for the Local Union or a related entity in a position for which contributions are made to the Plan.

(ii) The retiree performs work of the type covered by the Collective Bargaining Agreement for an employer who is signatory to a U.A. Local 393 Collective Bargaining Agreement.

(iii) The retiree becomes an employer, or a significant shareholder of a corporate employer, who or which is signatory to a Collective Bargaining Agreement with U.A. Local 393; or

(B) If an employee qualifies under paragraph (A), his or her eligibility as a retiree shall be suspended only as follows:

(i) A retiree who qualifies under paragraphs (A)(i) and (A)(ii) shall be eligible for medical benefits as an active employee on the first day of the month following the month in which the employee accrues a Basic Reserve Account equal to the Basic Monthly Charge-off. At that time his or her eligibility as a retiree shall be suspended in favor of eligibility as an active employee. Until the employee qualifies for coverage as an active employee under this subsection, the employee may maintain coverage by continuing to pay the applicable retiree self-payment. An employee who qualifies for self-payment under this rule shall be eligible only for medical, hospital and surgical benefits, and may maintain eligibility for dental benefits only if he or she had previously elected, and had made the required self-payments for, retiree dental coverage, and continues to make such self-payments.

(ii) The eligibility of a retiree who qualifies under paragraph (A)(iii) shall be suspended on the first day of the month following the month in which he or she became an Individual Employer, but he or she shall be eligible to enroll as an Individual Employer immediately.

(iii) The eligibility of a retiree who qualified under paragraph (A) shall recommence under these Retiree rules when his or her benefits recommence under the U. A. Local No. 393 Defined Benefit Pension Plan.

(g) Retiree welfare benefits are paid out of current revenues, and the ability of the Plan to continue such coverage is reviewed by the Board of Trustees. The Board of Trustees reserves the power to modify, change or terminate coverage, including the power to modify the required premium payments by retirees. In no event shall retiree coverage, or any particular element of retiree coverage, be considered vested.

## Hardship Waiver

14. The Hardship Waiver has been established to assist eligible retirees and surviving spouses with their required monthly payments. A retiree who qualifies for a hardship waiver shall have the entire amount of the monthly retiree premium waived. Surviving spouses who qualify for a hardship waiver will receive hardship relief in an amount equivalent to the Medicare Rate for participants who qualified for Medicare before 1993.

Under the Hardship Waiver, a retiree or surviving spouse's required monthly payment will be subsidized if his or her "total income" is less than $3,390 per month. (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 Part A Pension;

(b) Equivalent monthly pension benefits from the Defined Contribution Plan (Part B) - see below;

(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 - see below.

In order to determine the equivalent monthly pension benefit from Part B or from capital gains on the Hardship application, the employee's Part B 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 self-reporting of "total income" by retirees and surviving spouses who apply for the Hardship Waiver. To receive the Waiver, an employee or surviving spouse must complete a statement of income when he or she applies for the Waiver, and any time that his or her income increases. In addition, the employee 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.

# Eligibility Rules for Individual Employers

15. The rules for eligibility of Individual Employers for benefits under the Health and Welfare Plan are as follows:

(a) The following persons will, upon compliance with these rules, be eligible for medical and dental benefits under the Health and Welfare Plan.

(1) Self-employed persons, sole proprietors and bona fide members of partnerships and other unincorporated associations, and officers, directors and shareholders of corporations, who or which are engaged in business in the Plumbing and Pipefitting Industry and are signatory, or otherwise party, to a collective bargaining contract with U.A. Local Union No. 393. The term "Individual Employers" means only those persons who are described in this subsection (1), unless the context otherwise expressly requires, and who are actively engaged in the business, provided all such persons in the business are covered. Notwithstanding any other provision of this rule, an officer shareholder who meets the requirements of the Plan Rule 1(b) above, shall qualify for coverage as an active Employee, and not under these rules as an Individual Employer.

(2) Any full-time employees (employed for at least 20 hours each week) not covered by another Taft-Hartley Trust Health and Welfare Plan, of a covered Individual Employer, provided all such employees are covered.

(3) Dependents of any of the persons described in subsections (1) and (2) above.

(b) Individual Employers, already party to a Collective Bargaining Agreement with U.A. Local Union No. 393 as of the date hereof, may establish initial eligibility, or if already eligible, continue such eligibility, by making application in writing to the Administration Office on or before the 20th day of the calendar month next following the date hereof, or if not already party to a Collective Bargaining Agreement with U.A. Local Union No. 393, on or before the 20th day of the calendar month following the month in which becoming a party. Notwithstanding the foregoing, an Individual Employer who is receiving coverage under this Plan through his or her Basic Reserve Account because of work he or she performed under a Collective Bargaining Agreement as of the date he or she first becomes an Individual Employer shall continue to receive coverage under this Plan through his or her Basic Reserve Account until such Account is exhausted. Once his or her Basic Reserve Account is exhausted, he or she may receive coverage as an Individual Employer by making application in writing to the Administration Office in accordance with this Rule 15.

(c) Such application must include the names of all persons eligible for coverage under (a) and (b) above. Each such person will become eligible for benefits as of the first day of the second month following the month the hours are worked, provided payment of the monthly charge, as fixed from time to time by the Board of Trustees, is made for each such person on or before the 20th day of each month. Each such person's coverage will continue provided payment of the required charges is made on or before the 20th day of each successive month thereafter.

(d) The Individual Employer must notify the Administrative Office of the addition to coverage of each newly hired employee or other person within 30 days of the person becoming eligible.

(e) All Individual Employers, office clerical employees (except employees of U.A. Local 393) and their eligible dependents who enroll in this plan for the first time on or after April 1, 2009 shall be eligible for HMO coverage only.

(f) Individual Employers, office clerical employees or their eligible dependents, if eligible at the time of termination of employment, will continue to be eligible subject to COBRA continuation coverage, except as follows:

(1) An Employer shall be deemed to have a termination of employment only if he or she has completely terminated his or her connection to the participating company, or that company has ceased operations.

(2) No person shall be deemed to have had a qualifying event if the reason that the person's coverage is terminated is because the Individual Employer has failed to make a required payment for coverage, or has ceased to qualify to participate in this Plan.

(g) Individual Employers may, by notice in writing to the Administration Office, terminate coverage as of the first day of the calendar month next following, but will remain liable for any unpaid premium charges.

(h) An Individual Employer in default of any of the provisions of these eligibility rules will be terminated as of the first day of the calendar month for which no payment was made and the eligibility of all persons covered under Section (a) will terminate and may not again be renewed except upon re-application as provided in Section (b) together with proof of insurability satisfactory to the Trustees. Such application may be filed only between the 15th day of January and the 15th day of February of any given year.

(i) The terms "dependents" and "benefits" as used herein will have the same meaning as in the Eligibility Rules for Employees.

(j) Individual Employers, their dependents or office clerical employees, are not eligible for the weekly disability benefit.

(k) An Individual Employer may terminate coverage for himself or herself, and for all other persons covered under this section, through the Individual Employer, by providing written notice to the Administration Office at least 30 days in advance of the last day of the last month in which coverage is to be provided under the Plan. If notice is received in a timely fashion, coverage will then terminate in accordance with the Individual Employer's request. If notice is received less than 30 days before the last day of the requested termination month, the notice shall be treated as if it was a timely request for termination for the month following the requested termination month. After coverage is terminated, the Individual Employer shall receive a refund of any advance monthly charges paid pursuant to section (c) of this Rule (not including any reserve account of contributions made pursuant to a collective bargaining agreement), less any outstanding premiums, delinquent employer contributions, and other obligations to the Trust Funds.

(l) Any Individual Employer, as defined in section (a)(1) of this Rule, may elect upon retirement to continue coverage after retirement for himself or herself and his or her dependents if the Individual Employer (and dependent(s), if any) satisfy the following conditions:

(1) The Individual Employer had been continuously eligible for benefits under the Plan for at least 120 months immediately prior to retirement;

(2) The Individual Employer was at least 60 years of age at the time of retirement;

(3) The Individual Employer continues to make timely payment of such premium as the Board of Trustees determines applies to that person's coverage; and

(4) If the Individual Employer or dependent is eligible for Medicare, eligibility is maintained under Parts A and B of Medicare.

(5) Individual Employers are only eligible for retirement coverage through HMO. If the Individual Employer resides outside of the HMO coverage area, he or she may be eligible for retiree coverage under the PPO Plan or PPO Medicare Supplemental Plan if such coverage is approved by the Board of Trustees.

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

## Coverage During a Leave Under the Family and Medical Leave Act

16. If the employee works for an Individual Employer that is required to provide Health and Welfare plan coverage under the Family and Medical Leave Act (FMLA) during a qualified leave under the FMLA, and employee is eligible for, and takes, the leave, then the following rules apply under these general eligibility rules:

(a) The employee's employer must make contributions to this Plan on the employee's behalf for every period of FMLA leave. The amount of contributions for each month of FMLA leave will be equal to the rate then in effect for COBRA Continuation Coverage. 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 provide evidence 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 Reserve Accounts will not be charged for any period of coverage for which payment is made under these rules. All other Plan rules concerning Reserve Accounts remain in effect during FMLA leave.

(d) Crediting of hours for the employee, and the employer's obligation to contribute, terminates under these rules upon termination of FMLA leave. The employer must inform the Administration Office in writing when the employee's FMLA leave terminates. If the employee does not return to work for the employer at the

termination of FMLA leave, the employee is eligible for COBRA Continuation as provided in Appendix C, with the termination of FMLA leave deemed the qualifying event as a termination of employment.

## Qualified Medical Child Support Orders

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

## Rules Affecting Employees Called to Active Military Service

18. (a) If an employee is absent from covered employment due to qualifying military service under 38 U.S.C. § 4301 et. seq., and notifies his or her employer, the Trust Fund, or the Union of his or her entry into military service, and his or her entry into military service was voluntary, then the employee may elect any of the following options:

(1) To have his or her Basic Reserve Account frozen as of the first day of the month following the commencement of active service, and to have all eligibility for the employee and any dependents terminate on the first day of that month; or

(2) To have his or her Basic Reserve Account frozen as of the first day of the month following the commencement of active service, and have his or her dependents covered under COBRA Continuation Coverage (except for the 11-month extension on account of disability); or

(3) To continue the eligibility of the employee's dependents, at the Basic Monthly Charge against the employee's Basic Reserve Account, until that Basic Reserve Account is exhausted, followed by COBRA Continuation Coverage.

(b) If an employee who is eligible under subsection (a) fails to provide proper notice of his or her commencement of qualifying military service, or fails to make an election when offered, the employee shall be deemed to have elected Option No. 3.

(c) Effective February 1, 2003, if an employee is absent from covered employment due to qualifying military service under 38 U.S.C. § 4301 et. seq., and notifies his or her employer, the Trust Fund, or the Union of his or her entry into such military service, and his or her entry into military service was as a result of a call to active duty, then the employee's Basic Reserve Account shall be frozen. The period during which the employee's Basic Reserve is frozen will end at the earlier of: 1) the end of the employee's military service; or 2) 24 months, unless the employee's period of service is extended by presidential order. While an employee's coverage is frozen

under this subsection (c), coverage shall be provided to his or her dependents at no monthly cost. If the employee's period of service is extended beyond 24 months for any other reason, the options under subsection (a) shall apply.

(d) Coverage under the employee's Basic Reserve Account (if any remaining after discharge from active military duty) will recommence if and when the employee returns to work for a contributing employer or becomes available for work for a contributing employer as shown by application for employment at the Local Union, provided the employee returns to work or makes such application within 90 days of discharge.

## Rules Affecting Employees Serving as Public Safety Officers

19. An employee may request in writing that his or her Basic Reserve Account be frozen for up to one year during the period he or she is serving as a Public Safety Officer. The employee and his or her dependents will not be eligible to participate in the Plan while the Basic Reserve Account is frozen.

Coverage under the employee's Basic Reserve Account will recommence if the employee returns to work for a contributing employer within one year or becomes available for work for a contributing employer within one year as shown by his registering for work on the U.A. Local 393 Building Trades Joint Hiring Hall out-of-work list. The employee must provide adequate proof to the Trust Fund Office of his service as a Public Safety Officer before coverage will recommence.

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

## Rules Affecting Residential Employees, Service Tradesmen and Provisional Journeyman Service Plumbers under the UA National Plumbing Service Agreement

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

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

Your eligibility starts on the first day of the second month following the month in which you have completed 480 hours of covered residential plumbing, service tradesmen, or national service agreement work during the

previous consecutive 12-month period (provided your employer pays the required contributions).

**Maintaining Eligibility**

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

**Basic Reserve Account**

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

**Benefits**

Residential Employees, Service Tradesmen, and Provisional Journeyman Service Plumbers (Levels I through III) may only receive medical benefits from Kaiser under the applicable Evidence of Coverage Document and are not eligible to participate in the PPO Plan. The Kaiser Benefits are contained in the applicable Kaiser 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**

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

**Substance Abuse**

Residential Employees, Service Tradesmen, and Provisional Journeyman Service Plumbers (Levels I through III) 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:

1.19 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, 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. You do not have to be confined to home to receive benefits. This benefit is in addition to any payments from Workers' Compensation, State Disability Insurance or similar law. The benefit amount is $150 a week or 1/7th of $150 for each day of disability less than a full week. Payments continue for up to 52 weeks. There is no limit to the number of benefit periods for unrelated disabilities. If you have received Plan benefits, return to work and are absent again for the same cause within 52 weeks of the start of benefits, payments will begin again without a waiting period. They will continue until you receive 52 weeks of benefits. A disability occurring after you have been continuously engaged in covered work for 26 weeks after the first Plan payment for a related disability will be considered a new claim.

**Miscellaneous**

Residential Employees Service Tradesmen must pay for the full cost of their coverage at retirement and are not eligible 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.

Journeyman Service Plumbers under the UA National Plumbing Service Agreement shall be eligible for benefits under the same terms as employees working under the U.A. Local 393 Master Agreement.

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

# Termination and Suspension of Eligibility on the Grounds of Fraud

20. Notwithstanding any other provision of this Plan, if any person who is not eligible for benefits receives benefits or coverage as a result of a misrepresentation by the person or by the participant through whom the person claims eligibility, or accepts benefits or coverage if either the person, or the participant through who the person claims eligibility, knows that the person is not entitled to benefits or coverage, then the Board of Trustees, in its exclusive discretion, may take any or all of the following actions:

    (a) Terminate the person's eligibility for benefits, and/or the eligibility of the participant through whom the person claimed eligibility and the participant's dependents;

    (b) Cancel the Reserve Account(s) of the person or of the participant through whom the person claimed eligibility, and/or disqualify the person or participant from accruing Reserve Account credits for a period of time determined by the Board of Trustees, even if contributions are made on behalf of the person or participant; and

    (c) Suspend the eligibility of the person, or of the participant through whom the person claimed eligibility, and of the participant's dependent(s), for a period of time determined by the Board of Trustees, whether or not the person or participant has a balance in either or both of his or her Reserve Accounts.

    This reservation of powers is in addition to any rights of recovery or offset provided elsewhere in this Plan.

# FORMAL BENEFIT RULES

# ELECTION OF MEDICAL BENEFITS PROVIDER

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. As of July 1, 2003, the only HMO option is Kaiser Foundation Health Plan. Such elections may be made when first eligible for benefits, or during open enrollment periods established by the Board of Trustees. Effective with September 2018 eligibility, if an eligible employee fails to elect PPO coverage when eligible to do so, he or she shall be deemed to have elected coverage under the HMO 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.

An employee's election of a medical benefits provider also applies to all of his or her eligible dependents. If an eligible employee elects hospital, medical and surgical coverage through a Plan HMO, neither the employee nor his or her dependents are eligible for hospital, medical, surgical or hearing benefits from the PPO Plan. If an employee is enrolled in a Plan HMO, but he or she fails to enroll a dependent in a timely fashion, then no medical benefits are available to the dependent, except at the discretion of the HMO, until the calendar month following the month the enrollment form for the dependent is received. If an Employee is receiving benefits from the PPO Plan, no benefits are payable for an otherwise eligible dependent (other than a newborn child) until that dependent is properly enrolled. Claims for newborn children will be held and will not be paid until such time as an enrollment form and birth certificate for the child are received.

All eligible employees, even those who elect coverage through an HMO, are eligible for dental benefits, disability benefits, drug and alcohol abuse treatment through Beat-It, 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.

# MEDICAL BENEFITS - PPO PLAN

# GENERAL RULES FOR PAYMENT OF BENEFITS

## Priority of Rules

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

1. No benefits are paid for the following items:

   (a) Any expenses which are excluded from the Plan;

   (b) Any otherwise covered services or supplies if the claim for those services and supplies is submitted more than a year from the date the services or supplies were rendered.

   Payments by a covered individual for items listed above are not counted toward the Out-Of-Pocket Expense Limitation.

2. No benefits are paid on behalf of a covered individual in a calendar year until the individual or his or her family has satisfied the applicable annual deductible requirement.

3. If there is a specific limitation or special benefit rule for a particular service or supply, then that limitation or rule supersedes any more general schedule which would provide for a different benefit payment.

4. Except where a rule specifically states that it covers care outside of the geographical area of the Plan, the scheduled percentages stated in the rules below apply only to services and supplies rendered within the geographical area of the Plan.

5. Subject to the above, the Plan pays benefits at the stated percentage of the billed charge for a covered service or supply according to the applicable schedule, up to the maximum amount payable under that schedule. (Notwithstanding the above, to the extent allowed by U.S. Dept. of Labor Regulation 29 C.F.R. § 2560(b), the Trustees reserve the right to refuse to verify, to a non-PPO provider, the availability of benefits under the Plan, without the express written consent of the participant who is, or whose eligible dependents are, receiving services or supplies for which benefits may be payable under the Plan). However, the Plan provides "stop-loss" protection for participants and dependents who have substantial covered expenses in a calendar year, under the Out-Of-Pocket Expense Limitation. If an individual has satisfied that Limitation in a calendar year, and if he or she receives a service or supply which is covered under the Limitation and not subject to a special schedule or limitation, then the schedule of benefits under the Out-Of-Pocket Expense Limitation rule supersedes any general schedule which would provide for the payment of a lesser benefit payment.

# Annual Limits

There shall be no annual limit for Essential Benefits for plan years beginning on or after January 1, 2014.

Essential Benefits shall mean coverage for ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

The U.A. Local 393 Health and Welfare Plan uses the Utah Benchmark for determining what constitutes an essential benefit.

# Annual Deductible

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

All covered charges are subject to the deductible requirement except:

1. The first $600 of covered charges for medical care which are due to injuries sustained in an accident and which are incurred within 90 days of the accident, and

2. If two or more covered persons in the same family unit are injured in the same accident, only one deductible of $300 will be required with respect to covered charges resulting from the accident in excess of the first $600 incurred within 90 days of the accident due to that accident for that calendar year.

In the event an employee with a Basic Reserve Account is married to another employee with a Basic Reserve Account, the combined annual deductible for both employees shall be $300. The maximum family deductible of $600 shall apply.

# Standard Payment Rates and Usual, Customary and Reasonable Charges

1. The benefits payable for covered charges incurred at a Preferred Provider are not defined in terms of the Usual, Customary and Reasonable rate ("UCR"), but are based solely on the contracted rate in the contract between the Plan and the Preferred Provider. Subject to exclusions, conditions, and limitations for particular types of care, the following general rates apply:

   (a) For services and supplies provided by Preferred Providers, the Plan pays 90% of the provider's contracted rate.

   (b) For services and supplies provided by non-PPO providers for which there is a negotiated PPO contract rate, the Plan pays 60% of the UCR rate.

2. It is the responsibility of a participant to confirm that a hospital provider used by the participant is on the most current Preferred Provider list. If a hospital provider has been removed from the Preferred Provider list, the Plan will pay only the amount that the Plan would have paid had that provider remained a Preferred Provider, and the employee or dependent will be responsible for all charges above the amount that the Plan would have paid had that provider remained a Preferred Provider.

3. Charges above amount on which benefits are determined for a particular service or supply (that is, the PPO contracted rate or UCR rate, as applicable), are not considered allowable charges under the Plan for any purpose.

4. For any specific benefit rule which is defined by UCR other than an applicable contracted preferred provider rate, the UCR charge for any service or supply is the amount which the Trustees determine, in their exclusive discretion, after investigation by the Administration Office, Plan Consultant, or other expert engaged for this purpose, to be the fee which is reasonable and is usually and customarily charged for that service or supply by qualified providers in the area of service, except that in no event shall the UCR charge for a service or supply provided to a Medicare-eligible participant or dependent exceed the Medicare-limiting charge for that service or supply. Unless the Trustees have investigated the UCR charge for a particular service or supply, UCR shall be 90% of the standard rates specified in the reference document then in effect at Benesys.

## 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. Charges for treatment in an emergency room when there was no Qualified Emergency then in effect (including any supplementary deductible), any co-payment for care by a PPO or non-PPO Provider, or any charges by a non-PPO Provider in excess of the applicable UCR rate;

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

5. All charges paid to a non-PPO provider; and

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

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. Charges for treatment in an emergency room when there was no Qualified Emergency then in effect (including any supplementary deductible), any co-payment for care by a PPO or Non-PPO Provider, or any charges by a non-PPO Provider in excess of the applicable UCR rate;

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

5. All charges paid to a non-PPO provider.

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.

# COVERED MEDICAL CHARGES

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

1. Charges made by a surgeon, physician assistant, psychiatrist, psychologist, professional anesthetist, physiotherapist, radiologist, qualified speech therapist, chiropractor, laboratory or any person who is licensed to practice under the State Business and Professions Code or similar law, who performs the services which are payable under this Plan and services which are recognized by such Code or law to be within the scope of his or her license.

2. Charges made by a registered professional nurse (R.N.) or a licensed practical nurse (L.P.N.).

3. Charges made by a professional ambulance service, railroad or commercial airline for medically necessary transportation for a covered person from a place where the need for hospitalization arises for covered treatment of an illness or injury to the nearest hospital equipped to treat such illness or injury.

4. Charges made by any other person or institution for the following:

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

   (b) Blood or blood plasma which has not been replaced on the covered person's behalf;

   (c) Medical supplies, including (but not limited to):

      (1) Bandages and surgical dressings and other surgical supplies.

      (2) Braces (except dental), casts, splints and trusses; drugs and medicines while confined in a hospital.

      (3) Artificial limbs or eyes. This includes services of an orthotist and prosthetist in connection with evaluation or the fitting of an orthotic or prosthetic device when those services are billed as part of the charge of the artificial limbs or eyes, provided that benefits will cover artificial limbs or eyes only when such devices are:

         (A) Affixed to the body externally;

         (B) Required to replace all or any part of any limb or eye; and

         (C) Required to support or correct a defect of form or function of a permanently inoperative or malfunctioning limb or eye; and further provided that benefits do not extend to the repair or replacement of a prosthetic device occasioned by misuse or loss of the device.

      (4) Rental or purchase of dialysis equipment, dialysis supplies and rental or purchase of other medical equipment and supplies which are:

         (A) Ordered by a physician, and

         (B) Of no further use when medical need ends, and

(C) Usable only by the patient, and

(D) Not primarily for the participant's comfort and his or her hygiene, and

(E) Not for environmental control, and

(F) Not for exercise, and

(G) Manufactured specifically for medical use, and

(H) Approved as effective and usual and customary treatment of a condition as determined by the Plan, and

(I) Not for prevention purposes.

Notwithstanding the above, rental charges that exceed the reasonable purchase price of medical equipment are not covered.

If an eligible person obtains medical equipment or supplies from a non-PPO provider at a rate that is less than the negotiated PPO contract rate, the Plan shall pay 90% of the billed charges for the medical equipment or supplies if the charges are approved in advance by Benesys Administrators.

5. Charges made by any free-standing surgical facility for medical care, which would have been covered hospital charges if they had been performed as inpatient services in a hospital.

6. Charges for covered care for a newborn infant, but only if the participant-parent satisfies the enrollment requirements of the Plan.

7. Charges incurred when cosmetic surgery is performed by a licensed physician for the following circumstances:

   (a) When the treatment is for injuries sustained in an accident, or

   (b) When the treatment is for a congenital anomaly of an Eligible Dependent Child.

8. Charges for Services and Supplies Provided Outside United States and Canada, under the following rules:

   (a) Charges incurred for care provided to employees and eligible dependents while outside the United States and Canada are paid in accordance with the Plan's benefit rules for services and supplies rendered outside the geographical area of the Plan if the charges were incurred during the first 60 days of such an absence.

   (b) After the first 60 days, the benefit rules for services and supplies rendered outside the geographical area of the Plan continue to apply without special limitations to an employee, and to his or her eligible dependents residing with the employee, if a participating employer has requested approval of coverage for a period greater than 60 days connected to covered employment performed outside the United States and Canada. Approval may be given by the Board of Trustees, if in their sole discretion, they have determined that such coverage will pose no undue risk to the Plan.

   (c) If an employee or dependent is outside the United States and Canada for more than 60 days, and does not qualify under rule b, then benefits are paid in accordance with

the Plan's benefit rules for services and supplies rendered outside the geographical area of the Plan, subject to following special limitations:

(1) If the employee or dependent is entitled to Medicare, then the Plan will pay no more than the benefits that it would have paid (i.e., the same percentage of the same Medicare limiting charge) had the services or supplies been rendered in the United States under a Medicare limiting charge; and

(2) In no event shall the benefits be paid in excess of the contracted rate for similar services or supplies for Preferred Providers in the geographical area of the Plan; and

(3) All charges in excess of Plan benefits are the responsibility of the patient, but an employee or dependent will receive credit, for stop-loss purposes, only for the amounts for which the employee or dependent would have been credited had the services or supplies been rendered in the United States.

(d) Direct payments to providers are not authorized for services and supplies rendered outside the United States.

9. Charges incurred for dental care for the following items only:

(a) Surgery due to disease, other than a periodontal disease, or injury of the jaw or facial bones; removal of cysts, leukoplakia or malignant tissue; correction of harelip, cleft palate or protruding mandible; or freeing of muscle attachments; or

(b) Medical treatment of natural teeth injured in an accident if the treatment is begun within 90 days after the accident and the charges are incurred within one year after the accident.

10. Charges for midwifery services when the services are performed by a nurse-midwife who holds a Certificate of Nurse-Midwife issued by the State of California Board of Registered Nursing.

11. Charges made for services rendered by a registered nurse practitioner if the nurse practitioner meets all the necessary requirements.

12. Charges incurred for employees and dependents as a result of childbirth and pregnancy and related conditions, other than 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).

13. Charges for the following items if incurred in connection with a medically necessary mastectomy, if the covered individual so elects in consultation with her attending physician:

(a) Reconstruction of the breast on which the mastectomy has been performed;

(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(c) Prostheses and physical complications at any stage of mastectomy, including lymphedemas.

14. Charges for contraceptive medications and devices which are administered in a medical office.

15. Charges for services or supplies provided by a licensed hospital, as follows:

(a) Charges by a hospital during each day of a period of confinement for room and board only up to the daily room and board rate regularly charged for a semi-private room, except if intensive care is required, in which case the actual expenses incurred in such accommodations will be considered a covered charge.

(b) Charges for outpatient treatment.

(c) Charges for pre-admission x-ray or laboratory examination.

(d) Charges for medications provided by a hospital during confinement.

# CONDITIONS AND LIMITATIONS FOR PARTICULAR BENEFITS

## Alcohol and Substance Abuse Care

The Plan's PPO provider for alcohol and/or substance abuse (other than detoxification) is the Organization Beat It!.

Detoxification: After the annual deductible is paid, Detoxification is covered at 90% of the contracted Preferred Provider Rate 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.

Residential Treatment and Outpatient Care:

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.

## Ambulatory Surgery Centers

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

1. PPO Provider: 90% of the applicable contracted rate; and

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

## Bariatric Surgery

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

## Chiropractic and Acupuncture Care

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

The plan pays 90% of the PPO contract rate (60% of Usual Customary or Reasonable charge for non-PPO providers) for chiropractic care up to $1,500 per calendar year, for up to 26 visits per year. No maintenance care is covered.

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

# Emergency Care and Emergency Room Treatment

1. If A Qualified Emergency Is In Effect: In a Qualified Emergency, the Plan pays benefits at the following rates, for covered charges in excess of any then-applicable deductible:

   PPO Provider: 90% of the applicable contracted rate; and

   Non-PPO Provider: The greater of (1) 90% of the UCR charges, (2) 90% of the applicable contracted preferred provider rate or (3) 90% of the amount that would be paid under Medicare up to the applicable Out-Of-Pocket limit; counting the member's share towards the Out-Of-Pocket limit. After the Out-Of-Pocket limit has been reached, the Plan pays 100% of the applicable rate.

   For purposes of this section, a Qualified Emergency means a medical condition with acute symptoms of sufficient severity, in the opinion of the Board of Trustees, that one or all of the following conditions could occur, if medical attention is not provided immediately:

   (a) Permanent damage to the person's health;

   (b) Serious medical problems or impairment to bodily functions; or

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

2. If No Qualified Emergency Is In Effect: If a covered person seeks treatment in an emergency room when there is no Qualified Emergency in effect, the following benefit rates apply in place of any other rates otherwise applicable under the Plan, after payment of any annual deductible still unpaid:

   PPO Provider: 60% of the applicable contracted rate, after a $100 supplementary deductible; and

   Non-PPO Provider: 60% of the UCR charges, after a $100 supplementary deductible.

   When there is no Qualified Emergency in effect, the stop-loss benefits of the section entitled "Out-Of-Pocket Expense Limitation" do not apply to emergency room care. In addition, payments by a member toward such care (including the supplementary deductible, co-payments for care by PPO or Non-PPO Providers alike, and charges by a non-PPO provider in excess of the applicable UCR rate) are not counted toward the Out-Of-Pocket limit.

# Erectile Dysfunction Treatment

Surgical implants provided as treatment for erectile dysfunction for Eligible Employees, Individual Employers, Retirees, Dependent Spouses and Domestic Partners shall be covered at 90% of the applicable contracted Preferred Provider Rate if:

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

Erectile dysfunction drugs 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.

## Flu Shots

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

## Hearing Aids

After a separate $100 deductible is paid, the Plan pay 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.

## Hearing Exams

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

## Home Health Care

After the annual deductible is paid, Home Health Care is covered at 90% contracted Preferred Provider rate (or 60% UCR charges for non-PPO providers) up to 100 visits per calendar year.

## Hospice Care

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

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

**3. Benefits Payable**. Please contact the Fund Office to determine whether a particular hospice facility is a PPO provider:

(a) For hospice care provided by Preferred Providers, the Plan pays 90% of the provider's contracted rate after the applicable deductible.

(b) For hospice care provided by non-PPO providers, the Plan pays 60% of the Usual, Customary, and Reasonable charges after the applicable deductible.

## Laboratory Services

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

## 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.

## Low Level Laser Therapy

Eligible PPO Plan participants and beneficiaries are eligible for Low Level Laser Therapy up to $750 annual maximum with no deductible or other coinsurance applied.

## Lumbar Disectomy

All procedures must be pre-certified as medically necessary by the Plan's Independent Medical Consultant or the Plan's PPO Provider. After certification and after the annual deductible is paid, the Plan pays 90% of the applicable contracted Preferred Provider rate (or 60% of the Usual Customary and Reasonable Charge for non-PPO) for Lumbar Disectomy.

## Mental and Nervous Conditions

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

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

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

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

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

**Outpatient**: After the annual deductible is paid, benefits for outpatient treatment of Mental and Nervous Conditions is covered at 90% of the applicable contracted Preferred Provider Rate or 60% of UCR for non-PPO providers.

## 24/7 NurseLine

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

## Organ Transplants

Organ Transplants provided by a PPO provider will be covered on the same basis as any other illness under the PPO or Medicare Supplemental 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.

## 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. Up to an additional ten (10) visits may be approved if determined by the Plan's independent medical consultant to be medically necessary.

## 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 or other supporting devices for the feet. Open cutting operation of metatarsalgia or bunion, or for a partial or complete removal of nail roots, are covered charges.

# 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 |

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.

# Qualified Non-PPO Physicians

Charges by a licensed physician which are payable under this Plan shall be covered at the applicable general rate, except as follows:

1. If an eligible individual receives Emergency Care (as defined in that section) at a PPO hospital, and a treating doctor is not a PPO doctor, then benefits will be paid for the non-PPO doctor at 90% of the lesser of the billed rate or the Usual, Customary and Reasonable charge for such services.

2. If an eligible individual has surgery at a PPO hospital performed by a PPO surgeon, and either the anesthesiologist or the radiologist is not a PPO doctor, or both, then benefits will be paid for the non-PPO provider(s)' services at 90% of the lesser of the billed rate or the Usual, Customary and Reasonable charge for such services.

## Smoking Cessation Benefits

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

1. Screening for tobacco use; and,
2. For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:

    (a) Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and

    (b) All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

Smoking cessation benefits provided by non-PPO providers are not covered.

## Speech Therapy

The Plan covers charges at 90% of the applicable contracted Preferred Provider rate (or 60% UCR for non-PPO providers) for charges made for the services of a qualified speech therapist for restoratory or rehabilitory speech therapy for speech loss or impairment, if services:

1. Are due to an illness (other than a nervous disorder); or

2. Follow surgery to correct a congenital anomaly; or

3. Are for an eligible dependent child who is under the age of 6 and has not yet entered elementary school (including kindergarten).

## Supplementary Accident Expense Benefit

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

# Transgender Services

Services and supplies provided in connection with gender transition when you have been diagnosed with gender identity disorder or gender dysphoria by a physician shall be covered at 90% of the applicable contracted Preferred Provider rate (or 60% UCR for non-PPO providers) and subject to the applicable deductible. Coverage is provided according to the terms and conditions that apply to all other covered medical conditions, including medical necessity requirements, utilization management and exclusions for cosmetic services. Coverage includes, but is not limited to, medically necessary services related to gender transition such as transgender surgery, hormone therapy, and psychotherapy.

Coverage is provided for specific services that apply to that type of service generally. For example, transgender surgery is covered on the same basis as any other covered, medically necessary surgery; hormone therapy is covered under the plan's prescription drug benefits.

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

# Wellness Program

This benefit consists of physical examinations and health screenings.

1. Physical Examinations for Adults and Well-baby Care

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

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

2. Effective as of January 1, 2012, the Plan provides coverage for the following items and services at 100% of covered charges at a PPO facility (no copayment, coinsurance or deductible shall apply to these items and services):

- Evidence-based items or services that have in effect a rate of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;
- Immunizations for routine use in children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- Certain preventive care and screenings for infants, children and adolescents, as set forth in guidelines supported by the Health Resources and Services Administration (HRSA) as provided in Appendix E.
- Screening for obesity in adults;
- For adult patients with a body mass index (BMI) of 30 kg/m2 or higher, intensive multicomponent behavioral interventions for weight management, which shall include:
    - Group and individual sessions of high intensity (Limited to 12 sessions per year),
    - Behavioral management activities, such as weight-loss goals,

- Improving diet or nutrition and increasing physical activity,
- Addressing barriers to change,
- Self-monitoring, and
- Strategizing how to maintain lifestyle changes.

- Other preventive care and screenings for women in guidelines supported by the HRSA, including:

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

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

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

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

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

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

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

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

# EXCLUSIONS

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

1. Those paid for or furnished, to the extent paid for or furnished, under any group health plan arranged through any employer, association, trustee, union or employee benefit association.

2. Those due to war or an act of war.

3. Those due to an accidental bodily injury arising out of or in the course of employment, or a sickness entitling the insured individual to benefits under a Workers' Compensation Act or similar legislation.

4. Those rendered outside the United States and Canada, unless specifically approved in accordance with the Plan.

5. Those rendered for treatment in a Veterans Administration Hospital, either by the hospital or a physician employed by it unless both of the following apply:

   (a) The treatment is of an emergency nature, and

   (b) The eligible individual is not entitled to such treatment by reason of his or her status as a veteran or otherwise.

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

   (a) Radial Keratotomy or similar procedures.

   (b) Treatment of infertility, including in vitro fertilization or artificial insemination.

   (c) Elective abortions.

   (d) Biofeedback and Hypnotherapy.

   (e) Myofunctional therapy (facial exercises).

   (f) 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.

   (g) Holistic medicine or therapeutic injections.

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

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

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

   (k) Temporomandibular Joint Syndrome.

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

(m) Organ transplants not listed as covered.

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

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

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

7. Charges which are not medically necessary, except for medical services and supplies for which coverage is specifically provided.

8. Charges in excess of the applicable contracted Preferred Provider rates, unless specifically approved under the Plan.

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

10. Any claims submitted over one year from the date of service.

11. Charges made by any provider who is related to you by blood or marriage, unless the care is authorized by the Administration Office. Inquiry in all such cases should be made of the Administration Office before proceeding with treatment by any such practitioner.

12. Charges for any injury you receive while committing or attempting to commit a felony or any illegal activity, except if the injury resulted from mental illness or a condition arising out of acts of domestic violence.

13. Charges for treatment while incarcerated in a Federal or State penitentiary.

14. Charges in excess of the amount that would be payable by Medicare for durable medical equipment (or for any item that is treated as durable medical equipment by Medicare, including but not limited to kidney dialysis) which is provided to a person covered under Medicare.

15. Treatment of any injury, illness, disease or other condition for which a third party (individual or organization) is or may considered to be responsible.

# 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.

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:

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.

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.

# DENTAL CARE PLAN

**Active Employees**: For Eligible Active Employees and their Eligible Dependents age 19 or older, covered dental benefits are provided at no charge up to a maximum of $3,000 per year per covered person. Diagnostics and preventive care do not count toward this $3,000 maximum. Orthodontics are not a covered benefit for Eligible Active Employees and their Eligible Dependents age 19 or older. 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.

**Retired Employees**: Covered dental benefits are provided to retirees who choose to self-pay an amount established by the Board of Trustees for dental coverage at no charge to eligible retirees and their eligible dependents age 19 and older up to a maximum of $3,000 per year per covered person. Diagnostics and preventive care do not count toward this $3,000 maximum. Orthodontics are not a covered benefit for Retirees and their Eligible Dependents age 19 or older. For Eligible Dependent Children of Retirees 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.

Any participant retiring after January 1, 1993, has a one-time election to self-pay for dental coverage. 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.

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

Coverage is provided through a contract with Delta Dental Plan of California (Delta Dental), and Delta provides a separate booklet describing the benefits available through the Plan.

# DISABILITY BENEFITS

## 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. 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.

## Supplemental Long-Term Disability Benefit

If an employee is totally and permanently disabled so as to be unable to perform any gainful employment, has been awarded Social Security Disability Benefits, has 10 years of vesting credit in the U. A. Local No. 393 Defined Benefit Pension Plan, and was covered by the Health and Welfare Plan as an Active Employee for 5 out of the last 7 years, including 60 out of the last 84 months, prior to the onset of disability, but has not yet attained age 55, the Health and Welfare Plan will, during each year of the employee's disability subsequent to January 1, 1981, pay the employee a benefit equivalent to 12 times the monthly benefit he or she would have received from the Pension Plan had he or she been eligible for an

Disability Retirement under that Plan. The employee must provide proof of his or her Social Security Disability award before this benefit will begin, and must also provide proof annually thereafter and on request.

These benefits will terminate upon the occurrence of any of the following: 1) attainment of age 55; 2) termination of the employee's Social Security Disability Benefits; 3) two months after the employee has returned to covered employment, even if the employee continues to receive Social Security Disability Benefits or 4) payment of a pension benefit from the U.A. Local 393 Defined Benefit Plan. However, if, after an attempt to return to covered employment, an employee finds that he or she is still too disabled to perform such work, and the employee is continuing to receive Social Security Disability benefits, then this Supplemental Disability Benefit shall recommence upon the termination of the covered employment and the submission of a new application.

An employee who is receiving these benefits must notify the Administration Office immediately of a change in his or her disability status and termination of his or her Social Security Disability Benefits. If the employee receives any benefits when he or she is no longer eligible, the Plan provisions for recovery of overpayments will apply.

The benefit will be paid according to the following rules:

1. This benefit is separately funded on an annual basis. If the total amount of money available in the Supplemental Disability Benefit fund in any one Plan Year is not sufficient to pay the full benefit to all participants who qualify in that plan Year, eligible employees will receive a proportionate amount of the money available for that Plan Year.

2. 75% of an employee's annual benefit will be paid in monthly installments. The remaining balance will be paid at the end of the year, subject to availability of funds for this purpose

3. If the employee's disability begins, or the employee attains age 55, during a benefit year, he or she will be paid an annual amount for that year equivalent to the number of months he or she was eligible, times the monthly payments he or she would be eligible for at retirement.

4. If a participant dies during a Plan Year in which he or she is eligible for this benefit, his or her spouse will receive any further payments which the participant would have received in that Plan Year, only.

5. In no event will the Supplemental Disability Benefit fund be liable for greater payment than there are funds available at the time these benefits are due.

   This payment will be payable in addition to any weekly benefit an employee may receive under the State Disability Insurance Law, Workers Compensation Insurance Law, or any other benefit that might be available to the employee, but is not payable in addition to the Weekly Disability Benefit provided for under the Plan.

6. Payment of benefits for any eligible employee will be retroactive to the date of disability indicated in the Social Security Disability Award up to a maximum of thirty-six (36) monthly installments.

# Supplemental Long-Term Disability Benefits for Employees Who Have Applied for Social Security Disability But Have Not Yet Received a Determination

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

1. The employee has applied for a Social Security Disability Benefits award and the determination is still pending including the determination on appeal; and

2. The employee is certified by the Plan's Independent Medical Examiner to be totally and permanently disabled; and

3. The employee furnishes proof satisfactory to the Trustees that he or she is not gainfully employed.

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

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

# MISCELLANEOUS RULES

## Coordination of Benefits (Non-Duplication Provision)

1. In General:

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

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

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

(a) Group insurance coverage;

(b) Blanket insurance coverage which does not contain a non-duplication of benefits or excess policy provision;

(c) Group Blue Cross, Blue Shield, group practice and other prepayment coverage provided on a group basis;

(d) Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, employee benefits organization plans, or any other agreement or benefits provided on a group basis; and

(e) Any group coverage under governmental programs, and any group coverage required or provided by any statute.

2. Which plan pays first:

(a) If both plans have coordination of benefits provisions, the plan that insures you as an employee pays first.

(b) If you receive benefits as an active employee under one plan and as a retiree or COBRA participant under another, the plan you have as an active employee pays first. If you are insured as an employee under 2 plans, the plan which has insured you longer is primary.

(c) If one primary plan does not have a coordination of benefits provision, that plan is always primary.

(d) If a dependent child is covered under two plans, the plan of the parent whose birthday (month and day) is earlier in the year will pay its benefits first, except as follows: If the parents of a dependent child are divorced or legally separated, the plan of the parent with the custody of the child pays its benefits first. If the parent with custody remarries, the order of the payment is as follows:

(1) Natural parent with whom the child resides;

(2) Stepparent with whom the child resides;

(3) Natural parent not having custody of the child.

This order of payment can change if a Qualified Medical Child Support Order is issued (see Eligibility Rule 17).

# 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. 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.

## Waiver of Class, Collective, and Representative Actions

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

## Rights of States

1. Payment of benefits with respect to an employee will be made in accordance with any assignment of rights made by or on behalf of such employee or beneficiary of an employee as required by a state plan for medical assistance approved under title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of that Act.

2. In enrolling an individual as an employee or beneficiary or in determining or making any payments for benefits of an individual as an employee or beneficiary, the fact that the individual is eligible for, or is provided, medical assistance under a state plan for medical assistance under Title XIX of the Social Security Act will not be taken into account.

3. To the extent that payment has been made under a state plan for medical assistance approved under Title XIX of the Social Security Act in any case in which the Plan has a legal liability to make payments for items or service constituting such assistance, payment for benefits under the Plan will be made in accordance with any state law which provides that the state has acquired rights with respect to an employee to such payment for such items or services.

## Limitations on Liability of this Plan and Trust Fund

1. The benefits provided by this Plan are not in lieu of and do not affect any requirement for coverage by Workers Compensation Insurance laws or similar legislation.

2. The provisions of this Plan are subject to and controlled by the provisions of the Trust Agreement, and in the event of any conflict between the provisions of this Plan and the provisions of the Trust Agreement, the applicable provisions of the Trust Agreement will prevail.

3. The benefits provided by this Plan can be paid only to the extent that the Fund has available adequate resources for such payments. If the assets are insufficient to pay benefits as scheduled, they will be prorated and benefits paid accordingly. In the event that at any time the Fund does not have sufficient assets to permit continued payments, nothing contained in this Plan will be construed as obligating any contributing employer to make benefit payments or contributions (other than the contributions for which the contributing employer may be obligated by his or her collective bargaining agreement) in order to provide for the benefits established hereunder. Likewise, there will be no liability upon the Board of Trustees, individually or collectively, or upon any employer, the Union, signatory association or any other person or entity of any kind to provide the benefits established hereunder if the Fund does not have sufficient assets to make such benefit payments.

4. None of the benefits provided for in the Plan is insured except as provided herein, or as thereafter adopted by the Board of Trustees, and there is no liability on the Board of Trustees or any other individual or entity to provide payment over and beyond the amount in the Fund collected and available for the payment of benefits. Benefits which are provided under insurance contracts and designated provider contracts are payable only to the extent provided in the applicable contract.

## Clerical Error

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

1. Clerical error in reporting of hours and contributions by his or her employer or clerical error on the part of the administrator.

2. Failure of any Individual Employer to make payment of contributions promptly and in full.

## Right of Examination

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

## Board of Trustees' Reservation of Authority

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

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

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

3. To amend any provisions of this Plan and the procedures for administration of the Plan.

# Disclosure of Protected Health Information 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.

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

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

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

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

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

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

   (a) Not use or further disclose PHI other than as permitted in this Section or as required by law;

   (b) Ensure that any of its agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Board;

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

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

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

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

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

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

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

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

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

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

10. Non-Compliance. If any person described in paragraph 8 does not comply with the provisions of this Section or the provisions of 45 CFR § 164.504(f), the Board shall provide a mechanism for resolving the issue of non-compliance, which may include disciplinary sanctions.

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

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

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

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

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

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

# Federal Payroll Taxes Incidental to Domestic Partner Coverage

Effective for this Plan September 1, 2005, California state law requires insured health benefit contracts to include provisions offering dependent coverage to a limited group of domestic partners and their dependent children. As part of this coverage, this Plan pays the incidental federal employment payroll taxes, in accordance with governing IRS and U.S. Department of Labor rulings.

# Assignment

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

# Applicable Venue

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

# APPENDIX A:
# CLAIMS AND APPEALS PROCEDURE

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

The following claims and appeals procedures shall apply to matters within the discretion of the Board of Trustees of the U. A. Local 393 Health and Welfare Plan, filed on or after January 1, 2003, except as provided in Section 2 of this Appendix for claims and appeals for disability benefits. Such matters include, but are not limited to:

- Any claim or appeal regarding self-funded benefits, including but not limited to self-funded PPO (Indemnity) Plan, Wellness, and Hearing Aid benefits;

- Claims and appeals regarding eligibility under the Plan for any type of benefit; or

- Claim and appeals regarding medical and dental benefits when the claimant has made a specific claim for medical or dental care, and the HMO, insurance carrier, or other provider has denied the claim on the grounds that the claimant or family member is not eligible for the benefit under the terms of the Plan.

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

(a) FILING A CLAIM: Participants and family members (hereinafter "claimants") may initiate a claim for benefits by contacting the Administration Office and following the instructions given to access the benefit. An authorized representative may submit a claim on behalf of a claimant. In the case of a claim involving urgent care, a health care professional with knowledge of the claimant's medical condition may act as the authorized representative of the claimant.

(b) NOTIFICATION OF FAILURE TO FOLLOW PLAN PROCEDURES: If the claimant fails to follow the Plan's procedures for filing a claim for benefits, the Administration Office will notify the claimant as soon as possible, but within 5 days following the failure, or if the claim if for urgent care, within 24 hours of the failure. This notification may be oral, unless the claimant or authorized representative requests it in writing.

(c) NOTIFICATION OF CLAIM DECISION:

(1) Time Limits and Requests for Additional Information.

(A) Urgent Care Claims: The determination as to whether a claim involves urgent care is determined by the attending provider and the Plan defers to such determination. If a claim is for urgent care, the Administration Office will notify the claimant of its determination as soon as possible, but no later than 72 hours after receipt of the claim by the Administration Office. If the claimant fails to provide sufficient information to determine whether benefits are payable under the plan, then as soon as possible, but no later than 24 hours after receipt of the claim by the Administration Office, the Administration Office will notify the claimant what information is necessary. The claimant will have 48 hours to provide the specified information. The Administration Office will notify the claimant of its decision as soon as possible, but no later than 48 hours after the Administration Office's receipt of the specified information.

(B) Pre-service claims: If a claimant makes a claim for benefits before care has been provided to the participant or family member but the claim is not urgent, the Administration Office will notify the claimant of its decision as soon as reasonably possible, but no later than 15 days after the Administration Office received the claim.

The above 15 day time period may be extended for up to one additional 15-day period, but only due to matters beyond the Administration Office's control. If the Administration Office needs a 15-day extension, it will notify the claimant of the following: the reason for the delay; the expected date of decision; and any additional information the Administration Office needs to make the decision. If the Administration Office requires additional information, the claimant will have up to 45 days to provide the specified information. Once the specified information is provided, the Administration Office will notify the claimant of its decision within 15 days.

(C) Post-service claims: If a claimant makes a claim after care has been provided, the Administration Office will notify the claimant of its decision as soon as reasonably possible, but no later than 30 days after the Administration Office received the claim.

The 30-day time period may be extended for one additional 15-day period, but only due to matters beyond the Administration Office's control. If the Administration Office needs a 15-day extension, it will, before the end of the first 30 day period, notify the claimant of the following: the reason for the delay; the expected date of decision; and any additional information the Administration Office needs to make the decision. If the Administration Office requires additional information, the claimant will have up to 45 days to provide the specified information. Once the specified information is provided, the Administration Office will notify the claimant of its decision within 15 days.

(2) CONTENTS OF CLAIM DENIAL NOTICE: The Administration Office will provide the claimant with written notice if his or her claim for benefits is denied. If the claim involves urgent care, the information described below may be given orally, so long as a written notification is provided within three days after the oral notification. The notice will include the following information:

(A) A statement of the specific reason(s) for the denial;

(B) Reference to the specific Plan provision(s) on which the denial was based;

(C) If the Administration Office's decision relied upon an internal Plan rule, guideline, protocol or similar criterion, either the specific rule, or a statement that the specific rule was relied upon and that a copy of such rule will be provided free of charge upon request;

(D) A description of any additional information or documents that the claimant will need to submit if he or she wants the claim to be reconsidered, and an explanation of why that information is necessary;

(E) A description of the Plan's appeal procedures, including any expedited appeal procedures available if it is a claim for urgent care benefits; and

(F) A statement of the claimant's right to bring a civil action under ERISA § 502(a), if the appeal is unsuccessful.

(d) APPEAL PROCEDURES:

(1) The claimant may appeal any adverse action within the discretion of the Board of Trustees to the Board of Trustees. With respect to insured benefits and benefits administered by another entity, the Board of Trustees hears appeals only about eligibility issues, and does not hear appeals about unfavorable determinations by any Plan provider on matters within the provider's discretion. The Board of Trustees hears all appeals regarding self-administered benefits.

(2) SUBMISSION OF APPEAL: Appeals must be in writing, and state in detail the matter or matters involved. To submit an appeal, the claimant must send a letter with any documents and information that he or she wants the Board to consider to the Administration Office.

(3) TIME LIMITS: The deadline for submission of any appeal to the Board of Trustees is 180 days of receiving the denial of the original claim by the Administration Office. Failure to file an appeal within the 180-day period shall constitute a waiver of the claimant's right to the review of, and of the claimant's objections to, the denial of his/her claim, whether or not the Plan is prejudiced by the failure.

(4) STANDARD FOR REVIEW: The Board of Trustees has full discretionary authority to decide upon Plan benefits, to interpret the Plan language conclusively, and to make a final determination of the rights of any participant, beneficiary, or other person with respect to Plan benefits. The Board of Trustees will take into account everything that the claimant submitted, including material that was submitted or considered in the initial benefit determination. The Board of Trustees will not give deference to the initial determination. Neither a person who made the initial determination nor such a person's subordinate shall have a vote in the decision on appeal.

In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment is medically necessary or appropriate, the Board of Trustees shall consult with a health care professional. The health care professional shall not have participated in making the initial benefit determination. The Board of Trustees shall, upon claimant's request, identify the health care professional, regardless of whether the Board of Trustees relied on his or her advice in making the decision.

(5) NOTIFICATION:

(A) TIME LIMITS FOR NOTIFICATION:

(i) Urgent Care Claims: The Administration Office will notify the claimant of the Board of Trustees' determination as soon as possible, but not more than 72 hours after receiving the claimant's request for an appeal.

(ii) Pre-Service Claims: The Administration Office will notify the claimant of the Board of Trustees' determination as soon as possible, but not more than 30 days after receiving claimant's request for an appeal.

(iii) Post-Service Claims: The Board of Trustees will render a decision on the appeal at the regularly scheduled meeting immediately following the filing of the appeal, unless the appeal is filed within 30 days of the meeting, in which case the decision may be made at the second meeting following the appeal.

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

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

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

(i) The specific reason(s) for the denial;

(ii) Reference to the specific Plan provision(s) on which the denial is based;

(iii) If the decision relied upon an internal Plan rule, guideline, protocol or similar criterion, either the specific rule, or a statement that the specific rule was relied upon and that a copy of such rule will be provided free of charge upon request;

(iv) If the decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the Plan's terms to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(v) A statement that the claimant may view and receive copies of documents, records or other information relevant to the claim, upon request and free of charge; and

(vi) The claimant's right to bring a civil action under ERISA § 502(a).

(6) Time Limit for Bringing a Lawsuit: No legal action may be commenced or maintained against the Trust or the Plan more than two (2) years after an appeal for benefits has been denied. No lawsuit may be filed without first exhausting the applicable appeal procedures in this Plan. In any such lawsuit, the determinations of the Board of Trustees are subject to judicial review only for abuse of discretion.

(e) Provisions Under the Affordable Care Act

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

(1) An adverse benefit determination eligible for internal claims and appeals includes a rescission of coverage. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect.

(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 or a rescission of coverage are entitled to an external review. The Plan is required to pay the cost of an independent review organization (IRO) to conduct the external review. You are entitled to request an external review after receipt of an adverse benefit determination, in accordance with applicable regulations under the Act, as described below:

Standard External Review

(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.

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

If a claim for medical or dental benefits is denied on grounds other than eligibility under the U. A. Local 393 Health and Welfare Plan, the claimant may submit an appeal to the insurance carrier or HMO, pursuant to the appeals procedures of the insurance carrier or HMO. Filing an appeal in a timely manner with an HMO, insurance company, or other provider is the sole responsibility of the claimant.

## 3. Special Claims and Appeal Procedures for Disability Benefits, Including Eligibility for Benefits Under Formal Plan Rule 10

Filing a Claim for Weekly or Supplemental Disability Benefits

1. To file a claim for Weekly or Supplemental Disability Benefits, you must submit a completed Disability Application Form, with proof of disability, to the Plan's Administration Office. The form must be submitted within a reasonable time of the onset of your disability. Along with the claim form, you may submit written comments, documents, records or other information relating to your claim. The Plan will provide you with access to and/or copies of all documents, records and other information relevant to your claim, upon request and free of charge. An authorized representative may act on your behalf in filing a claim for disability benefits under this Plan.

   All claims and appeals pertaining to disability benefits (including eligibility for benefits under Formal Plan Rule 10) shall be adjudicated in a manner designed to ensure independence and impartiality of the persons involved in making the determination. Decisions covered by the authority of the Plan regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) making determinations with respect to disability benefits of the Plan will not be made based upon the likelihood that the individual will support the denial of benefits.

Notification Rules If Your Claim For Benefits is Denied

2. Time Limits and Requests for Additional Information. If your claim for disability benefits is denied, the Plan will notify you as soon as reasonably possible, but no later than 45 days after the Plan received your claim. That time period may be extended for up to two additional 30-day periods, but only due to matters beyond the Plan's control. If the Plan needs a 30-day extension, it will notify you, within 45 days of receiving the claim, of the following:

   (a) The reason for the delay,

   (b) The expected date of decision,

   (c) The basis on which the decision will be made,

   (d) Any unresolved issues preventing a decision now, and

   (e) Any additional information the Plan needs to make the decision.

You will then have up to 45 days to provide the specified information. The Plan's response period will be extended by any additional time it takes for you to provide the requested information.

3. Contents of Notice. The Plan will provide you with written notice if your claim for disability benefits is denied. The notice will include the following information:

(a) A statement of the specific reason(s) for the denial;

(b) Reference to the specific Plan provision(s) on which the denial was based;

(c) Either a copy of the specific internal rules, guidelines, protocols, standards or similar criteria of the Plan relied upon in making the decision or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;

(d) A discussion of the decision including an explanation of the basis for disagreeing with or not following the views of:

(1) a healthcare professional or vocation professional who treated or evaluated you;

(2) the views of healthcare professional or vocation professional consulted by the Plan during the claim determination; or

(3) any disability determination made by the Social Security Administration.

(e) If the determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(f) A description of any additional information or documents that you will need to submit if you want your claim to be reconsidered, and an explanation of why that information is necessary;

(g) A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

(h) A description of the Plan's appeal procedures. These will be found in a separate document, and must be followed if you wish to appeal the denial of benefits; and

(i) A statement of your right to bring a civil action under ERISA § 502(a), if your appeal is unsuccessful.

Appeal Procedures

4. Time Limits. If your claim for disability benefits has been denied, you may appeal the denial to the Board of Trustees. Appeals must be in writing. To submit an appeal, send a letter with any documents and information that you want the Board to consider, to:

U.A. Local 393 Health and Welfare Plan
c/o Benesys Administrators
1731 Technology Drive, Suite 570
San Jose, California 95110

For your appeal to be timely, you must submit your appeal within 180 days of receiving a denial of benefits. If you do not submit an appeal within 180 days of receiving a denial, you will be deemed to have waived your objection to the denial.

5. The Board of Trustees has full discretionary authority to decide upon Plan benefits, to interpret the Plan language conclusively and to make a final determination of the rights of any participant, beneficiary, or other person with respect to Plan benefits.

6. Standard for Review. In deciding the appeal, the Board of Trustees will take into account everything that you submitted, even material that was submitted or considered in the initial benefit determination. The Board of Trustees will not give deference to the initial determination. Neither a person who made the initial determination nor such a person's subordinate will take part in the decision on appeal.

7. In deciding an appeal that is based in whole or in part on a medical judgment (including experimental, investigational, and medically necessary or appropriate decisions), the Board of Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The Board of Trustees will identify to you any medical or vocational experts whose advice was obtained by the Plan in connection with the decision, whether or not the advice was relied upon in making the decision. The health care professional consulted on appeal will not be an individual who was consulted in connection with the initial benefit denial, or such a person's subordinate.

8. Upon request and free of charge, you or your representative will be provided with or have reasonable access to all documents, records, and other information relevant to your claim for benefits.

Notification of the Board's Decision on Appeal

9. Time Limits. The Board of Trustees will render a decision on appeal at the meeting immediately following the filing of the appeal, unless the appeal is filed within 30 days of the meeting, in which case the decision may be made at the second meeting following the appeal.

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

11. The Plan will notify you of the decision as soon as possible, but no later than 5 days after the decision is made. The Plan's response period will be extended by any additional time it takes for you to provide the requested information.

12. Contents of Notice. The Plan will send you written notice of the Board of Trustees' decision on appeal. If your appeal has been denied, the notice will include the following information:

(a) The specific reason(s) for the denial;

(b) Reference to the specific Plan provision(s) on which the denial is based;

(c) Either a copy of the specific internal rules, guidelines, protocols, standards or similar criteria of the Plan relied upon in making the decision or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;

(d) A discussion of the decision, including an explanation of the basis for disagreeing with or not following the views of:

(1) a healthcare professional or vocation professional who treated or evaluated you;

(2) the views of healthcare professional or vocation professional consulted by the Plan during the claim determination; or

(3) any disability determination made by the Social Security Administration.

(e) A statement that you may view and copy any documents, records or other information relevant to your claim, upon request and free of charge;

(f) If the decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the Plan's terms to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(g) A description of any further appeal procedures, and your right to receive information about the procedures, and your right to bring a civil action under ERISA § 502(a) within two (2) years after the denial and the calendar date which the period to bring a civil action expires; and

(h) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance or managed-care regulatory agency."

13. The Trust Fund Office shall automatically provide to you, free of charge, any new evidence or rationales, if any, as soon as possible and sufficiently in advance of the date on which the appeal determination is to be made in order to give you a reasonable opportunity to address the new evidence or rationale prior to that date. You shall have the right to review and respond to new evidence or rationales considered, relied upon or generated by the Plan in connection with your claim during the pendency of any appeal.

14. All notices and disclosures under this Section 3 shall be provided in a culturally and linguistically appropriate manner. The Trust Fund Office will also provide customer service with oral language services in an Applicable Non-English language and provide written notices in the Applicable Non-English language upon request. An Applicable Non-English Language shall mean, with respect to an address in any United States County to which a notice is sent, a Non-English Language in an Applicable Non-English Language if ten percent or more of the population residing in the county is literate only in the same Non-English Language, as determined in guidance published by the U.S. Secretary of Labor.

15. Time Limit for Bringing a Lawsuit. No legal action may be commenced or maintained against the Trust or the Plan more than two (2) years after an appeal for benefits has been denied. In any such lawsuit, the determinations of the Board of Trustees are subject to judicial review only for abuse of discretion.

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

# APPENDIX B:
# YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

U.A. Local 393 Health and Welfare Plan
c/o Benesys Administrators
1731 Technology Drive, Suite 570
San Jose, California 95110

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called

"fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other

person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a health and welfare or vacation benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court, although your right to sue may be limited if you have not used the Plan's appeal procedures. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

# APPENDIX C:
# FORMAL RULES FOR COBRA CONTINUATION COVERAGE

1. If you are an EMPLOYEE enrolled in this group health plan and you lose health coverage because of:

   (a) A reduction in hours, or

   (b) Termination of your employment through resignation, layoff, firing, retirement, strike or lockout, unless the cause of your termination was gross misconduct,

   then, except as provided in Rule 9 below, you and your eligible dependents are entitled to continue your health coverage by paying for it yourself for up to 18 months (or up to 29 months if you or one of your dependents are totally and permanently disabled when you lose coverage or within 60 days of losing coverage, and at the end of the first 18 months you (or your disabled dependent) qualifies for Social Security Disability Benefits). For purposes of this rule, eligible dependent means any person who was an eligible dependent immediately before the employee had a COBRA qualifying event, or a child who would have qualified as an eligible dependent but was born while the employee was covered through COBRA.

2. If you are the SPOUSE OF AN EMPLOYEE who is enrolled in this group health plan, you are also covered by the plan, and you lose your coverage because:

   (a) Your spouse has died,

   (b) You and your spouse have divorced or legally separated, or

   (c) Your spouse loses coverage because of a reduction in hours or termination of employment as a result of resignation, layoff, firing, retirement, strike or lockout, or your spouse qualifies for Medicare,

   then, except as provided in Rule 9 below, you are entitled to continue your health coverage by paying for it yourself for up to:

      (1) 18 months: if your spouse loses coverage because of a reduction in hours or termination of employment, or

      (2) 36 months: if your spouse dies or you and your spouse divorce.

3. If you are the DEPENDENT CHILD OF AN EMPLOYEE enrolled in this group health plan, and you were covered by the plan, and you lose your coverage because:

   (a) Your parent covered by the plan has died, or

   (b) Your parent covered by the plan has lost his/her benefits because of a reduction in hours or termination of employment as a result of resignation, layoff, firing, retirement, strike or lockout, or

   (c) You cease to be a dependent under the provisions of the plan (for example, you reach the maximum age under the Plan), or

(d) Your parent covered by the plan qualified for Medicare,

then, except as provided in Rule 9 below, you are entitled to continue health coverage by paying for it yourself for up to:

(1) 18 months: if your covered Employee parent loses coverage because of a reduction in hours or termination of employment, or

(2) 36 months: if your covered Employee parent dies, or if you no longer qualify as a dependent under the terms of the plan.

4. Coverage of Spouse or Dependent of Medicare-Eligible Employees.

If an employee becomes entitled to Medicare and no coverage is lost, but a later subsequent qualifying event occurs (such as loss of employment), the spouse and each dependent child of the employee are entitled to 36 months of COBRA coverage from the date the employee becomes eligible for Medicare. If, during an 18-month COBRA continuation period, a former employee becomes entitled to Medicare, the eligible spouse or dependent children of the former employee who are COBRA beneficiaries are entitled to continue their coverage for a total of 36 months from the date of the original qualifying event instead of the original 18 months.

5. Notice and Deadlines.

(a) You and your dependents must inform the plan administrator where you want the notices regarding your COBRA rights sent. Notify the plan administrator whenever you or your dependents change address.

(b) You must notify the plan administrator within 60 days after you lose coverage because of:

(1) Divorce or legally separate; or

(2) The end of a dependent child's eligible dependent status.

(c) Your employer or you must inform the plan administrator in the event of an employee's death.

(d) The plan administrator will notify you of a qualifying event arising from the loss of coverage due to termination of employment, reduction of hours or Medicare eligibility.

(e) After receipt of notice from you or your employer that a COBRA qualifying event has occurred the plan administrator will notify you of your rights and obligations for continuation coverage. You will be asked to choose between:

(1) Core coverage - medical care only, or

(2) Core plus non-core coverage - medical care and dental coverage.

Core plus non-core coverage will require a higher monthly payment than core coverage only.

(f) You must make your first payment for continuation coverage retroactive to the date you lost coverage under the Plan, within 45 days after you have elected to self-pay, and you must make monthly payments thereafter by the 15th day of each month for the next month's coverage.

6. Automatic Coverage for Dependents of Covered Employees Choosing Continuation Coverage.

When a covered employee chooses to continue coverage, coverage for his or her spouse and dependents will continue automatically unless the spouse independently declines coverage. But, if a covered employee chooses not to continue coverage, his or her spouse and eligible dependents may still choose coverage. In all circumstances, anyone electing COBRA coverage must pay for it.

7. Transfer Rights.

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

8. Conversion Privilege.

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

Notwithstanding any other provisions of this Appendix:

(a) The period of eligibility for benefits under COBRA continuation coverage for any individual will be reduced by the period of time during which the individual received other continuation coverage for which the monthly charge was equal to, or less than, the charge for the equivalent COBRA coverage, including but not limited to coverage provided under Formal Eligibility Rules 4(f), 9, 10, and 11; and

(b) An individual's COBRA continuation coverage will terminate upon his or her becoming eligible for coverage under another group health plan without a pre-existing condition exclusion applicable to the individual, or upon the end of the application of a pre-existing condition exclusion to him or her.

(c) An Individual Employer shall be deemed to have a qualifying event on the grounds of termination of employment only if the Individual Employer's company entirely ceases operations, or the Individual Employer totally severs all ties to the company.

IN WITNESS WHEREOF, the Trustees have approved and adopted this Health and Welfare Plan on this1st day of November 2019.

| Chairman | Co-Chairman |
| --- | --- |
| /s/Steve Flores | /s/Alex Hall |
| Steve Flores | Alex Hall |

# SUPPLEMENTAL UNEMPLOYMENT PLAN
# FORMAL PLAN RULES

**1. Who is Eligible for Benefits**

The following participants shall, upon compliance with the rules set forth herein, be eligible for the benefits available under the Plan:

Employees and former employees of employers signatory to U.A. Local 393 Collective Bargaining Agreement who contributed to the Supplemental Unemployment Benefit Plan (hereinafter the SUB Plan), subject to the rules below.

**2. Benefit Credit Account**

(a) Benefit Credit Account: A Benefit Credit Account will be established for each eligible employee for whom employer contributions have been made to this SUB Plan.

(b) Initial Benefit Credits: All A List Journeymen, B List Journeymen and Building Trades Apprentices, who worked for one or more contributing employers and/or were registered on U.A. Local 393's Building Trades Joint Hiring Hall out-of-work list from July 1, 1993 through December 31, 1993, will be initially eligible. Employees meeting these requirements will be granted 26 benefit credits in the SUB Plan effective January 1, 1994.

(c) Accrual Rate: Effective January 1, 1994, for employees who met the requirements of Rule 2(b), and effective July 1, 1993, for all other employees, each employee shall earn one benefit credit for performing, in any month, at least 40, but no more than 80, hours of employment requiring contributions to this plan, and a second benefit credit for performing more than 80 such hours.

(d) Maximum Benefit Credit Amount: The maximum benefit credit amount an employee may accrue is 26 credits.

(e) Crediting Procedures:

(1) No benefit credits are available to an employee until the employee has accumulated 26 benefit credits in a 24-month period. All benefit credits earned prior to the 24-month period in which the employee satisfied the 26-credit requirement are not eligible to be credited, and will be cancelled.

(2) After an employee has accumulated 26 credits in a 24-month period, if the employee suffers a break in contributions to this Plan of 60 months, all of his or her benefit credits shall be cancelled, and the employee's account is subject again to Rule 2(e)(1).

(f) Use of Benefit Credit: One (1) benefit credit will be cancelled for each weekly SUB payment.

(g) Fraud Against the Plan: If an Eligible employee commits a fraud against the plan his or her benefit credits will be cancelled, and he or she will be permanently barred from having an account and from receiving any benefit payment from this Plan.

For purposes of this Plan, fraud includes, but is not limited to: (1) filing a false claim for SUB benefits; and (2) continuing to draw SUB Plan benefits after you start working, including working in self-employment or as an employee of another person or company, whether you are paid or not.

**3. Rules for Drawing Earned SUB Benefits**

(a) To be eligible to receive SUB Benefits, you must satisfy all three of the following requirements:

(1) Unemployment Insurance Benefit:

(A) You must be receiving California State Unemployment Insurance benefits ("UI"); or

(B) You must satisfy the following requirements:

(i) You must have been laid off from your last employment, and provide written verification thereof from your employer;

(ii) You must have applied for California State Unemployment Insurance benefits ("UI") in accordance with 3(a)(1)(A) above, and have been denied solely on the grounds of having insufficient earnings in your UI base contribution period, and you provide a copy of such the denial of your UI claim; and

(iii) You must provide written verification from U. A. Local No. 393 that you are available for employment in the Plumbing and Pipefitting Industry.

(2) Unemployment and Continuous Availability for Employment: You must be both:

(A) Unemployed for reasons other than expulsion or termination from the U.A. Local No. 393 Joint Apprenticeship Training Fund due to insubordination, bad behavior, misconduct, delinquency, or otherwise pursuant to the Board of Trustees' sole and absolute discretion; and

(B) Registered on U.A. Local 393's Building Trades Joint Hiring Hall A, B, or apprentice out-of-work list continuously since your last employment for which contributions were made to this Plan.

(3) Benefit Accruals: You must have accumulated 26 benefit credits in accordance with Rule 2(e)(1), not thereafter suffered a break in service under Rule 2(e)(2) or had your benefit credits cancelled under Rule 6, and have at least one benefit credit remaining.

Notwithstanding the foregoing, if you become unemployed between January 1, 2008 and December 31, 2009, you may receive up to an additional 13 weeks of supplemental unemployment extension benefit credits if you remain unemployed and registered on U.A. Local 393's Building Trades Joint Hiring

Hall out-of-work list, in accordance with Section 3(a)(2) above, after you exhaust all your earned benefit credits. If you are unemployed at any time in 2010 and as a result you use up all your earned unemployment benefit credits, you may receive up to 26 weeks of additional extension unemployment benefit credits (less any extension benefit credits received by reason of unemployment in 2008 or 2009) if you remain unemployed and registered on U.A. Local 393's Building Trades Joint Hiring Hall out-of-work list, in accordance with Section 3(a)(2) above, after you exhaust all your earned benefit credits. The additional extension benefit credits must be used on or before December 31, 2010, at which time any unused extension benefit credits you still have will expire.

Notwithstanding the foregoing, if an apprentice becomes unemployed between January 1, 2009 and December 31, 2010, he may receive up to 26 weeks of supplemental unemployment benefits even if he has not established his initial eligibility so long as he remains unemployed and registered on U.A. Local 393's Building Trades Joint Hiring Hall out-of-work list, in accordance with Section 3(a)(2) above, and has earned at least one benefit credit. Any benefit credits he subsequently earns shall first be credited toward the benefits he receives under this paragraph before he begins accumulating any benefit credits.

Notwithstanding the foregoing, if a new employee who becomes enrolled in the Plan because he left employment with a non-contributing employer for employment by a contributing employer and subsequently becomes unemployed due to the Layoff provisions of the Collective Bargaining Agreement, he may receive up to thirteen (13) weeks of supplemental unemployment benefits even if he has not established initial eligibility so long as he remains unemployed and registered on the U.A. Local 393 Building Trades Joint Hiring Hall out-of-work list in accordance with Section 3(a)(2) above, and has earned at least one benefit credit. Any benefit credits he subsequently earns shall first be credited toward the benefits he receives under this paragraph before he begins accumulating any benefit credits. This provision shall expire July 1, 2016.

Notwithstanding the foregoing, if an Employee working as a residential plumber for an Employer signatory to a U.A. Local No. 393 Collective Bargaining Agreement becomes unemployed and has provided proof of his or her California State Unemployment Insurance benefits, he or she may receive up to twelve (12) weeks of supplemental unemployment benefits in the amount of $100 per week even if he or she has not established his or her initial eligibility, so long as he or she remains continuously unemployed and registered on the U.A. Local No. 393 Building Trades Joint Hiring Hall out-of-work list since he or she last worked for an Employer signatory to a collective bargaining agreement with U.A. Local No. 393. Notwithstanding Section 4, a residential plumber satisfying these conditions shall receive a weekly benefit amount of $100 per week for up to twelve (12) weeks.

Notwithstanding the foregoing, Employees working under the U.A. National Plumbing Service Agreement shall be eligible for supplemental unemployment benefits under this Plan under the same conditions as Employees working in the building trades journeyman classification under the U.A. Local 393 Collective Bargaining Agreement.

(b) Notwithstanding subsection (a), no benefits will be paid under the following circumstances:

(1) You will not receive SUB benefits during the one-week waiting period for UI, or if you qualify under Rule 3(a)(1)(B), for the first week after the termination of your last employment (your "SUB waiting period").

(2) You are not eligible for SUB benefits if you are receiving Social Security, Workers' Compensation, State Disability Insurance, disability or family leave benefits of any kind from the U. A. Local No. 393 Health and Welfare Plan or pension benefits of any kind from the U. A. Local No. 393 Pension Trust Fund.

(3) You will not be eligible for SUB Benefits for partial weeks of unemployment.

**4. Amounts of Benefits**

Until further action of the Board of Trustees, the weekly benefit amount is $200.

**5. How to apply for SUB Benefits**

(a) You must apply for SUB benefits, in writing, within 180 days from the end of the covered week as printed on the California State Unemployment Insurance ("UI") check stub. If you fail to submit your SUB benefit application within that deadline, your SUB payment starting date will be the date your written application for SUB benefits is received, and all benefits for a preceding period will be lost.

(b) Subsequent continuing claims must be filed within 180 days from the end of the covered week as printed on the California State Unemployment Insurance ("UI") check stub. If you fail to file a continuing claim within that deadline, your claim will be considered a new claim, with the starting date the date your continuing claim is received, and all benefits for a preceding period will be lost.

(c) Filing must be in writing and mailed to BeneSys Administrators with the proper forms and check stubs, in accordance with Sections 5(a) and 5(b) above. SUB forms are available from BeneSys Administrators or the Union Office, or you may call (408) 588-3770 to request that they be mailed to you.

(d) The following is necessary in order to file the first claim for benefits:

(1) You must complete and sign an SUB application.

(2) You must complete and sign an IRS Form W-4.

(3) You must submit a copy of your California State Unemployment Insurance check stub, in accordance with Section 5(a) above.

(e) A continuing claim requires only a copy of your California State Unemployment Insurance check stub, in accordance with Section 5(b) above, with your name, address and telephone number.

**6. Termination for Cause**

(a) If an employee performs any employment of the type covered by a Collective Bargaining Agreement with U.A. Local 393 for any employer not signatory or otherwise party to an agreement with U.A. Local 393 (without the approval of U.A. Local 393) or engages in such business for his or her own account without being party to such an agreement, then the eligibility of the member shall be terminated and his or her credit account will be cancelled as of the date of commencement of such employment.

(b) An employee's credit account will be cancelled in the event he or she refuses to leave employment after being notified in writing that his or her employer is not contributing fringe payments.

(c) An employee's credit account will be cancelled in the event the employee knowingly participates with his or her employer paying less than the full hourly contract rate of wages and or contributions for every hour worked by him or her.

(d) An employee whose credits are cancelled under this Rule shall have his or her credits calculated under Rule 2(e)(1) as if he or she was a new employee, starting with the first hour of covered employment after the misconduct.

**7. Reservation of Rights**

The Board of Trustees of the U.A. Local 393 Health and Welfare Trust Fund reserve the right to amend any provision of the SUB program.

IN WITNESS WHEREOF, the Trustees have approved and adopted this Supplemental Unemployment Plan on this 1st day of November 2019.

| Chairman | Co-Chairman |
|---|---|
| /s/Steve Flores | /s/Alex Hall |
| Steve Flores | Alex Hall |