

U. A. LOCAL NO. 159 HEALTH AND WELFARE PLAN
FORMAL PLAN RULES
(As Revised September 1, 2019)

I. ACTIVE EMPLOYEE ELIGIBILITY RULES

A. Basic Eligibility Rules for Active Employees

1. Eligibility to Participate. The following classes of persons are eligible to become participants in the Plan:

- a. All active employees covered by any collective bargaining agreement negotiated by Local Union No. 159 of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada, AFL-CIO, ("the Union") requiring standard contributions by contributing employers into the health and welfare fund, under the conditions authorized by the Board of Trustees in this Plan.
- b. Signatory Individual Employers and their Non-Bargaining Unit Employees, pursuant to eligibility rules and subscription agreements approved by the Board of Trustees. (Eligibility Rules for these participants are in Section III.)
- c. Employees of the Union and related organizations.

2. Basic Hour Bank Rules. Coverage for new and continuing employees is based on the accrual of Hour Bank credit. Each covered employee's Hour Bank is credited with one Hour for each hour of covered employment for which contributions are made at the rates stated in Rule 5.c. (Credit for hours at other rates is adjusted proportional to the rates for commercial or industrial plumbing or pipefitting stated in Rule 5.c.) Coverage is provided at a fixed Monthly Charge against that Hour Bank. If, in any month, an employee performs more hours of covered employment than the current Monthly Charge, the employee's Hour Bank shall accrue a reserve, up to the Maximum Reserve Amount. The Trustees, from time to time as they deem necessary in their discretion but at least annually, shall determine the Monthly Charge and the Maximum Reserve Amount permitted for each employee or class of employee. The Trustees also reserve the right to adjust the amount of credits in each employee's Hour Bank, if, in their exclusive discretion, they determine that conditions so warrant.

3. Initial Coverage For New Employees.

- a. A new employee will become eligible for coverage on the first day of the second calendar month following the month in which the employee has worked the 300th hour of covered employment in a six-month period. If a new employee fails to accrue the required reserve amount by the end of a six-month period starting with the first month in which the employee first performs covered employment, the employee shall lose the credit earned in the first month, and the next month shall be treated as the first month in which the employee

performed covered employment.

b. Notwithstanding Rule 3.a, medical coverage shall only be provided to an employee after submission of an enrollment form for one of the Plan's HMOs and all required supporting documents.

4. Initial Coverage For Newly Organized Employees. At the sole discretion of the Trustees, if an employee leaves non-covered employment for covered employment due to Union-related organizing, the 300-hour requirement for Initial Coverage for New Employees may be waived, in accordance with the following rules. Upon completion of 40 hours of covered employment and with the approval of the Board of Trustees, a newly organized employee shall be credited with an Hour Bank advance of 300 hours, and shall be provided coverage under the Plan on the first day that it is administratively practical to do so if he or she continues to be employed in covered employment on the date coverage would commence. If the employee leaves covered employment before completing 300 hours, and the employee is not immediately and continuously available for employment through the Union, then all Hour Bank credit and coverage will be terminated at the end of the month in which the employee became unavailable for covered employment. The only benefits provided to an employee under this rule shall be medical coverage, until such time as the employee has completed 300 hours of covered employment, at which time he or she shall be entitled to full benefits under the Plan.

5. Hour Bank Charges and Maximum. Until further action of the Board of Trustees:

a. the Monthly Charge for Plan coverage shall be 130 Hours for employees who are covered by Kaiser, and 140 Hours for employees who are covered by Blue Shield of California;

b. the Maximum Reserve Amount shall be six (6) times the Monthly Charge for coverage, as set forth in sub-section (a) above; and

c. the amount required to be contributed on behalf of an employee per hour for one Hour Bank credit is the applicable amount required under the Union's Master Labor Agreement for commercial or industrial plumbing or pipefitting of any kind, residential plumbing or service work, or work as a Residential Specialist.

6. Suspension of Hour Bank Charges for Disability ("Disability Extension"). If an employee has a qualifying disability, coverage shall be continued during the period of disability up to a maximum of six months for any one disability. In order to receive coverage under this rule, the employee must remain a member in good standing of the Union. For purposes of this rule, an employee has a qualifying disability if all of the following are true:

a. he or she is unable to work either because of an occupational disability for which he or she receives benefits from Workers' Compensation or State Disability Insurance, or a non-occupational disability for which he or she may be entitled to benefits under this Plan;

b. the employee became disabled while covered under the Hour Bank or Self-Payment

program; and

c. the employee reported his or her disability to the Trust Fund Office within 60 days of the onset of the disability described in paragraph a.

There shall be no charge to the employee's Hour Bank for coverage during this period, and the employee's Hour Bank reserve, if any, shall be frozen at the amount in reserve before coverage began under this provision. Once this six-month period of coverage ends, the employee's Hour Bank reserve shall be charged for further coverage, until coverage terminates under the rules stated herein.

If an employee returns to work after receiving coverage under this Disability Extension rule, he or she shall not be eligible for Disability Extension coverage again until he or she has earned a minimum of three months of Hours Bank coverage through active employment.

No employee shall receive more than eighteen (18) months coverage under this Rule 6 during his or her lifetime.

7. Election of Limited Coverage.

a. **Election Rights and Procedures.** Any employee who has coverage under another group health plan that provides minimum value within the meaning of Internal Revenue Code Section 36B(c)(2)(C)(ii) may elect in writing, according to procedures adopted by the Trustees, not to be eligible for medical, dental or vision benefits under the Plan. When an employee so elects to "opt-out," a copy of the election form shall be provided to the Union so that the employee may be dispatched in the appropriate referral class. If he or she is then covered under the Plan, his or her medical, dental, and vision coverage shall terminate on the last day of the month so designated by the Trustees in the election procedures, and he or she shall remain covered only under the Plan's life insurance and accidental death and dismemberment insurance benefits.

b. **Hour Bank Rules for Opted-Out Participants.** Whenever such an election becomes effective, the employee's Hour Bank shall be frozen, except that if the employee does not have an Hour Bank reserve of 300 Hours, he or she shall continue to be credited with each month's hours, adjusted to reflect the lower contribution rate for his or her class of employees, until he or she has an Hour Bank reserve of 300 hours.

c. **Reenrollment Rules.** An employee who has elected not to be covered under the medical, dental, and vision benefits of the Plan may elect to be covered again either during an annual open enrollment period, or within 30 days of the termination of other group health plan coverage. An employee who elects coverage again under the Plan must make a new election of HMO. If the employee has a sufficient Hour Bank reserve to pay for coverage, the election to become covered again shall be effective at the first opportunity under the contract with the applicable HMO, subject to completion of a new enrollment package and presentation of supporting documents. If the employee does not have a sufficient Hour Bank

reserve to pay for a month's coverage, the employee may self-pay for coverage for any months for which the employee would have been eligible under the rules of self-payment.

8. Special Rules for Employees Working in Public Employment. If an employee is eligible for benefits under the Plan's Hour Bank as an active or retired employee, and takes a position in public employment where benefits that provide minimum value within the meaning of Internal Revenue Code Section 36B(c)(2)(C)(ii) are provided, he or she may elect in writing, within 30 days of commencing such employment, to freeze any unused Hour Bank credit for as long as he or she remains employed by a public employer. If the employee leaves public employment and, within 30 days, either becomes employed in covered employment or registered for work (and actually available for work) through the Union's Hiring Hall, or retires, and he or she was a member in good standing of the Union for the entire period of his or her public employment, then he or she may use the frozen Hour Bank credit, at the then-current rates, to restore coverage under the Plan, until the Hour Bank is exhausted, and thereafter may maintain eligibility under the rules for self-payment or retiree coverage. If an employee takes a position in public employment while eligible for benefits under the rules for self-payment, he or she may elect to terminate eligibility for benefits under those rules, and use the remaining months of self-payment after termination of such public employment, under the same conditions stated above for the use of Hour Bank credits.

9. Termination of Coverage of Employees

a. **Depletion of Hour Bank.** An employee's coverage shall terminate at the end of any month in which the employee's Hour Bank falls below the Monthly Charge. An employee who has an Hour Bank which is less than the Monthly Charge may at his or her option use the Hour Bank and pay the difference in order to maintain coverage for one month. At the end of that month, the Hour Bank would be exhausted. The option to make a partial payment for full coverage is not available again until the employee reestablishes coverage under the Hour Bank. If an employee's coverage terminates under the Hour Bank rules, the employee may qualify for Continuation of Coverage through Self-Payment, or COBRA Continuation Coverage, or may requalify for coverage under the Reinstatement provision, all described below.

b. Cancellation of Hour Bank For Misconduct

i. An employee's coverage and Hour Bank shall be cancelled immediately if the employee takes any type of action which is deemed to be misconduct under the Plan. If such cancellation occurs, the employee may not qualify for coverage under the provisions for Suspension of Hour Bank Charges for Disability, or Continuation of Coverage By Self-Payments. In addition, the employee may not requalify for coverage under the Reinstatement provision, but must qualify under the rules for Initial Coverage.

ii. For purposes of the Plan, the term "misconduct" shall include, but not be limited to:

A. Performing employment of the type performed by employees of employers who contribute to the Plan pursuant to collective bargaining agreements, for an employer who does not contribute to a health and welfare plan maintained pursuant to a collective bargaining agreement of a local union of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada, AFL-CIO; and

B. Continuing to work for an employer which the Board of Trustees has determined to be chronically or substantially delinquent, after notification, or reasonable efforts at notification, of such determination.

c. **Rescission of Coverage.** After an employee is covered under the Plan, his or her coverage will not be rescinded by the Plan, unless the employee has performed an act, practice or omission that constitutes fraud, or unless the employee makes an intentional misrepresentation of material fact. For purposes of this Rule, a rescission is a retroactive cancellation or discontinuance of coverage, other than for a failure to timely pay required premiums or contributions toward the cost of coverage.

10. Reinstatement. An employee whose coverage has terminated shall again become covered on the first day of the second calendar month after the month in which the employee has performed sufficient hours of covered employment to accrue a reserve of 130 Hours for Kaiser coverage or 140 Hours for Blue Shield of California coverage, if this occurs within the twelve-month period immediately following the termination of coverage. If an employee is not reinstated within the twelve-month period, any reserve in his or her Hour Bank shall be cancelled and he or she must again qualify under the rules for Initial Coverage; provided, however, that the Hour Bank of any employee shall not be cancelled during the period that the employee is on the out-of-work list at the Union and continuously available for employment since his or her last month of coverage under the Plan, and the Hour Bank of such employee may be used towards re-qualification for Initial Coverage.

11. Continuation of Coverage by Subsidized Self-payments. If an employee's coverage terminates due to disability or unemployment, HMO coverage, life insurance and accidental death and dismemberment insurance may be kept in force by making payments in an amount determined by the Board of Trustees. The first payment must be remitted to the Trust Fund Office by the 15th day of the month following the date coverage would otherwise terminate. Payments may be made for a maximum period of six months for coverage for these benefits. After an employee has received six months of subsidized coverage under this rule, he shall not be eligible for such coverage again until he has earned a minimum of 36 months of Hour Bank coverage under the Plan. This coverage is available only if the employee is a member in good standing of the Union, and is either disabled or on the out-of-work list of the Union and continuously available for employment. Coverage under this paragraph shall include only medical benefits, life insurance and accidental death and dismemberment insurance, and not dental or vision care benefits.

12. Special Coverage Under the Family and Medical Leave Act. If an employee works for an Individual Employer which is required to provide health and welfare plan coverage under the Family and Medical Leave Act (“the FMLA”) during a qualifying leave under the FMLA, and the employee is eligible for, and takes, such leave, then the following special rules apply:

- a. The employee’s medical benefits will be continued by the Plan during the period of FMLA leave. The employer is legally obligated to make the required contribution for the employee’s coverage during an FMLA qualifying leave. The required contribution amount will be established under rules determined by the Board of Trustees. An employee’s Hour Bank will not be used to provide coverage until the qualified FMLA leave ends.
- b. Crediting of hours for an employee, and the Individual Employer’s obligation to contribute, shall terminate under these rules upon termination of the employee’s FMLA leave. The Individual Employer shall inform the Trust Fund Office in writing when an employee’s FMLA leave terminates. If an employee does not return to work for the Employer at the termination of his or her FMLA leave, then the employee shall be eligible for COBRA Continuation Coverage as provided elsewhere in this Plan, with the termination of the FMLA leave as the qualifying event under COBRA.

13. Rules Affecting Employees Called to Active Military Service

- a. If an employee is called to active military duty for a period of 30 days or longer, the employee may elect one of the following options:
 - i. to have his or her Hour Bank frozen as of the first day of the month following the commencement of active service, and to have all eligibility for the employee and any dependents terminate on the first day of that month;
 - ii. to continue the eligibility of the employee’s dependents, at the normal monthly charge against the employee’s Hour Bank, until that Hour Bank is exhausted; or
 - iii. where the employee was covered under the Plan by reason of Hour Bank credits for at least 12 out of the 18 months immediately preceding the call to military duty, to continue the eligibility of the employee’s dependents, at one-half the Subsidized Self-Payment rate, for a period not to exceed the lesser of the period of active military duty or 24 months. If the 24 months coverage has been exhausted, or if the employee stops making the required monthly payment prior to the end of that period, the employee may then elect between Option Nos. i and ii, above. An employee who is eligible for and elects this Option No. iii shall have the option of using some or all of his or her Hour Bank eligibility before continuing coverage under this paragraph.

If an employee fails to make an election, the employee shall be deemed to have elected Option No. ii.

- b. If an employee elects Option No. i, the employee and any dependents of the employee

will immediately be eligible for a maximum of 24 months of COBRA Continuation Coverage under the Plan rules governing that form of coverage. Coverage under the employee's Hour Bank will recommence after discharge from active military duty if the employee returns to work for a contributing employer or becomes available to work for a contributing employer as shown by application for employment at U. A. Local No. 159, provided the employee returns to work or makes such application within 90 days of discharge.

c. If Option No. ii above is elected, the 24 months of COBRA coverage will begin when the employee's Hour Bank is exhausted. If the employee returns to work for a contributing employer within 90 days of discharge from the military, the Plan will waive the current Monthly Charge for coverage in the month that the employee returns to covered employment and for the month following the month when the employee returns to covered employment. Thereafter, coverage will be provided at the current Monthly Charge for each month of coverage under the Plan's Basic Hour Bank Rules.

14. Special Coverage for Employees Working in Non-Covered Employment. An employee who is employed in non-covered employment as part of a Union organizing drive may be eligible for coverage under this Plan, under the following rules: In order for the employee to be eligible for coverage under this Rule, the Union must notify the Trust Fund Office in writing that the employee qualifies for this coverage, based on his or her participation in an organizing drive. Coverage under this Rule shall continue during the period of such employment, up to a maximum of six months for any one period, or until the Union notifies the Trust Fund Office in writing that the employee no longer qualifies for this coverage, whichever comes first. In order to receive coverage under this rule, the employee must remain a member in good standing of the Union. There shall be no charge to the employee's Hour Bank for coverage during this period, and the employee's Hour Bank reserve, if any, shall be frozen at the amount in reserve before coverage began under this provision. Once the period of coverage under this Rule ends, the employee's Hour Bank reserve shall be charged for further coverage, until coverage terminates under the rules stated herein.

B. Dependent Eligibility Rules

1. Dependent Eligibility. If an employee has eligible dependents, each dependent will be covered for benefits, commencing when an employee's eligibility is effective or when the individual becomes an eligible dependent. However, the coverage of each dependent is conditioned on compliance with the Plan's enrollment procedure, as established from time to time by the Trustees, and compliance with any applicable HMO enrollment procedure. Otherwise available coverage may be denied if a dependent is not properly enrolled. Newly-acquired dependents because of birth, adoption, or placement for adoption become eligible the date of the birth, adoption, or placement for adoption. Newly-acquired dependents because of marriage or registration of domestic partnership become eligible for benefits on the first day of the month after they are properly enrolled as dependents.

2. Eligible Dependent Defined. For purposes of this Plan, "Eligible Dependent" means the employee's lawful spouse or domestic partner as defined below, and/or any children (including

stepchildren, legally adopted children, children of domestic partners, or foster children) from birth to the last day of the month in which the dependent reaches age 26, except as follows:

- a. A newborn child is not covered under the life insurance provision until he or she is 14 days old;
- b. A dependent child will be covered for life insurance to age 19, unless he or she is a Full-Time Student, in which case coverage for life insurance will continue to age 25;
- c. For Plan Years beginning before January 1, 2014, no coverage is provided to any dependent while the dependent is in full-time military service; and
- d. A minor child placed with an employee for the purpose of legal adoption shall be deemed a "legally adopted child" from the moment the child is placed in the employee's physical custody, or from the moment the employee has assumed and retained a legal obligation to provide total or partial support for the child in anticipation of adoption of the child, whichever is earlier.

3. Full-Time Student Defined. "Full-time student" means a child who is an Eligible Dependent, and who is actually dependent on the employee for more than one-half of his or her support, and who is enrolled in a state-accredited full-time school, university or college for at least the minimum number of hours required by the educational institution to be considered full-time. Eligibility for students attending schools which are not state-accredited will be considered by the Trustees on a case-by-case basis. Periods of vacation from full-time enrollment shall not terminate coverage provided that proof is furnished and establishes to the satisfaction of the Board of Trustees that the dependent intends to continue as a full-time student following such vacation.

4. Termination of Dependent Eligibility. Except as provided in Section I., Rule B.5., a dependent's eligibility shall terminate when the employee's coverage terminates, or when the individual ceases to be an eligible dependent. However, if a covered employee dies, his or her dependents' coverage shall continue, at the cost of the Monthly Charge, until the employee's Hour Bank has less than the Monthly Charge. After that occurs, the surviving spouse and/or dependent(s) may qualify for COBRA Continuation Coverage, or Plan Continuation Coverage under the Retiree Eligibility Rules, Section II., Rule B.3.

5. Continued Coverage for Disabled Children. A dependent child whose health coverage would otherwise terminate solely due to attainment of age 26 shall continue to be an eligible dependent if he or she is incapable of self-sustaining employment by reason of developmental or physical disability upon reaching age 26 so long as he or she remains disabled, unmarried and dependent on the employee for support and maintenance, and provided that written evidence of such incapability is furnished to the Trust Fund Office within 31 days after the child attains the maximum age. Proof of the continued existence of such disability must be furnished from time to time upon request.

6. Qualified Medical Child Support Orders. The Plan will comply with any Medical Child Support Order ("MCSO") with which it is properly served and which is a Qualified Medical Child

Support Order (“QMCSO”) under applicable federal law. No QMCSO may require the Plan to provide benefits to a person who is not a “dependent child” as defined in the Plan and whose participant-parent is not then eligible for benefits, or to provide benefits in excess of those provided in the terms of the Plan. Upon service with an MCSO, the Trust Fund Office and Legal Counsel will review the MCSO under procedures adopted by the Trustees, and determine within a reasonable time whether or not the MCSO is a QMCSO. The determination that an MCSO is not a QMCSO is subject to the Appeals Procedures provided elsewhere in this Plan. The Plan’s procedures for review of MCSOs are available free of charge from the Trust Fund Office.

7. Domestic Partner Defined. 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:

- a. Both persons have a common residence;
- b. Neither person is married to someone else or is a member of another domestic partnership that has not been terminated, dissolved or judged a nullity;
- c. The two persons are not related by blood in a way that would prevent them from being married to each other in this state;
- d. Both persons are at least 18 years of age;
- e. Both persons are capable of consenting to the domestic partnership; and
- f. Either of the following must be true:
 - i. Both persons are members of the same sex, or
 - ii. 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.

In addition, as part of the Plan’s coverage of domestic partners, this Plan pays the incidental federal employment payroll taxes relating to such coverage, in accordance with governing IRS and U.S. Department of Labor rulings.

8. Special Enrollment. If an eligible dependent declines enrollment under the medical, dental, and vision benefits of the Plan, the eligible dependent may elect to be covered again either during an annual open enrollment period, or within 30 days of the termination of other group health plan coverage. In addition, if an employee has a new dependent as a result of marriage, birth, adoption, or placement for adoption, the employee may be able to enroll the eligible dependent, provided that enrollment is requested within 30 days after the marriage, birth, adoption or placement for adoption.

Eligible dependents may be enrolled in 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. An eligible dependent must file an enrollment form with the Trust Fund Office within 60 days of losing coverage under Medicaid or a State Sponsored Children's Health Insurance Plan or within 60 days of becoming eligible for premium assistance under Medicaid or a State Sponsored Children's Health Insurance Plan.

C. Benefits Provided

1. Medical Benefits.

a. Medical and prescription drug benefits shall be provided only through health maintenance organizations ("HMOs") and insurance providers selected by the Board of Trustees. If an employee has not elected Limited Coverage, the employee and his or her eligible dependents shall receive medical and prescription drug benefits from the HMO in which they are enrolled, whenever the employee is eligible under the Hour Bank or Self-Payments. For employees enrolling in the Plan prior to August 1, 2007, each employee shall make an HMO election when first eligible under the Plan, and may change the election during open enrollment periods established by the Board of Trustees. For employees enrolling in the Plan between August 1, 2007 and December 31, 2011, all employees who live within the Kaiser service area shall be enrolled in Kaiser, and shall remain enrolled in Kaiser at least until the Plan's next open enrollment period. Effective January 1, 2012, all new employees first enrolling in the Plan, and all employees who are classified as Residential Specialists, shall be enrolled in Kaiser. An employee who has elected Limited Coverage shall make a new HMO election if and when he or she terminates his or her election of Limited Coverage.

b. Effective for claims incurred January 1, 2014 through December 31, 2019, employees enrolled in the Blue Shield of California Out-of-Area PPO plan shall be eligible for reimbursement of the amount of out-of-pocket costs that they incur and pay resulting from the co-insurance requirement under the PPO plan, in excess of \$300 for an individual and \$600 for a family, up to the applicable out-of-pocket maximum amount.

c. Effective for claims incurred January 1, 2013 through December 31, 2019, active employees shall be eligible for reimbursement of the amount of out-of-pocket costs that they incur and pay resulting from the co-insurance requirement under the Plan's insurance carriers, in excess of \$300 for an individual and \$600 for a family, up to the applicable out-of-pocket maximum amount.

d. Effective July 1, 2014, the stipend benefit described in this Rule C.1.d is discontinued. Effective March 1, 2013 to June 30, 2014, if a participant covered as an active employee resides outside the service area of all Plan medical benefit providers, then the only medical benefit available to him or her is a monthly stipend for the purchase of HMO or insurance

coverage for himself or herself and his or her eligible dependents. The stipend benefit shall be subject to the following rules:

- i. The amount of the stipend shall be the lesser of: (a) the cost of the coverage that he or she has purchased; or (b) the lower of the premiums for HMO coverage for active employees residing in the Plan service area.
- ii. To receive a stipend payment, the participant must provide proof, satisfactory to the Board of Trustees, that he or she has actually purchased health care coverage for the amount reported by the participant.

e. Nothing in this Plan shall be deemed a guarantee of medical benefits. Failure to make an HMO election promptly when first eligible or when terminating Limited Coverage, or at succeeding open enrollment periods, may result in no medical benefits being provided to the employee and his or her dependents. Failure to enroll a new dependent promptly may result in no medical benefits being provided to the dependent. Violation of the HMO's rules may result in disqualification of the employee, or the employee and his or her eligible dependents. These decisions are at the discretion of the HMO, and not the Board of Trustees.

2. Other Benefits. All employees who are covered through the Hour Bank or Self-Payments, or on Limited Coverage with an Hour Bank reserve, shall be eligible for life insurance and accidental death and dismemberment insurance and dependent life insurance. Employees who have not elected Limited Coverage and who are covered under the Hour Bank shall receive dental and vision benefits; employees on Self-Payments shall not receive dental and vision benefits. If an employee elects coverage with an HMO which does not provide hearing benefits, he or she shall also be eligible for the self-administered Hearing Benefits.

II. RETIREE ELIGIBILITY RULES

A. Basic Eligibility Rules for Retired Employees

1. General Requirements. In order to be eligible for benefits under this plan, a retiree must satisfy all of the following five tests stated in Subsections a-e:

a. Covered Employment Requirements. The retiree must satisfy one of the following three activity tests:

- i. A. The retiree was eligible for benefits by reason of Hour Bank credits under the U. A. Local No. 159 Health and Welfare Plan Active Employee Eligibility Rules for at least 12 of the last 18 months immediately preceding his retirement. For purposes of these General Requirements, months of eligibility under the Disability Extension, Self-Payment Program, or COBRA Continuation Coverage are not counted.

B. For purposes of this test, a Disability Retiree may substitute one month of time on the out-of-work list at the Union for each month of required eligibility under the Active Employee Eligibility Rules, if the retiree was continuously available for employment since his or her last month of coverage under the Active Employee Eligibility Rules.

C. For purposes of this test, the Plan may disregard months in calendar years 2009, 2010, 2011 and 2012, if the retiree was on the out-of-work list at the Union and continuously available for employment for all months since his or her last month of coverage under the Active Employee Eligibility Rules.

ii. The retiree was receiving benefits from California State Disability Insurance ("SDI") for no more than a twelve-month period immediately preceding retirement, before which he or she had been eligible for benefits under the Active Employee Eligibility Rules for at least 12 of the preceding 18 months.

iii. A. The retiree was eligible for benefits by reason of Hour Bank credits under U. A. Local No. 159 Health and Welfare Plan Active Employee Eligibility Rules for at least 12 of the last 18 months at the time that the retiree became employed in qualifying employment under Subsection B; and remained employed in such position until retirement under the U. A. Local No. 159 Defined Benefit Plan; and at the time the retiree took the employment listed below, notified the Trust Fund Office of the commencement of such employment.

B. Qualifying employment, for the purposes of deferred eligibility under Subsection A above, means employment with a public employer doing plumbing and pipefitting work.

b. Pension Accruals Requirements. The retiree must satisfy one of the following requirements for accrual of benefits under the U. A. Local No. 159 Defined Benefit Plan:

i. The retiree had accrued at least 10 Years of Future Service Credits under the U. A. Local No. 159 Defined Benefit Plan, or

ii. The retiree had accrued at least 9 Years of Future Service Credits under the U. A. Local No. 159 Defined Benefit Plan, and received benefits from SDI, commencing within twelve months of the employee's last performance of covered employment under the Defined Benefit Plan, which, if each week of SDI benefits was counted as 40 hours per week of covered employment under the Defined Benefit Plan, would give the employee the equivalent of a total of 10 Years of Future Service Credits.

c. Receipt of Pension Benefits. The retiree must actually be receiving a pension from the U.A. Local No. 159 Defined Benefit Plan.

d. Union Membership. The retiree must be a member in good standing of the Union.

e. Residence Requirement. If pre-Medicare, the retiree must reside within the service area of the Plan HMOs.

2. Reservation of Powers. Notwithstanding any provision of this Section II, retiree coverage is not a vested right, even if an employee qualified for such coverage at the time of retirement. The Board of Trustees reserves the power to amend these rules from time to time as they deem necessary or proper, including the power to terminate eligibility for any or all classes of participants, to change the conditions under which any or all classes of participants are eligible to participate, and to establish a charge, or increase the charge, for coverage.

3. Initial Eligibility. A retiree who qualifies under Section II, Rule A.1., and his or her eligible dependents, shall become eligible for coverage as a retiree on the later of the effective date of retirement under the U. A. Local No. 159 Defined Benefit Plan, or the first day of the month following termination of coverage under the Hour Bank system. In order to receive coverage, a retiree must elect coverage, in writing on the designated Plan form, at one of the following times:

- a. upon retirement;
- b. upon eligibility for Medicare; or
- c. within thirty (30) days of termination of other group coverage, other than a plan of this Fund, with the presentation of proof of such termination of coverage at that time.

In addition to the above, a retiree who has not elected coverage at one of the required times may enroll in a Medicare Risk program of one of the Plan's health maintenance organizations ("HMOs") any time that such a program is available to him or her.

4. Medicare Requirements. In order for a retiree and his or her eligible dependents to become covered under the Plan if the retiree retires after becoming eligible for Medicare, or to maintain coverage upon the retiree's becoming eligible for Medicare, the retiree must enroll in Medicare Parts A and B. For an otherwise eligible dependent to receive coverage under this Plan, the dependent must enroll in Medicare Parts A or B upon enrollment under this Plan or, if later, upon becoming eligible for Medicare.

5. Termination of Coverage. Eligibility under this Plan terminates for a retiree and his or her eligible dependent(s) upon the first day of the month following the month in which any of the following events occur:

- a. The retiree's pension benefits from the U. A. Local No. 159 Pension Trust Fund (the Fund) terminate for any reason, including for suspension on return to covered employment;
- b. The retiree ceases to be a member in good standing of the Union;
- c. The retiree fails to make a required contribution in a timely fashion;

- d. The retiree elects to suspend coverage under the rules of the Plan; or
- e. The retiree becomes eligible for Medicare, and fails to enroll in Medicare Parts A and B.

Coverage for a dependent shall terminate upon the dependent's becoming eligible for Medicare, if the dependent fails to enroll in Medicare Parts A and B.

6. Suspension and Reinstatement of Eligibility of Retirees Returning to Industry Service.

a. If a retiree returns to Industry Service for which his or her pension benefits are suspendible under the U. A. Local No. 159 Defined Benefit Plan, other than employment described in paragraph b. of this Rule 6., the retiree's coverage shall be terminated. To receive coverage under these Retiree Eligibility Rules again, the retiree must requalify under Rule A.1. of this Section II as a new retiree.

b. If a retiree returns to covered employment under a collective bargaining agreement of U. A. Local No. 159 during a certified period of full employment, under the rules of the U. A. Local No. 159 Defined Benefit Plan, Article VII, Section 6(e)(2), the following rules shall apply:

i. The retiree shall be required to make a premium payment for eligibility for the first three months in which he or she returned to covered employment. Coverage under these Retiree Eligibility rules (Section II) shall be terminated at the end of the third month.

ii. While the retiree remains employed in covered employment, his or her eligibility shall be determined under the Plan's Hour Bank, under Section I, Rule A.10 (Reinstatement), as if the retiree had been eligible under the Hour Bank within the last twelve months. If a retiree does not have sufficient Hours for coverage in any month, he or she may make partial or full self-payments.

iii. If the retiree terminates his or her covered employment in accordance with the rules of the U. A. Local No. 159 Defined Benefit Plan, Article VII, Section 6(e), the retiree shall remain covered under the Hour Bank until it is exhausted, and is eligible immediately thereafter for coverage under this Section II. If the retiree fails to terminate his or her covered employment under the above-referenced rules, the retiree shall remain covered under the Hour Bank until it is exhausted, but he or she must requalify for retiree coverage under Rule A.1. of this Section II, as a new retiree.

B. Other Retiree Coverage Rules

1. Option To Suspend Coverage. A retiree who elects coverage upon retirement may suspend coverage for himself or herself and his or her eligible dependents when first covered under another

group health plan. To benefit from this provision, the retiree must provide proof of other coverage when suspending coverage. A retiree whose coverage was delayed at retirement or suspended under this provision may elect coverage only within the first thirty (30) days after the other coverage terminates.

2. Eligible Dependents Defined. The definition of eligible dependent in Section I., Rules B.2. and B.3., shall apply to retirees, except as follows. A retiree's eligible dependents will be limited to those persons who were eligible dependents on the retiree's date of retirement, or, in the case of a pre-retirement death, on the date of the employee's death. No dependent acquired after such date shall be covered.

3. Plan Continuation Coverage of Surviving Dependents.

a. The surviving spouse of an employee who dies while covered under this Retiree Plan or while covered under the Hour Bank or Self-Payment provisions of the Active Employee Eligibility Rules may elect coverage under this Retiree Plan for himself or herself and for the children who were eligible dependents of the employee at the time of his or her death. The surviving spouse may make this election only when coverage terminates under the Retiree or Active Employee eligibility rules

b. If there is no surviving spouse, the surviving eligible dependent child(ren) of an employee who dies while covered under this Retiree Plan or while covered under the Hour Bank or Self-Pay provision of the Active Employee's Eligibility Rules, may elect coverage until the first day of the month following the month in which the dependent would have ceased being eligible for coverage if the employee were still alive.

c. Other than as provided above, the only coverage available to surviving spouses or surviving eligible dependents shall be through COBRA Continuation Coverage.

4. Retiree And Survivor Contributions (for eligible persons residing in the service area of the Plan). Except as provided in Rule B.6. of this Section II, any retiree otherwise meeting the requirements for coverage who wishes to continue coverage for himself or herself, and his or her dependents, through the Plan's HMOs, and all surviving spouses or surviving eligible dependents who wish to continue coverage through the Plan's HMOs, must pay a monthly charge as provided in the following Sub-sections. The Trustees reserve the power to change the required monthly charge for any or all retirees or survivors at any time.

a. Retiree Contributions. Effective with payments made for coverage on or after September 1, 2013, the following monthly charges will apply to retirees until further action of the Trustees:

i. Before Medicare eligibility:

A. For any retiree who retired before his or her age 55: \$715 per month,

from retirement until the retiree has been covered as many months after the attainment of age 55 as he or she was covered before the attainment of age 55, at which time his or her rate shall be \$515 per month.

B. For any retiree who retired on or after his or her age 55 but before age 60: \$515 per month, from retirement until the retiree has been covered as many months after the attainment of age 60 as he or she was covered before the attainment of age 60, at which time his or her rate shall be \$430 per month.

C. For any retiree who retired on or after his or her age 60 but before his or her age 65: \$430 per month.

ii. On or after Medicare eligibility:

A. If enrolled in Kaiser, the retiree's contribution shall be \$165 per month.

B. If enrolled in United HealthCare, the retiree's contribution shall be \$220 per month.

b. Survivor Contributions. Effective with payments made for coverage on or after September 1, 2013, the following monthly charges will apply to survivors until further action of the Trustees:

i. For surviving eligible dependents receiving benefits from the U. A. Local No. 159 Defined Benefit Plan: The rate for any month for surviving eligible dependents shall be \$715, unless the participant had qualified, or would have qualified, for a lower rate, in which case that rate applies, with the following adjustments:

A. If there are one or more surviving eligible dependent(s) who are not eligible for Medicare, but the participant was already retired and Medicare-eligible, the rate shall be \$430.

B. If, or when, all covered survivors are Medicare-eligible, the rate shall be the applicable rate under Rule 4.a.ii. of this Section.

ii. Surviving eligible dependents who are not receiving benefits from the U. A. Local No. 159 Defined Benefit Plan may continue coverage, by paying the full monthly charge as determined by the Board of Trustees.

5. Retiree Welfare Stipend Program. Effective July 1, 2014, the stipend benefit described in this Rule B.5 is discontinued. For Plan Years beginning prior to June 30, 2013, a person who is eligible for benefits under these Retiree Rules, who resides outside the service area of the Plan HMOs, and who is eligible for Medicare, shall be eligible for a monthly stipend from the Plan to reimburse the cost of purchasing his or her own coverage. The amount of such stipend shall be \$100 if there is a Medicare-risk program available to the person, or \$170 if not. To receive stipend payments, the person must apply for them on the proper Plan form, and must submit proof in a form satisfactory to

the Board of Trustees, annually and on request of the Plan, that he or she has actually paid for coverage. The Trustees reserve the power to change the amounts payable under this Program at any time. Effective August 1, 2009, should the service area of the Plan's HMOs be expanded, any person who is receiving a stipend under this rule who then becomes eligible for coverage under a Plan HMO may elect such coverage, in lieu of the stipend benefit. Such an election may be made only during the Plan's open enrollment period, or within thirty days of termination of his or her other coverage.

6. Hardship Reduction.

- a. Any eligible retiree who demonstrates to the satisfaction of the Board of Trustees that he or she meets the following qualifications shall have his or her monthly charge for coverage determined under Subsection (d) of this Rule 6:

The retiree, if unmarried, has a total income of less than \$1,650 per month, or, if married, has a total income (including the income of both the retiree and his or her spouse) of less than \$2,200 per month.

- b. For purposes of this rule, "total income" includes all of the following items, counting each item of both the retiree and his or her spouse:

- i. Monthly pension benefits, including benefits from the U. A. Local No. 159 Defined Benefit Plan and benefits received from the U. A. Local No. 159 Defined Contribution Plan.
- ii. Social Security benefits.
- iii. Wages.

- c. To receive a Hardship Reduction, a retiree must submit the following documents:

- i. when first applying for the reduction, and at any time that his or her income (or his or her spouse's income) increases, a complete statement of income; and
- ii. for each year after the retiree's retirement, a copy of the first page of his or her Federal Income Tax Form 1040 filed the previous year, signed by the retiree.

The retiree's Form 1040 for each year must be mailed to the Trust Fund Office, postmarked no later than April 30 of the following year. Failure to submit a Federal Income Tax Form 1040, or report a change in income, in a timely fashion will result in disqualification of the retiree for the Hardship Reduction. In addition, if the retiree paid only the Hardship Reduction rate when he or she was not actually eligible to do so, the Plan shall increase his or her monthly charge by an amount determined at the time by the Board of Trustees, until all overpayments of the Hardship Reduction are recovered.

d. Any retiree who is found to be eligible for the Hardship Reduction shall have no increase in his or her required monthly payment above the amount required prior to July 1, 2011. Once a retiree qualifies for a reduction in the required monthly charge to an amount less than his or her Hardship Reduction rate, the Hardship Reduction rate shall no longer apply.

e. A surviving eligible dependent whose retiree had been covered under this Hardship Reduction shall continue to be eligible to pay no more than the monthly charge that was paid while the retiree was alive, subject to the same requirements and conditions as apply to retirees.

C. Benefits Provided

a. The only benefits which shall be provided to an eligible retiree or eligible dependent who resides in the service area of the Plan's HMOs are the medical, hospital, surgical, prescription drug, hearing aid, and related benefits provided by the HMO, vision benefits, and, if the HMO does not provide hearing exams and hearing aids, the Plan's self-funded hearing benefit.

b. Effective January 1, 1995, a Medicare-eligible retiree or eligible dependent may be required by their HMO to elect only to receive benefits through the Medicare-Risk program of the HMO in which he or she is enrolled.

c. Effective for claims incurred January 1, 2013 through December 31, 2019, retired employees who are not Medicare-eligible shall be eligible for reimbursement of the amount of out-of-pocket costs that they incur and pay resulting from the co-insurance requirement under the Plan's insurance carriers, in excess of \$300 for an individual and \$600 for a family, up to the applicable out-of-pocket maximum amount.

D. Retiree Dental Coverage

Notwithstanding any other provision of this Section II, a retiree who meets the requirements of this Rule D may elect dental coverage for himself and his eligible dependents through the Plan's retiree dental carrier. In order to qualify for this coverage, a retiree must:

- a. be receiving a pension from the U. A. Local No. 159 Defined Benefit Plan;
- b. be a member in good standing of the Union; and
- c. make the required monthly contribution, as set from time to time by the Board of Trustees.

Enrollment in the retiree dental plan shall be for a minimum one-year term, except that dental coverage will terminate for a retiree and his eligible dependents upon the first day of the month following the month in which any of the above eligibility requirements are no longer met.

III. COVERAGE OF PARTICIPATING INDIVIDUAL EMPLOYERS AND OTHER NON-BARGAINING UNIT PERSONNEL

A. Basic Eligibility Rules

1. Eligibility to Participate. A qualifying Individual Employer, as defined herein, who is signatory, or otherwise party, to a collective bargaining agreement with the Union, may obtain coverage for himself or herself, for his or her dependents, and for all office employees not in a collective bargaining unit, by filing an application with the Trust Fund Office upon a form to be supplied for that purpose. This coverage is available only if all of the Individual Employer's office employees who are not in a collective bargaining unit are covered under this Plan at all times, unless eligible to defer coverage.

2. Definitions.

a. The term "Individual Employer" shall, for this purpose, be limited to persons who are sole proprietors, members of partnerships or other unincorporated associations, and managing officers of corporations who are employed in the signatory business full time, and who spend their entire working time in the type of work covered by the Union's Master Labor Agreement or in work related to that type of work.

b. The definition of "dependent" in Section I., Rules B.2. and B.3., shall apply to this Section.

3. Disqualifying Employment. Notwithstanding the above, coverage shall not be provided to any individual if either the individual or the individual's Individual Employer is associated in any way, directly or indirectly, with an employer which is not party to a collective bargaining agreement with a U. A. Local Union but which performs work of the type covered thereby.

4. Payment Requirements. The Board of Trustees, in its exclusive discretion, shall determine the charges for coverage under these rules, which shall pay for the full cost of such coverage. Coverage for any individual shall continue only for so long as the Individual Employer satisfies the following rules:

a. The Individual Employer continues to pay, promptly and in full, on or before the 20th day of each month, all payments required for coverage under this Section III. A payment for coverage under this Section III shall be applied to pay for coverage for the month immediately following the month in which the payment is made.

b. The Individual Employer pays all contribution amounts required under any applicable collective bargaining agreement for the coverage of all of its bargaining unit employees, in accordance with the procedures of such agreements.

B. Procedures for Individual Employer Coverage

1. Enrollment Requirements. Except as provided in Rule B.2, an Individual Employer must apply for coverage within the later of 60 days of becoming a party to a collective bargaining agreement or exhausting his/her own active Hour Bank coverage, and must execute a Subscription Agreement in a form satisfactory to the Board of Trustees. The Individual Employer must provide the name, Social Security Number and address of each individual to be covered, and indicate whether each person named is an owner or a non-bargaining unit office employee of the Individual Employer. If an individual is first employed or becomes associated with the Individual Employer after the initial application is filed, a separate application must be filed for that person within thirty (30) days after first employment. Coverage shall commence on the first day of the month following approval of the relevant application and receipt of the required contribution amount.

2. Deferral or Temporary Discontinuance of Enrollment. An Individual Employer may defer enrollment, or may temporarily discontinue coverage, under these rules for himself or herself or for any non-bargaining unit employee if that person has other group health coverage (including Hour Bank coverage under this Plan). A person whose enrollment is deferred or discontinued thereafter may enroll only within 30 days of termination of such other group health coverage, or at open enrollment.

3. Relationship to Other Forms of Coverage.

- a. Covered individuals shall accrue no Hour Bank, shall not be entitled to any subsidized rate of "self-pay" extended coverage or disability extension, and shall not be entitled to receive retiree welfare coverage, except as is expressly set out in Rule C. of this Section III.
- b. Covered individuals shall be eligible for COBRA Continuation Coverage under the rules stated in that Section, except that an Individual Employer and his or her dependents shall be eligible for COBRA coverage on the grounds of termination of employment of the Individual Employer only if the termination is caused by liquidation of, or complete cessation of, operation of the business or the complete severance of the relationship between the Individual Employer and the business.

C. Retiree Coverage for Individual Employers

1. Eligibility for Individual Employers. An Individual Employer may elect upon retirement to continue coverage for himself or herself and his or her dependents if he or she satisfies all of the following conditions:

- a. The Individual Employer had been continuously eligible for benefits under the Plan for at least 120 months immediately prior to retirement; and
- b. The Individual Employer was at least 60 years of age at the time of retirement; and
- c. The Individual Employer makes timely premium payments in such amounts as are

determined from time to time by the Board of Trustees; and

d. The Individual Employer and his or her spouse maintain eligibility for Medicare Parts A and B, commencing as soon as each is eligible to do so.

For purposes of this Section III., Rule C., the definition of “dependent” in Section II., Rule B.2., applies.

2. Eligibility for Surviving Spouses of Individual Employers. The surviving spouse of an Individual Employer may, upon the death of the Individual Employer, elect to continue coverage for himself or herself and the other then-covered dependents of the Individual Employer, under the conditions stated in Subsection 1., if the Individual Employer was either covered, or eligible to elect coverage, as a retired Individual Employer at the time of his or her death.

3. Termination of Retiree Coverage. Coverage will terminate for any person covered under this Rule C upon the occurrence of any of the events which would cause termination of coverage of a Retired Employee, except failure to maintain membership in good standing in U. A. Local No. 159.

D. Benefits Provided

1. Except as provided in Subsection 2, individuals covered under this Section III and their dependents shall be entitled to the same options of HMO, and the same other scheduled benefits, as active employee participants and their dependents, and are subject to the same exclusions and conditions with the exception that the calendar year deductible for the dental plan is \$150 per individual and \$450 per family.

2. Prior to July 1, 2014, no person covered under these Individual Employer rules shall be entitled to any benefits from this Plan for any condition pre-existing the date of enrollment for a period of twelve (12) months after enrollment. The term “condition pre-existing the date of enrollment” shall mean any condition for which any treatment was sought or received, or for which a reasonable person would have sought treatment, within the six (6) months prior to the date of enrollment. Each month of prior “creditable coverage” as defined by 29 U.S.C. Section 1181(c) shall be counted as one (1) month toward the twelve (12) months referenced above. However, this exclusion shall not apply to medical benefits provided by a Plan HMO if the rules of that HMO covering an individual do not include such pre-existing condition exclusions.

IV. COBRA CONTINUATION COVERAGE

A. Eligibility for COBRA

1. An employee or dependent may elect continuation coverage under the following rules, subject to payment of the required monthly premium, unless all plans of the Fund are terminated before the person’s qualifying event:

a. An employee or dependent may elect continuation coverage for a period of 18 months including periods of coverage at no charge or a lower monthly charge, if the individual's coverage under the Plan has terminated because of the termination of employment, or reduction of hours, for any reason other than gross misconduct.

b. An employee or dependent may elect continuation coverage for an additional 11 months, if the employee or dependent is totally and permanently disabled, such that the employee or dependent receives a Social Security Disability Award within the initial 18 months of COBRA coverage which finds that the person was so disabled within 60 days of the effective date of initial COBRA coverage.

c. A dependent is eligible for continuation coverage, for up to 36 months, if the dependent is about to lose coverage because of one of the following qualifying events:

- i. the death of the employee;
- ii. divorce of the employee and spouse;
- iii. a child loses eligibility as a dependent; or
- iv. the employee becomes entitled to Medicare.

2. The period of coverage under this Section IV shall run from the initial qualifying event except if the qualifying event is Rule 1.c.iv., in which case the period shall run from the effective date of the employee's Medicare entitlement if that entitlement precedes the other qualifying event. The period of coverage under this Section shall be reduced by any period in which the employee or dependent was provided coverage by the Fund at lower cost than coverage under this Section.

B. Procedures of COBRA Coverage

1. If an employee is about to lose coverage because his or her Hour Bank has run out, the Trust Fund Office will notify the employee of the qualifying event, and of the right to elect this coverage.

2. A dependent who is about to lose coverage because of divorce, death of the participant, termination of dependent status, or entitlement of the employee for Medicare, must notify the Trust Fund Office within 60 days of the qualifying event. The Trust Fund Office will then notify the dependent of his or her COBRA rights.

3. The election of COBRA coverage by an employee with dependents applies to his or her dependents as well, including dependents acquired during the period of COBRA coverage. However, if an employee does not elect COBRA coverage, his or her dependent(s) at the time of the election may elect coverage for themselves.

4. After a person receives notification from the Plan of the right to elect COBRA continuation coverage, he or she has 60 days to submit a written election of such coverage.

5. An employee and/or dependent(s) who elects COBRA coverage must make the first monthly premium payment within 45 days of the election of COBRA coverage, including payment of the premiums for the period before the election. Thereafter, an employee and/or dependent(s) who desire to continue coverage shall be solely responsible for the timely payment of the premium for such continued coverage. Each month's premium must be paid before the 25th day of the previous month. Covered persons will not be billed, unless there is an adjustment in the monthly rate.

6. The cost of COBRA coverage shall be the amount determined by the Board of Trustees, but shall not exceed 102% of the applicable group cost, except during the 11-month extension for disabled participants or beneficiaries, during which it shall not exceed 150% of the applicable group cost. The Board of Trustees reserves the right to adjust any individual's COBRA rate if the underlying costs to the Plan change. If an election is made after the Qualifying Event, the premium payment for continuation coverage during the period preceding the election must be remitted at the time the election is made.

C. Termination of COBRA Coverage

1. COBRA coverage will be terminated for all persons if all Plans of this Fund are terminated.
2. Coverage for any individual is terminated if:
 - a. payment for that individual is not made in a timely manner; or
 - b. the individual becomes covered under another group health plan, either as an employee or dependent, unless that other plan has a pre-existing condition exclusion which affects the person; or
 - c. the individual becomes entitled to Medicare; or
 - d. the former employee is covered beyond 18 months because of disability, and ceases to be disabled.

V. SUPPLEMENTAL BONUS BENEFIT FOR RESIDENTIAL EMPLOYEES

A. Definitions. For purposes of this Benefit, the following definitions apply. If a term is not defined herein, the general definition, if any, of such term in the Plan or Trust Agreement shall apply.

1. **Determination Period** for any year means the 12-month period ending September 30 of that year.
2. **Eligible Employee** for any Determination Period means any person:

- a. who performed Residential Plumbing work during the Determination Period; and
- b. who, during the Determination Period or thereafter, did not perform work of any type covered under any collective bargaining agreement of U. A. Local No. 159, except under a U.A. collective bargaining agreement; and
- c. who does not have any ownership interest in the contributing employer by whom he or she is employed; and
- d. who satisfies one of the following tests:
 - i. As of the last day of the Determination Period, the employee was employed in Residential Plumbing work; or
 - ii. The employee was employed in Residential Plumbing work in the Determination Period, and did not voluntarily leave Residential Plumbing work during the Determination Period to perform work at the commercial or special projects wage rates of U. A. collective bargaining agreements.

3. Residential Plumbing work means work as a Building Trades journeyman or apprentice on any residential plumbing project covered by a U. A. collective bargaining agreement for which contributions are required to be made to this Trust Fund.

B. Basic Procedures. This Benefit shall be funded entirely from contributions made to the Health and Welfare Trust Fund specifically for this Benefit. No part of the Plan shall be construed to require payments from the Plan in excess of the contributions actually received for this Benefit. Each year, following the end of the Determination Period, the Board of Trustees shall determine the amount of funds available for benefits from contributions received for this Benefit during the Determination Period. The Board of Trustees shall then allocate those available funds among Eligible Employees in proportion to their hours of Residential Plumbing work during the Determination Period. Benefit payments shall then be distributed to the Eligible Employees during December of that year.

C. Payments to Beneficiary. If any employee performed Residential Plumbing work during a Determination Period, but dies before receiving his or her benefits under this Section V, then such benefits shall be payable to his or her surviving spouse, if any, or if none to his or her children, if any, who were eligible dependents under this Plan or would have been eligible dependents if the employee had been eligible for Plan benefits at the time of his or her death. If there are no eligible beneficiaries, then no benefits shall be payable on account of such employee.

VI. HEALTH REIMBURSEMENT ACCOUNTS

A. Establishment of Health Reimbursement Accounts

1. Each active employee for whom contributions are made under a collective bargaining agreement for the purpose of a Health Reimbursement Account ("HRA") will receive HRA credit for those contributions. These HRAs will be separate from, and in addition to, the amounts credited to each active employee for the purposes of determining current coverage and accruing a reserve Hour Bank. Notwithstanding the above:

a. If an employee working under a collective bargaining agreement of U. A. Local No. 159 has reciprocity in effect, he or she shall not have an HRA in this Plan. Instead, his or her HRA contributions shall be reciprocated to his or her home trust, to be allocated at the discretion of the home trust's trustees.

b. If a member of U. A. Local No. 159 is working under a collective bargaining agreement of another U. A. Local Union which has contributions dedicated to HRAs or the equivalent, the employee shall receive HRA credit for such dedicated contributions which are reciprocated to this Plan.

2. HRAs may be used for any of the purposes allowed under the Plan rules below, and only for such purposes. Nothing in these rules for HRAs shall be construed as making HRAs vested at any time, or subject to use in any manner except as provided in these rules.

3. HRAs that have a year-end balance may be credited (or charged) an amount reflecting the income (or loss) on those Accounts for the Plan year, at the discretion of the Board of Trustees. Regardless of whether income or losses are allocated to HRAs, the Board of Trustees reserves the power to assess an administrative charge against HRAs.

4. An employee or retired employee may permanently opt out of and waive all future reimbursements from his or her HRA annually and upon loss of eligibility for coverage. The account balance of any employee or retired employee who elects to permanently opt out of and waive all future reimbursements from his or her HRA will be forfeited in accordance with Rule C below.

B. Use of HRAs

1. **Retiree Health & Welfare Payments.** Once an employee is receiving a pension benefit from the U. A. Local No. 159 Defined Benefit Plan and is enrolled for retiree welfare coverage under this Plan, the credits accrued in his or her HRA may be used to pay the monthly charge set by the Board of Trustees for retiree coverage.

2. Other Plan Premiums.

a. An employee may use his or her HRA to pay the premium for medical coverage for any

month for which he or she, or his or her spouse or eligible dependents, is covered by another group medical plan that provides minimum value within the meaning of Internal Revenue Code Section 36B(c)(2)(C)(ii).

b. Any employee may use his or her HRA to make Self-Payments for his or her coverage under this Plan, when otherwise eligible to make Self-Payments.

c. An employee may use his or her HRA to pay for COBRA coverage, under this Plan or any other plan for which COBRA coverage is available.

d. A surviving spouse or surviving eligible dependent of an employee may use the employee's HRA to make monthly payments required for Plan survivor benefits, or to pay premiums for COBRA coverage based on the death of the employee as the qualifying event. If the eligible dependent(s)' Plan survivor coverage or COBRA continuation coverage period ends before the employee's HRA is exhausted, that Account may be used to pay for extended coverage for the employee's dependent(s), at the COBRA continuation coverage rate, until the earlier of the following times:

- i. the HRA is exhausted;
- ii. other coverage becomes available (including, but not limited to, coverage through Medicare or through another group health plan); or
- iii. in the case of a surviving child, the child attains the applicable limiting age under the plan.

3. Qualified Expenses. Any active, prior or retired employee may be reimbursed from his or her HRA for any qualified expenses that are not otherwise covered under the Plan. In order to qualify for payment through an employee's HRA, an expense must satisfy all of the following requirements:

a. The expense must have been for medical care as defined in Internal Revenue Code Section 213(d), except an expense for premiums for medical coverage shall be reimbursable only if:

- i. the expense is authorized under Rule B.2. of this Section; or
- ii. the employee is on COBRA or covered as a retiree, and the premium is for coverage of a dependent under insurance or a group health plan other than this Plan.

b. The expense must have been incurred by the employee or by a person who was then:

- i. a covered eligible dependent of the employee (active participants), and
- ii. a spouse or dependent within the meaning of Internal Revenue Code Section 152 (active, prior and retired participants).

c. The claim for HRA benefits must be made within one year of the time the expense is actually incurred. Extensions of this time limit will be granted only for good cause shown, at the sole discretion of the Board of Trustees.

d. The expense must have been incurred on or after January 1, 2012.

e. The employee or dependent must provide proof, satisfactory to the Board of Trustees, that the claim satisfies the requirements of this Rule B.3.

4. Procedures for Payment of Benefits.

a. Benefits will be paid only to an employee or surviving eligible dependent. Benefits will be paid only after an eligible person has incurred a Qualified Expense, and submitted a claim with supporting documents. Assignment of HRA benefits is not allowed.

b. Benefits will be paid once per quarter, at dates designated by the Board of Trustees. 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 elsewhere in the Plan.

C. Forfeiture of HRAs

1. The HRA of an employee shall be immediately and permanently forfeited if either of the following apply to the employee:

a. The employee accepts employment in any capacity and of any duration from a contractor in the Plumbing and Pipefitting Industry who is not signatory to the collective bargaining agreement of the U. A. Local Union having jurisdiction of the work; or

b. The employee is an owner of a company in the Plumbing and Pipefitting Industry which is not signatory to a collective bargaining agreement of the U. A. Local Union having jurisdiction of the work.

2. The HRA of any employee or retired employee shall be forfeited if he or she elects to permanently opt out and waive all future reimbursements from his or her HRA.

3. The HRA of any retired employee shall be forfeited if he or she is no longer a member in good standing of the Union.

4. The HRA of any employee shall be forfeited if he or she has a permanent break in service under the U. A. Local No. 159 Defined Benefit Plan, such that he or she shall never be eligible for benefits under that Plan.

5. The HRA of a deceased employee shall be forfeited if the employee dies without any dependents

eligible for any form of extended benefits under this Plan.

6. Once an employee's HRA has been forfeited, it cannot be used by the employee or by surviving eligible dependents for any purpose, even for expenses that were incurred before the forfeiture occurred. Any employee who regains eligibility for coverage under the Plan after forfeiture of his or her HRA shall be allowed to accrue new credits, but will not regain the credits that were forfeited.

7. Forfeitures shall be either (1) used to pay administrative expenses of the Plan, or (2) credited to the HRAs of other employees, in the same manner as earnings, at the sole discretion of the Board of Trustees.

D. Effective Date

The first distribution from HRAs under this Section shall be made on or after July 1, 2012.

VII. SELF-ADMINISTERED BENEFITS

The following benefits are self-funded, and administered directly through the Trust Fund Office:

A. Hearing Benefits. Participants who are enrolled in an HMO which does not cover hearing examinations and/or hearing aids are eligible for the following Hearing Benefits:

1. One examination is covered every twelve months, and one device is covered every three years.
2. Benefits will be paid for covered examinations and devices, after payment of a \$100 deductible per individual per year, at 80% of the billed rate, up to a maximum of \$800 in benefits per device, and \$1,600 in total benefits, in any three-year period.
3. No hearing benefits shall be paid unless and until a claim is submitted, including documentation of the amount charged and of the amount paid by the participant or dependent. Assignment of benefits is not permitted. No claim for hearing benefits shall be payable if first submitted more than twelve months from the date of service.

B. Reimbursement of Out-of-Pocket Costs

1. Pursuant to Section I., Rules C.1.b., c. and d., qualifying employees shall be eligible for reimbursement of certain out-of-pocket costs that they incur and pay for health care provided under the Plan.
2. No reimbursement of costs shall be paid under this Section unless and until a claim is submitted, including documentation of the amount incurred and paid by the employee and/or his or her dependent. No claim for reimbursement under this Section shall be payable if first submitted more than twelve months from the date of service.

VIII. SPECIAL CLAIMS AND APPEAL PROCEDURES IN CASE OF DENIAL OF MEDICAL, VISION OR DENTAL BENEFITS DUE TO INELIGIBILITY, DISABILITY STATUS, AND DENIAL OF SELF-ADMINISTERED BENEFITS

The following claims and appeals procedures shall apply to claims for medical, vision and dental benefits that are denied on the grounds that the individual was ineligible for the benefit under the terms of the Plan, claims for disability status, and to all claims for self-administered benefits. However, these procedures apply only to determinations of eligibility made in conjunction with a request for specific care. These claims and appeals procedures do not apply to routine requests for determinations of medical, dental or vision benefit eligibility that are not made in conjunction with a specific request for medical care.

Important Note Concerning Appeals: The Board of Trustees hears appeals only about eligibility issues, disability status, and self-administered benefits, and not about determinations by Plan HMOs or other providers. The Plan's appeal procedures do not apply to claims or appeals for benefits which are denied by a provider on the grounds of lack of medical necessity or any other matter under the discretion of the provider. In such cases, the only claims and appeal procedures available shall be the provider's own procedures.

Each of the Plan's HMOs and other benefit providers has its own appeal procedures which are described either in this booklet or in the respective service booklet of each provider. Representatives of the Trust Fund Office or Local Union may help you with an appeal at an HMO or other benefit provider, but such appeals are ultimately your own responsibility.

A. Filing a Claim for Benefits. If the claimant has been denied preauthorization for treatment, or has been sent a bill by a Plan provider, because he or she was deemed ineligible for medical, vision or dental benefits under the Plan, or has been denied disability status, the claimant may submit a claim by contacting the Trust Fund Office. 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.

Participants may initiate a claim for self-administered benefits by submitting an application on the form provided by the Trust Fund Office.

All claims and appeals under this Article 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.

B. Notification of Failure to Follow Plan Claims Procedures. If, in filing a claim for

benefits, the claimant fails to follow the Plan's claim procedures, the Trust Fund Office will notify the claimant as soon as possible, but within 5 days following the failure, or if the claim is for urgent care, within 24 hours of the failure. This notification may be oral, unless the claimant or authorized representative requests it in writing.

C. Notification Rules if the Claim For Benefits is Denied on the Grounds of Ineligibility.

1. Time Limits and Requests for Additional Information.

a. **Urgent Care Claims.** If a claim is for urgent care and the medical, vision or dental benefits are denied because a participant is ineligible for Plan benefits, the Trust Fund Office will notify the claimant of the Trust Fund Office's eligibility determination as soon as possible, but no later than 72 hours after receipt of the claim by the Trust Fund Office.

If an urgent claim for self-funded hearing benefits is denied, the Trust Fund Office will notify the claimant as soon as reasonably possible, but no later than 72 hours after the Trust Fund Office received the claim.

If the claimant fails to provide sufficient information to determine whether benefits are payable under the plan, the Trust Fund Office will notify the claimant what information is necessary as soon as possible, but no later than 24 hours after receipt of the claim by the Trust Fund Office. The claimant will have 48 hours to provide the specified information. The Trust Fund Office will notify the claimant of its decision as soon as possible, but no later than 48 hours after the Trust Fund Office's receipt of the specified information. If the claimant fails to provide the information, the Trust Fund Office may notify the claimant of its decision at the end of the period given to the claimant to provide the information.

b. **Pre-service claims.** If a claim for non-urgent medical, vision, or dental benefits made prior to the participant receiving medical treatment is denied because a participant is ineligible for medical, vision or dental benefits, the Trust Fund Office will notify the claimant of its decision as soon as reasonably possible, but no later than 15 days after the Trust Fund Office received the claim.

If a claim for non-urgent self-funded hearing benefits made prior to the participant receiving hearing care or devices is denied, the Trust Fund Office will notify the claimant of its decision as soon as reasonably possible, but no later than 15 days after the Trust Fund 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 Trust Fund Office's control. If the Trust Fund 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 Trust Fund Office needs to make the decision. If the Trust Fund Office requires additional information, the claimant will have up to 45 days to provide the specified information. Once the specified information

is provided, the Trust Fund Office will notify the claimant of its decision within 15 days.

c. **Post-service claims.** If a claim for medical, vision or dental benefits made after the participant received medical, vision or dental treatment is denied because a participant was ineligible for medical, vision or dental benefits at the time the individual received the treatment, the Trust Fund Office will notify the claimant of its determination as soon as reasonably possible, but no later than 30 days after the Trust Fund Office received the claim.

If a claim for self-funded hearing benefits is denied, the Trust Fund Office will notify the claimant as soon as reasonably possible, but no later than 30 days after the Trust Fund 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 Trust Fund Office's control. If the Trust Fund 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 Trust Fund Office needs to make the decision. If the Trust Fund Office requires additional information, the claimant will have up to 45 days to provide the specified information. Once the specified information is provided, the Trust Fund Office will notify the claimant of its decision within 15 days.

2. Contents of Notice. The Trust Fund 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. the internal Plan rule, guideline, protocol, standard, or similar criterion, applied and relied upon in making the determination, including the basis for disagreeing with the view of health care professionals, or with the disability determinations by the Social Security Administration (if no such criterion was used, then an affirmative statement to that effect must be provided);
- d. an explanation of the scientific or clinical judgment for the determination if the adverse benefit determination was based on medical necessity or other similar exclusion or limitation;
- e. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to claimant's claim;
- f. 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;

g. a description of the Plan's appeal procedures, including any expedited appeal procedures available if it is a claim for urgent care benefits;

h. a statement of the claimant's right to bring a civil action under ERISA Section 502(a), within one (1) year after an appeal has been denied; and

i. contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Patient Protection and Affordable Care Act.

D. Appeal Procedures

1. Right to Appeal. If a claim for benefits has been denied by the Trust Fund Office or other agent of the Board of Trustees or by the Board, the claimant may appeal the denial to the Board of Trustees.

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 Trust Fund Office.

3. Time Limits for Filing Appeal. Claimants must submit their appeals within 180 days of receiving the denial of the original claim by the Trust Fund Office. If a claimant does not submit an appeal within 180 days of receiving a denial, he or she will be deemed to have waived any objection to the denial.

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, assignee, or other person with respect to Plan benefits, except to the extent that the determination of available benefits has been assigned to a provider in its agreement with the Board of Trustees. The Board of Trustees will take into account everything that an appellant has 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 shall have a vote in the decision on appeal.

5. Right to Review New Evidence. The Trust Fund Office shall automatically provide to the claimant, 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 the claimant a reasonable opportunity to address the new evidence or rationale prior to the appeal date. The claimant shall have the right to review and respond to new evidence or rationales considered, relied upon or generated by the Plan in connection with the claimant's claim during the pendency of any appeal.

6. Notification of the Board's Decision on Appeal

a. Time Limits for Board of Trustees' Determination on Appeal.

i. **Urgent Care Claims.** In the case of a claim involving urgent care, the Trust Fund 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.** In the case of a claim made before the participant has received care, the Trust Fund Office will notify the claimant of the Board of Trustees' determination within 30 days after receiving the appeal.

iii. **Post-Service Claims.** If the claim is made after the claimant has received care, the Board of Trustees will render a decision on the 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. The claimant shall be notified of the time and place of the meeting. The Board of Trustees, in their exclusive discretion, may allow any information to be presented, and/or allow the aggrieved individual to appear before them in person or present witnesses.

If special circumstances require further extension, the decision will be made no later than the third meeting following the filing of the appeal. In such cases, the Trust Fund 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 Trust Fund 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 Regarding Determination on Appeal.** The Trust Fund 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. the internal rule, guideline, protocol, standard or other similar criterion, applied and relied upon in making the determination, including the basis for disagreeing with the view of health care professionals, vocational professionals or with the disability determinations by the Social Security Administration (if no such criterion was used, then an affirmative statement

to that effect must be provided);

- iv. an explanation of the scientific or clinical judgment for the determination if the denial was based on medical necessity or other similar exclusion or limit;
- v. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of documents, records or other information relevant to the claim;
- vi. a description of any further appeal procedures, and the claimant's right to receive information about the procedures;
- vii. the claimant's right to bring a civil action under ERISA §502(a) within one (1) year after a claim has been denied; and
- viii. contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Patient Protection and Affordable Care Act.

All notices and disclosures under this subsection shall be provided in a culturally and linguistically appropriate manner. The Trust Fund Office will also provide customer service with oral language services in the appropriate non-English language and provide written notices in the appropriate non-English language upon request.

E. Finality of Claim

The denial of an application or claim after the right to review has been waived or the decision of the Board of Trustees on petition for review has been issued, shall be final and binding upon all parties, including the claimant. No lawsuit may be filed without first exhausting the above appeals or a showing that the Plan was not compliant with the above procedures (unless the Plan's actions 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). A civil action arising from the denial of benefits must be filed within one year from the date on which the Board of Trustees provides notice that the claimant's appeal has been denied, regardless of any state or federal statutes establishing provisions relating to limitations of actions.

IX. DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE BOARD OF TRUSTEES AND "MINIMUM NECESSARY" POLICY

A. Definitions. Whenever used in this Section, the following terms shall have the respective meanings set forth below.

1. Plan means this U. A. Local No. 159 Health and Welfare Plan.
2. Board means the Board of Trustees of the U. A. Local No. 159 Health and Welfare Trust Fund, which is the plan sponsor as defined in ERISA Section 3(16)(B).
3. 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 CFR Section 160.103), employer, life insurer, school or university, or health care clearinghouse (as defined in 45 CFR Section 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.
4. 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:
 - a. names;
 - b. geographic information more specific than state;
 - c. 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);
 - d. other identifying numbers, such as Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers;
 - e. facial photographs or biometric identifiers (e.g., fingerprints); and
 - f. any information the Board does not have knowledge of that could be used alone or in combination with other information to identify an individual.
5. 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.

B. Disclosure of Summary Health Information. Except as prohibited by 45 CFR Section 164.502(a)(5)(i), 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.

C. 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.

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

E. 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.

F. 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 Section 164.504(f).

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

1. not use or further disclose PHI other than as permitted in this Section or as required by law;
2. ensure that any agents to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Board with respect to such PHI;
3. not use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan;
4. report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses and disclosures in this Section;
5. make PHI available to individuals in accordance with 45 CFR Section 164.524;
6. make PHI available for individuals' amendment and incorporate any amendments in accordance with 45 CFR Section 164.526;
7. make the information available that will provide individuals with an accounting of disclosures in accordance with 45 CFR Section 164.528;
8. 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;
9. 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

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

H. Disclosure Only to Designated Parties. Pursuant to this Section, the Plan will disclose PHI only to the Board and/or to individual Trustees.

I. Disclosure Only for Designated Purposes. Access to and use of PHI by the parties described in paragraph H. 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.

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

K. 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 Section 164.520.

L. 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:

1. 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,
2. ensure that adequate separation between the Plan and Board, as required by this Section and by 45 CFR Section 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures,
3. ensure that any agent to whom the Board provides this information agrees to implement reasonable and appropriate security measures to protect the information, and
4. report to the Plan any security incident of which it becomes aware.

M. “Minimum Necessary” Standard. In accordance with 45 CFR Section 164.502(b), as amended from time to time, reasonable efforts will be made to limit any use or disclosure by the Plan of PHI, including ePHI, or request for PHI, to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

X. MISCELLANEOUS RULES

A. Reservations of Authority. No employee, dependent, beneficiary, assignee, or other person shall have any right or claim to benefits or to payments from the Plan except as provided in these rules and as specified in the contracts or policies procured by the Board of Trustees. Nothing in any Plan document is intended to, or should be construed to, extend or increase the benefits provided pursuant to such contracts or policies beyond the benefits provided under such contracts or policies. The Board of Trustees reserves the power to amend, modify, or discontinue all or part of the Plan and/or the contracts or policies under which benefits are provided, whenever, in their exclusive discretion, conditions so warrant. The Board of Trustees also reserves the power to increase or decrease amounts charged for coverage to any or all classes of participants or beneficiaries, or to establish a charge for any or all types of coverage. If this Plan is ever terminated, its remaining assets shall be used to continue to provide benefits for so long as Plan assets permit, or the Trustees may provide for the transfer to a successor plan providing similar benefits to employees in the Plumbing and Pipe Fitting Industry. In no event shall any assets of the Plan or Trust Fund revert to a contributing employer.

B. Claims and Appeals

1. The procedures specified in Rule B.2. below and in Section VIII, and any supplemental procedures adopted by the Board of Trustees, shall be the sole and exclusive procedures available to any such individual who is dissatisfied with an eligibility determination or a benefit award, or who is adversely affected by any action of the Trustees, the Trust Fund Office or any other Plan fiduciary or agent, on matters within the discretion of the Board of Trustees. Except for matters which are assigned to the discretion of a provider, the Board of Trustees reserves full discretionary authority to interpret Plan language and to decide all claims or disputes regarding eligibility for benefits and the type, amount or duration of benefits.

2. Except as provided in Section VIII, if an employee, dependent, or other person considers that the action of the Trust Fund Office or any other agent of the Board, concerning the application of the terms of the Plan, is not in accordance with those terms, the aggrieved individual may appeal such action to the Board of Trustees under the following procedures. To be timely, an appeal must be submitted in writing, and must be received within 60 days of notification of such adverse action. Failure to appeal an adverse action within 60 days shall constitute a waiver of objections to the action. The Trustees, in their exclusive discretion, may allow any information to be presented, and/or allow the aggrieved individual to appear before them in person or to present witnesses. The Trustees shall decide the matter being appealed within a reasonable period of time, and present their decision to the appellant in writing in a manner calculated to be understood by him or her.

3. The decision of the Board of Trustees on any matter within its discretion shall be final and binding on all parties. A civil action arising from the denial of benefits must be filed within one year from the date on which the Board of Trustees provides notice that the claimant's appeal has been denied, regardless of any state or federal statutes establishing provisions relating to limitations of actions

C. Coordination of Benefits. If a contracted insurer or health maintenance organization has rules for coordination of benefits, those rules shall apply to benefits or care provided by that organization. If no such rule applies to a benefit received from the Plan, and if a covered employee or dependent is entitled to benefits from another group plan or a government plan, the benefits provided hereunder will be paid in accordance with standardized coordination of benefit provisions then approved by the National Association of Insurance Commissioners.

D. Rights of States.

1. Payment of benefits with respect to a participant shall be made in accordance with any assignment of rights made by or on behalf of such participant or beneficiary of a participant 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 a participant or beneficiary or in determining or making any payments for benefits of an individual as participant 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 shall 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 shall be in accordance with any state law which provides that the state has acquired rights with respect to a participant to such payment for such items or services.

E. Subrogation Rights of Plan. The Plan reserves the right to be reimbursed for any claim paid to an employee, retiree or dependent resulting from illness or injury caused by a third party, out of any recovery or any settlement received by the employee, retiree or dependent from the third party, but not in excess of the claim or claims actually paid from the Plan, or the premiums paid by the Plan. The Trustees may require, as a condition of payment of any claim hereunder, that an employee or eligible dependent agree in writing to reimburse the Plan out of any recovery or settlement. The Trustees also reserve the right to seek reimbursement from any party who may be liable for costs which were the basis of claims paid by the Plan. The Trustees may assert these rights regardless of any agreement between an employee or a dependent and any third party, and regardless of whether or not the employee or dependent were made whole. A participant or beneficiary is also subject to any subrogation provision of the rules of the HMO in which he or she is enrolled.

IN WITNESS of the adoption of these Formal Plan Rules as restated effective September 1, 2019, the Chairman and Co-Chairman hereby subscribe their names, on the date indicated.



Chairman

Date: 12/17/2019



Co-Chairman

Date: 12/19/19