

U. A. LOCAL NO. 159 HEALTH AND WELFARE PLAN

**SUMMARY PLAN DESCRIPTION
AND FORMAL PLAN RULES**

September 1, 2019

For Plan Information
Contact the Plan Administration Office:

HS&BA
4160 Dublin Blvd., Suite 400
Dublin, CA 94568
Phone: (925) 833-7300
Fax: (925) 833-7301

Summary of benefits begins on page 14.

Spanish-language benefit summaries begin on page 93.

Tablas de ventajas en español estan en la página 93.

Para obtener mas asistencia en servicios bilingües,
por favor llame a HS&BA al teléfono (925) 833-7300.

INTRODUCTION

Your union, U.A. Local No. 159, along with the participating employers and the Trustees of the U.A. Local No. 159 Health and Welfare Trust Fund, have worked together to provide you with a comprehensive health plan. This Plan covers active employees working in all types of employment under the collective bargaining agreements of U.A. Local No. 159, as well as qualified retired employees, signatory employers and their non-bargaining unit employees, and eligible dependents of all of the above. Regular coverage for active employees is entirely funded through employer contributions.

What does this booklet cover?

This booklet is the summary plan description of the Health and Welfare Plan as in effect on September 1, 2019. It includes a Summary of Eligibility Rules and a Summary of Benefits, describing all of the benefits available under the Plan. This booklet also includes the Formal Plan Rules, administrative information, and general information about your rights as a Plan participant.

No difference is intended between these summaries and the Formal Plan Rules, the contracts with the Plan service providers, or evidence of coverage documents ("service booklets") of the various providers. However, if any differences exist, the terms of the Formal Plan Rules, contracts, or service booklets govern. Copies of the contracts with Plan service providers, service booklets, the Trust Agreement and other documents governing the Plan, are available for inspection by a participant or beneficiary at the Trust Fund Office or Local Union during normal business hours, upon reasonable notice. A participant or beneficiary may also request, in writing to the Trust Fund Office, a copy of any Plan service provider contract, service booklet, or other Plan document, subject to payment of a copying charge.

Your Obligations under the Plan

Your eligibility for benefits, and the eligibility of your dependents, depends on timely enrollment of, and current information about, you and your dependents. Contact the Trust Fund Office, Health Services & Benefit Administrators, Inc. ("HS&BA"), whenever you acquire a new dependent, or when any of the following events occur:

- Change of name
- Change of address
- Change in marital status
- Change in beneficiary
- Change or addition of eligible dependents
- Member or dependent becoming eligible for Medicare.

PLAN SERVICE PROVIDERS INFORMATION

If you need further information about your eligibility status or your rights and duties under the Plan, or you want to file a claim for life, accidental death or dismemberment insurance, contact the Trust Fund Office at this address and phone number:

U. A. Local Union No. 159 Trust Funds
c/o HS&BA
4160 Dublin Blvd., Suite 400
Dublin, CA 94568
Phone: (866) 295-6402
Fax: (925) 833-7301

You may also request assistance with any aspect of the Plan from the Local Union:

U. A. Local No. 159
1308 Roman Way
Martinez, CA 94533
Phone: (925) 229-0400 or (800) 443-0220 (toll-free)
Fax: (925) 229-1101

If you need information or assistance concerning a particular provider, you may contact the provider directly, at the following addresses, phone numbers, or web sites:

Kaiser Permanente, Northern California Region 1800 Harrison Street, 6th Floor Oakland, CA 94612 (800) 464-4000 www.kponline.org (Group #31159)	Blue Shield of California 50 Beale Street San Francisco, CA 94105 (800) 393-6130 www.blueshieldca.com
Vision Service Plan, Customer Service Dept. 333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195 www.vsp.com (Group #12145043)	Delta Dental Plan of California P.O. Box 997330 Sacramento, CA 95899-7330 (800) 765-6003 www.deltadentalins.com (Group #01513)
UnitedHealthcare Insurance Company 680 Blair Mill Road Horsham, PA 19044 800-392-7537 Aarpmedsuppreirees.com (Group #1242)	CIGNA Group Insurance 1600 West Carson Street, Suite 300 Pittsburgh, PA 15219 (800) 362-4462 www.cigna.com (Life Policy #FLX961752) (AD&D Policy #OK961836)
Cigna Dental (800) 997-1654 my.cigna.com	

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HIGHLIGHTS OF THE PLAN

1. Benefits Available. The Plan provides the following types of benefits, through the Plan service providers listed below:

- Medical, hospital, surgical and prescription drug benefits are currently provided through one of two health maintenance organizations ("HMOs") Kaiser Permanente Health Plan or Blue Shield of California. Members who enroll in the Plan on or after January 1, 2012, and all Residential Specialists, may enroll only in Kaiser.
- Dental benefits are provided on an insured basis through Delta Dental Plan of California. Retiree dental benefits are provided through CIGNA Dental.
- Vision benefits are provided on an insured basis through Vision Service Plan.
- Life and Accidental Death & Dismemberment Insurance benefits are provided through CIGNA Group Insurance.
- Hearing benefits for active employees are currently provided through the HMO in which you are enrolled. The Plan also provides hearing benefits on a self-funded basis to members enrolled in an HMO which does not cover hearing aids.

2. Enrollment requirements. You must enroll in a Plan HMO, and comply with the HMO's rules, to be eligible for any medical, hospital, surgical or prescription drug benefits. Effective January 1, 2012, new members who enroll in the Plan, and all Residential Specialists, shall be enrolled in Kaiser, and must remain enrolled in Kaiser. At open enrollment, members who enrolled prior to January 1, 2012 may elect to enroll in either Kaiser or Blue Shield of California.

Be sure to enroll all of your dependents, or they will not be covered. Once you have enrolled in an HMO, you are automatically covered under the other benefits applicable to you.

New dependents must be enrolled within 30 days, or 60 days as applicable, to guarantee their right to immediate enrollment. For example, you must enroll a new spouse within 30 days of your marriage, and a new child within 30 days of his or her birth, adoption, etc. If you fail to enroll a dependent in a timely manner when you or the dependent is first eligible for benefits, your dependent may not be able to receive medical benefits until the next open enrollment. See pages 10-11 for more information about enrollment rights and requirements.

3. Election of Limited Coverage. Any active employee who has other group health coverage, which provides minimum value within the meaning of Internal Revenue Code Section 36B(c)(2)(C)(ii), may opt out of the medical benefits portion of the Plan, and get a \$6.00 per hour increase in contributions to the Defined Contribution Plan. If you make this election, you and your dependents will be eligible only for life and accidental death and dismemberment insurance benefits through the Plan. You will then be eligible to receive medical coverage from the Plan only when your other coverage terminates, or at the next open enrollment.

Please note that the increase in contributions to the Defined Contribution Plan applies only when you are working under the collective bargaining agreements of U.A. Local No. 159. It does not apply if you are working in another area and having contributions reciprocated here, or if you are a retiree, Individual Employer, or non-bargaining unit employee who has opted out of this Plan while covered under another group health plan.

4. Authority to act on behalf of the Board of Trustees. Only the Trust Fund Office is authorized to provide information about eligibility for benefits under the Plan, and about the benefits for which you qualify. Information from any other source, including the Local Union, a Trustee, or an employer, is not binding on the Plan. As a convenience, the Trust Fund Office may respond to oral requests, and the Local Union may provide assistance in utilizing your Plan benefits. However, only written responses from the Trust Fund Office or the Plan's Legal Counsel are the authorized responses of the Board of Trustees.

5. Right of Appeal. If you are dissatisfied with an action or decision of the Trust Fund Office or other agent of the Board of Trustees, you may appeal that action to the Board of Trustees. You must submit a written request for appeal of the unfavorable action to the Trust Fund Office, or you will be deemed to have waived your objections to it. See the section below entitled Summary of Claims and Appeals Rules for more details regarding how to file an appeal.

Limitation: Any civil action that you decide to file which arises from a denial of benefits must be filed within one year from the date that the Board of Trustees notifies you that your appeal has been denied.

Important Note Concerning Appeals: The Board of Trustees hears appeals only about eligibility issues and self-administered benefits, and not about determinations by Plan HMOs or other Plan service providers. Each of the Plan's HMOs and other Plan service providers has its own appeal procedures, which are described either in this booklet or in the respective service booklet of the HMO or other Plan service provider. Representatives of the Trust Fund Office or Local Union may help you with an appeal to an HMO or other Plan service provider, but such appeals are ultimately your own responsibility.

6. Reservation of Rights. The Board of Trustees has been conferred exclusive discretion, under the U. A. Local No. 159 Health and Welfare Trust Fund Trust Agreement, to establish and amend the plan(s) of the Trust Fund, in accordance with the procedures determined in the Trust Agreement. The Board of Trustees reserves the right to amend, modify, or discontinue all or part of the Plan and/or the contracts or policies under which benefits are provided, whenever, in its exclusive discretion, conditions so warrant. In no event shall any benefits provided under this Plan be deemed vested. Any amendments to the Formal Plan Rules, or changes to the contracts with Plan service providers, which are adopted by the Trustees after the publication of this booklet, supersede the summaries in this booklet.

7. Distribution on Termination. 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 or the Plan or Trust Fund revert to a contributing employer.

SUMMARY OF ELIGIBILITY RULES

Basic Eligibility Rules for Active Members

Whenever you perform an hour of covered employment under a collective bargaining agreement of U. A. Local No. 159, you receive one Hour of credit under the Plan's Hour Bank. This is true, regardless of whether you are working in commercial or industrial plumbing or residential plumbing, or as a residential specialist, so long as your employer is contributing the standard contribution for your classification of work. You also receive credit for hours worked under other U.A. collective bargaining agreements, through reciprocity, but your Hours are adjusted proportionally to reflect any difference between the actual contribution rate, and the standard rate then in effect for your classification of work.

To qualify for benefits as a new employee, you must perform 300 hours of covered employment in a six-month period. Once you have qualified for benefits, your Plan Hour Bank is charged a fixed amount each month for that month's coverage. Any excess Hour Bank credit is accumulated, up to a Maximum Hour Bank Amount, to be used when you have low hours of covered employment. The Plan's Monthly Charge is currently 130 Hours for a month's coverage for employees who are covered by Kaiser, and 140 Hours for a month's coverage for employees who are covered by Blue Shield of California. The Maximum Hour Bank Amount is currently six times the Monthly Charge (that is, 780 Hours for employees who are covered by Kaiser, and 840 Hours for employees who are covered by Blue Shield of California). These amounts are set by the Board of Trustees, who may change the Hour Bank rules from time to time, and may adjust the amounts of hours in participants' Hour Bank reserve accounts. If the Monthly Charge and/or Maximum Hour Bank Amount are changed, or if your Hour Bank is adjusted, you will be informed by the Trust Fund Office.

Your employer reports the hours you work each month in the following month, and they can be used to pay for coverage in the month after that ("the skip-month system"). For example, your hours of covered employment in January are reported in February, and are used to provide coverage in March. This may cause a delay in your initial eligibility or create a gap in coverage even after a month in which you worked the number of hours required to maintain coverage.

EXAMPLE 1: INITIAL ELIGIBILITY. Mike is a new member of Local No. 159. He must work 300 covered hours before he can qualify for benefits, at which time he will be enrolled in Kaiser. He works the following amounts of covered employment:

Work Month	Eligibility Month	Prior Hour Bank	Hours Worked	New Hour Bank Total	Hours Deducted for Kaiser	Eligibility Status	Ending Hour Bank Total
Jan	March	0	130	130	0	Ineligible	130
Feb	April	130	0	130	0	Ineligible	130
March	May	130	135	265	0	Ineligible	265
April	June	265	130	395	130	Eligible	265
May	July	265	145	410	130	Eligible	280
June	Aug	280	0	280	130	Eligible	150
July	Sept	150	40	190	130	Eligible	60

Mike worked 130 hours in January, 135 hours in March, and 130 hours in April. These hours will take his Hour Bank up to 395 Hours, which is more than the 300 hours required for initial coverage. Since his April hours are reported in May, he will be eligible for coverage effective the first day of the next month, June 1.

Each month the hours Mike worked in the previous month are added to his Hour Bank, and 130 hours are deducted to pay for coverage in the next month. After 130 hours are deducted from Mike's Hour Bank to pay for September coverage, he is left with an hour bank of 60. He will not qualify for October coverage unless he works at least 70 hours of covered employment in August.

Since the Maximum Hour Bank Amount is six times the Monthly Charge (currently 780 hours), Mike's Hour Bank will never be more than 780 hours, after work hours are added for the prior month and hours for next month's eligibility are subtracted.

Opting Out of Medical, Dental and Vision Coverage

Every active employee who is a member of Local 159 and who has other group health coverage, which provides minimum value within the meaning of Internal Revenue Code Section 36B(c)(2)(C)(ii), has the option of declining medical, dental and vision benefits. If you make this election, the following things will happen:

1. The only benefits for which you will be eligible are the Plan's life and accidental death or dismemberment insurance.
2. If you are working under a collective bargaining agreement of U. A. Local No. 159, you will receive an additional \$6 per hour contribution to the Defined Contribution Plan on your behalf. This additional \$6 per hour is not available through reciprocity.
3. Your Hour Bank will be frozen, unless it is under 300 Hours, in which case you will continue to accrue up to 300 Hours.

You may elect to become covered again either during the annual open enrollment period in July, or within 30 days of the termination of your other group health plan coverage. At that time, you must submit a new HMO enrollment form. Members who opt out may use their Hour Bank reserve to restore coverage when rejoining the Plan. However, if you do not have a sufficient Hour Bank reserve to pay for a month's coverage, you may self-pay for coverage for any months where you would have been eligible to make self-payments.

Special Disability Coverage

If you become disabled from working in the trade while you are eligible for benefits under the Hour Bank or Subsidized Self-Payment rules described below, you will remain eligible for 6 months of coverage for any one disability at no charge. After that, you will continue to be eligible by reason of your remaining Hour Bank credits, if any, and after that by means of subsidized self-payments for up to 6 months.

If you return to work after receiving this disability extension, you must earn a minimum of 3 months of Hour Bank coverage through active employment before you can be eligible for another disability extension, and you may not receive more than 18 months of such coverage during your lifetime.

Self-Payment and Reinstatement for Active Members

If you are on the Union's out-of-work list and are actually available for dispatch, or you are disabled and have exhausted the Special Disability Coverage, and your Hour Bank runs out, you are eligible to make self-payments for extended HMO and life insurance coverage. Subsidized self-paid coverage includes medical coverage and life and accidental death and dismemberment coverage only, but no dental or vision care benefits.

First, if you have some hours remaining in your Hour Bank to apply toward your last month of Hour Bank coverage, you may make a self-payment to make up for the missing hours for that one month of full coverage at the collective bargaining agreement contribution rate (that is, to bring your Hour Bank up to 130 hours if you are enrolled in Kaiser, or up to 140 hours if you are enrolled in Blue Shield of California).

After that, you may make subsidized self-payments for 6 months, if you continue to be disabled, or on the Local Union's out-of-work list and continuously available for dispatch.

Your plan coverage will be reinstated, if you work 130 hours for Kaiser coverage or 140 hours for Blue Shield of California coverage in the 12 months immediately following your termination of coverage. If your coverage is not reinstated within that 12-month period, your Hour Bank will be canceled, unless you have been on the Local Union's out-of-work list and continuously available for dispatch since your last month of coverage under the Plan. In that case, you may use any reserve in your Hour Bank to re-qualify for initial eligibility. If your Hour Bank has been cancelled, you may only be reinstated as a new employee, and must again meet the requirements for initial eligibility by accumulating a new Hour Bank of 300 hours in a 6-month period.

Other Special Eligibility Rules

Initial Eligibility for Newly Organized Employees. At the sole discretion of the Board of Trustees, a new member enrolled as part of an organizing drive sponsored by the Local Union may be granted 300 Hours credit upon completing the first 40 hours of covered employment. However, this grant is conditioned on the employee's continuing to be employed in covered employment. If a newly organized member leaves covered employment before working 300 hours, then his or her Hour Bank will be cancelled, even if the employee is not found to have committed misconduct. The benefits provided under this rule are limited to medical coverage, until the Employee has completed 300 hours of covered employment and qualifies for full benefits under the Plan.

Public Employees. There are special Hour Bank rules for persons who leave covered employment to work for a public agency that provides medical benefits which provide minimum value within the meaning of Internal Revenue Code Section 36B(c)(2)(C)(ii). If you take this type of job, and you notify the Trust Fund Office within 30 days, you may have your Hour Bank frozen. Then, when you leave that public employment, you may have your Hour Bank reinstated if: a) you either become employed in covered employment or registered for work (and actually available for work) through the Union's Hiring Hall, or retire, within 30 days; and b) you were a member in good standing of the Union for the entire period of your public employment.

EXAMPLE 2: SELF-PAYMENT AND REINSTATEMENT. Jim is a regular member of Local No. 159, who has established Kaiser coverage under the Plan. He worked 100 hours in November and his Hour Bank reserve is 300 hours. However, because overall work has slowed down, he works the following amounts of covered employment during the next 6 months:

Work Month	Eligibility Month	Prior Hour Bank	Hours Worked	New Hour Bank Total	Hours Deducted for Kaiser	Self-Payment	Ending Hour Bank Total
Nov	Jan	300	100	400	130	N/A	270
Dec	Feb	270	0	270	130	N/A	140
Jan	March	140	40	180	130	N/A	50
Feb	April	50	0	50	130	80	0

Based on current rates, Jim would be eligible for benefits in January, February and March at a "cost" of 130 hours for each month, leaving him with an Hour Bank reserve of 50 hours. In April, he does not have the required 130 hours to maintain coverage. He maintains coverage in April by making a partial self-payment to make up his shortage of 80 hours. His Hour Bank is then reduced to zero. For coverage in May, he must make a full self-payment, since he has 0 hours in his Hour Bank.

If Jim earns 130 hours of Hour Bank credit within twelve months of his last Hour Bank coverage, his coverage will be reinstated. If he does not earn 130 hours of Hour Bank credit within 12 months of his last Hour Bank coverage, he will have to re-qualify as a new employee, by working 300 hours of covered employment in a six-month period.

Coverage During Military Service

No person is covered who is in active military service in the Armed Forces of the United States. If you are called to active military service, you may elect to:

1. have your Hour Bank frozen, and terminate coverage of your dependents, on the first day of the month following your entry into active military service. (Under this option, you may choose to continue coverage for your dependents for up to 24 months under COBRA.);
2. continue coverage of your dependents at the normal monthly charge against your Hour Bank until it is exhausted. (Thereafter, you may choose to continue coverage for your dependents for up to 24 months under COBRA.); or
3. if you were covered under the Plan by reason of Hour Bank credit for at least 12 out of the 18 months immediately preceding your call to active military duty, continue coverage for your dependents, at one-half the Subsidized Self-Payment rate, until the earlier of 1) the end of your active military service, or 2) 24 months after your entry into active military service.

If you elect option 3, and you stop making the required payments or the 24-month period is exhausted, you may then elect options 1 or 2.

To make your election of one of the three options above, you must notify the Trust Fund Office of your call to active duty. If you do not give proper notice, you will be deemed to have elected option 2 above.

For additional information regarding reemployment after military service, see the Formal Plan Rules, Section I, Rule A.13.

Family and Medical Leave Act

If you work a qualifying number of hours for an employer who employs at least fifty employees, you may be eligible for a leave of absence under the Family and Medical Leave Act ("FMLA"). If the FMLA applies to your employer, your employer is responsible for making contributions for your coverage while you are on FMLA qualifying leave. FMLA leave may be taken because of the birth or placement of a son or daughter with you for adoption or foster care; to care for your spouse, son, daughter, or parent who has a qualifying "serious health condition"; because of your own qualifying "serious health condition"; because of a "qualifying exigency" related to service in the United States Armed Forces by your spouse, son, daughter, or parent; or if you are the spouse, son, daughter, parent or next of kin of a member of the United States Armed Forces who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness, to care for the service member. The definition of qualifying FMLA leave may change as the law is amended. Your Hour Bank, if you have one, will not be charged for coverage while you are on FMLA qualifying leave. If you believe this law applies to you, contact the Trust Fund Office for more information.

Dependent Eligibility

Your Eligible Dependents are generally covered whenever you are covered, if they have been properly enrolled. Your Eligible Dependents are your spouse or domestic partner, and your children, up to the Plan's limiting age, as described below.

For purposes of this rule, "children" means:

1. your natural children;
2. your stepchildren, foster children, children of your domestic partner, or children under your legal guardianship;
3. any minor child placed with you for the purpose of legal adoption, from the moment the child is placed in your physical custody, or from the moment you have 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.

The Plan also covers your natural or adopted children when you have been ordered to maintain their coverage in a court order called a "Qualified Medical Child Support Order" ("QMCSO") or equivalent. If the Plan receives a Medical Child Support Order, it will review it promptly to determine if it is qualified. The determination that an order is not a QMCSO is appealable to the Board of Trustees. The Plan procedures for review of QMCSOs are available free of charge from the Trust Fund Office.

For Plan Years beginning before January 1, 2014, no coverage is available to any dependent who is in full-time military service.

Limiting Age for Children

Children are covered until the end of the month in which they reach their 26th birthday for medical benefits, unless extended due to disability. Dependent children are covered for life insurance until their 19th birthday, unless they are full-time students and primarily supported by the Employee, in which case they are covered until their 25th birthday.

Exception for Disabled Dependents. Coverage for medical benefits may be extended after a child's 26th birthday, and coverage for life insurance may be extended after a child's 19th birthday, if he or she has a physical or developmental disability which began before coverage would otherwise have ended, and which makes him or her incapable of self-sustaining employment, so long as he or she remains disabled, unmarried and dependent on you for support and maintenance. Proof of the disability must be provided within 31 days of the termination of regular coverage of the child, and from time to time as requested by the Trust Fund Office, or the life insurance carrier, thereafter.

Enrollment of Dependents

New participants may enroll dependents when they first become eligible for benefits. After initial enrollment, if you acquire new dependents, to be certain that they become eligible as soon as

possible, you must enroll the dependents within 30 days of the birth, marriage, or other event which makes a dependent eligible. For example, if you get married, you must enroll your new spouse within 30 days of your marriage. If you have a newborn child, you must enroll the child within 30 days of birth.

If the event which caused you to have a new dependent was a birth, adoption, or placement for adoption, your new dependent becomes eligible on the date of the birth, adoption, or placement for adoption. If you have a new dependent because of your marriage or registration of a domestic partnership, your spouse or domestic partner becomes eligible for benefits on the first day of the month after he or she is properly enrolled as a dependent.

Failure to enroll a new dependent in a timely manner may result in your dependent not being eligible for medical benefits until the next open enrollment in July. The decision whether or not to allow late enrollment is up to your chosen medical plan, not the Board of Trustees.

Special Enrollment Rules:

1. If you have failed to enroll your spouse, and you have a newborn baby, your spouse may be enrolled within 30 days of the baby's birth along with the baby.
2. If you fail to enroll your eligible dependents because they have health coverage elsewhere, and coverage under that other plan ends, you may enroll your eligible dependents in health care coverage under this Plan. You must submit your enrollment form within 30 days of loss of coverage under the other plan, or at open enrollment.
3. If your dependent(s) are eligible but not enrolled for coverage in this Plan, your dependent(s) can be enrolled if: 1) your dependent(s)' Medicaid or State Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, or 2) your dependent(s) become eligible for employment assistance under Medicaid or CHIP. In order to benefit from this option, you must submit your enrollment form within 60 days of the termination from, or eligibility for, such assistance.

Termination of Dependent Status

If a dependent ceases to qualify as an Eligible Dependent under the Plan, either you or the dependent must contact the Trust Fund Office immediately. A dependent's right to COBRA coverage depends on providing timely notice to the Plan. See the section entitled "Your Rights Under COBRA" for more detailed rules of COBRA coverage.

If you die while covered as an active member under the Plan, your surviving spouse may elect to continue coverage at a reduced rate for herself or himself, and for the other eligible dependents who were covered at the time of your death. If you have no surviving spouse, your surviving eligible dependent children may elect to continue coverage at a reduced rate until the Plan limiting age applicable to each dependent. Other than this special continuation coverage for surviving dependents, the only coverage available to surviving spouses or surviving eligible dependents shall be through COBRA continuation coverage.

COBRA Continuation Coverage

In addition to the other forms of extended coverage discussed above, the Plan provides COBRA continuation coverage to any covered person who loses coverage due to a qualifying event. COBRA qualifying events include termination of employment or reduction of hours, death, divorce, loss of dependent status, or loss of coverage due to the member's entitlement to Medicare. If any of these events occur, contact the Trust Fund Office. See the section entitled "Your Rights Under COBRA" for more detailed rules of COBRA coverage.

Loss of Rights Due to Misconduct

Plan rules provide that all coverage, all Hour Bank credits, and all the special rights listed above are subject to loss by any Plan participant who works in either of the following situations:

1. The member works in the type of employment for which employers contribute to this plan, for an employer who does not contribute to a health and welfare trust fund affiliated with a local union of the United Association; or
2. The member works for an employer who is chronically or substantially delinquent in contributions to the Plan, after notification of the same by the Board of Trustees.

You may also lose your right to coverage from your selected HMO, if you commit misconduct as defined in its rules. If that occurs, you may not be eligible for medical benefits until the next open enrollment date, and you may not then be eligible to elect coverage from that HMO.

Eligibility of Retirees and their Dependents

A retired member of U. A. Local No. 159 is eligible to participate in the Plan if:

1. he or she was covered under the Hour Bank rules for at least 12 of the last 18 months before his or her retirement; and
2. he or she had accrued at least 10 Years of Vesting Credit under the U. A. Local No. 159 Defined Benefit Plan (or its prior plans); and
3. he or she is receiving a pension from the U. A. Local No. 159 Defined Benefit Plan; and
4. he or she is a member in good standing of the Union; and
5. if pre-Medicare, he or she resides within the service area of the Plan HMOs.

There are exceptions to the 12-months-coverage rule and/or the 10 Years of Vesting Credit rule for disabled participants, qualifying employees on the out-of-work list during the years 2009 through 2012, and employees of qualifying public employers. See the Formal Plan Rules, Section II, Rule A.1., for the complete rules.

Please note that if your benefits under the Defined Benefit Plan are suspended for working in Industry Service, your retiree benefits under the Health and Welfare Plan will also be terminated. If that occurs, you must requalify as a new retiree in order to receive benefits under this Plan again. The only exception to this requalification rule is for retirees who return to Industry Service during a certified period of full employment. Special rules govern retiree eligibility in that situation; information about those rules is provided to retirees whenever such a certified period of full employment is in effect.

Early retirees who live within the service areas of the Plan HMOs will receive medical benefits through one of the two Plan HMOs (Kaiser or Blue Shield). Medicare-eligible retirees may elect to receive medical benefits through the Kaiser Senior Advantage, if living within Kaiser's service area, or the AARP Medical Supplement Plan. To receive retiree coverage, you must pay a monthly premium determined by the Board of Trustees. You may have your premium deducted from your pension, so that your payments will always be on time.

The amount of your payment depends on your age when you retired, your Medicare status, and in some cases how long you were covered after retirement. These rates are subject to change from time to time by the Board of Trustees, to reflect the changing costs of coverage, and are also changed for each retiree when he or she qualifies for a new rate.

Retiree Hardship Reduction. To protect retirees from some of the impact of higher medical costs, the Trustees have adopted a Hardship Reduction for retirees with lower incomes. If a person qualifies for the Hardship Reduction, his or her monthly charge will not be raised above the amount that was charged prior to July 1, 2011. For a retiree to qualify for this benefit, his or her "total income" must not exceed \$1,650 per month if not married, or \$2,200 if married. If you receive a notice of an increase in your monthly payment, and you believe you may qualify for the Hardship Reduction, contact the Trust Fund Office.

In addition to medical benefits, participating retirees and their Eligible Dependents may elect and pay for dental benefits.

Dependents of Retiree Plan participants are eligible for medical benefits under the same eligibility rules as apply to dependents of active employees, except that no new dependents may be added after a participant's retirement. Surviving dependents of deceased retired employees are also eligible to elect coverage under the Retiree Plan, subject to payment of a monthly premium. Surviving dependents of retirees who were eligible for the Hardship Reduction may also continue to benefit from that Reduction, as long as they qualify.

Please note the following other rules of Retiree coverage:

1. Eligible retirees may elect to begin coverage under the Plan only upon retirement, upon becoming eligible for Medicare, or within 31 days of termination of other group health coverage in effect at retirement. If you do not elect coverage at one of these times, you may also elect to enroll in the Medicare-Risk program of a Plan HMO any time that it is available to you.
2. A covered retiree may suspend coverage if he or she later becomes covered under another group health plan, in which case you may rejoin at any of the times listed in the prior paragraph.

3. To be eligible in the Plan, all retirees must maintain their membership in good standing in the Union, continuously from retirement.
4. Medicare-eligible retirees and dependents must be enrolled in Medicare Parts A and B, and may be required to enroll in a Plan HMO's Medicare-Risk program as well.
5. Retiree care is not a vested right. The Trustees have reserved the right to terminate retiree coverage, and to change the eligibility rules and/or the conditions of retiree coverage such as the amount of the required monthly payment, for all participants, including already-enrolled retirees.

Individual Employers and Non-Bargaining Unit Employees

Qualifying Individual Employers and their non-bargaining unit employees are eligible to participate in the Plan, if certain conditions are satisfied. In order to participate, the Individual Employer must pay a monthly premium, representing the full cost of coverage, on behalf of the employer and all office employees who are not in a collective bargaining unit and who are not covered by another group health plan. See the Formal Plan Rules for complete rules regarding Individual Employer coverage.

Health Reimbursement Accounts (HRAs)

Beginning January 1, 2012, active employees working in covered employment earn credit in a Health Reimbursement Account (HRA), based on contributions made for that purpose. Effective July 1, 2012, covered active and retired employees may use their HRA accounts to pay certain Plan premiums and have qualified medical expenses reimbursed.

Eligible Plan Premiums:

1. Retirees who are receiving a pension benefit from the U. A. Local No. 159 Defined Benefit Plan and are enrolled for retiree welfare coverage under this Plan may use their HRA accounts to pay the monthly charge set by the Board of Trustees for retiree coverage.
2. Active employees who are on the Union's out-of-work list and are actually available for dispatch may use their HRA accounts to make self-payments for extended HMO and life insurance coverage.
3. Disabled employees who have exhausted their Special Disability Coverage may use their HRA accounts to make self-payments for extended HMO and life insurance coverage.
4. COBRA-eligible employees may use their HRA accounts to pay for COBRA.
5. After your death, your eligible dependents may use your HRA account to pay their COBRA premiums.

Qualified Medical Expenses

Active employees may use their HRA accounts to pay for qualified medical expenses which are not otherwise covered under the Plan. A qualified medical expense is any expense which qualifies as a deductible medical care expense under the Internal Revenue Code. A qualified expense may be incurred by you or by an eligible dependent, provided the dependent is one who may qualify as a dependent under the Code.

Examples of reimburseable medical expenses include: employee out-of-pocket expenses paid toward the annual plan deductible or required copayments, dental expenses above Plan limits, eye examinations or procedures not otherwise covered under the Plan, laboratory tests and services ordered by your doctor but not covered under the Plan, and chiropractor's fees above Plan limits.

Examples of non-reimburseable expenses include: elective cosmetic surgery, funeral expenses, health club fees, marriage counseling, smoking cessation devices, and non-prescription over-the-counter medications.

To receive reimbursement for qualified medical expenses, an employee or dependent must submit a Plan claim form, supporting documents and proof of payment. Benefits will be paid once per quarter.

An employee or retired employee may permanently opt out of and waive all future reimbursements from his or her HRA account annually and upon loss of eligibility for coverage. The HRA account of an employee who opts out will be forfeited.

The HRA account of an employee will also be forfeited under the following circumstances:

1. if the employee works for, or is, a non-signatory employer;
2. if the retired employee is no longer a member in good standing of the Union;
3. if the employee has a permanent break-in-service under the U.A. Local No. 159 Defined Benefit Plan; or
4. if an employee dies with no eligible dependents.

SUMMARY OF BENEFITS

MEDICAL BENEFITS

The Plan provides coverage for medically necessary hospital, medical, and surgical care, prescription drugs and related services and supplies through Kaiser Permanente Health Plan and Blue Shield of California, the Plan's designated health maintenance organizations ("HMOs"). On or after January 1, 2012, all new members enrolling in the Plan, and all Residential Specialists, will be enrolled in Kaiser.

Kaiser and Blue Shield of California have their own rules for coverage and co-payments. The complete rules for co-payments and coverage are explained in each HMO's booklet. A summary of the medical benefits currently provided under the HMOs is included on the following pages.

At open enrollment in July, eligible members will receive summaries of each HMO's benefits. A full set of enrollment documents for either HMO is also available at any time from the Trust Fund Office on request. Read your enrollment packages carefully whenever you have an option, because once your enrollment period passes, you may not change your choice of provider until the next open enrollment period.

The benefits provided by the Plan HMOs may change from time to time, at the discretion of the Board of Trustees. You will receive revised schedules of benefits each July at open enrollment, and whenever changes are adopted between open enrollments. Any schedules of benefits that you receive are considered part of this Summary Plan Description, so always keep the latest schedules with this booklet or with your other documents from your HMO.

Once you have enrolled in an HMO, you and your family will receive only the medical benefits available to members covered through that HMO. You are required to make all co-payments, and to comply with all of your HMO's rules, to remain eligible for benefits through the rest of the enrollment year.

WARNING: If you have not enrolled in one of the Plan's HMOs, or you violate your HMO's rules, you may not receive medical benefits from the Plan.

Reimbursement of Your Costs

The Plan's designated insurance carriers, Kaiser and Blue Shield of California, require you to pay a percentage of the cost of services through co-payments, after paying an annual deductible, up to your annual out-of-pocket maximum. If you are an active employee or a non-Medicare retiree, for claims incurred from January 1, 2013 through December 31, 2019, the U.A. Local No. 159 Health and Welfare Plan will reimburse you for out-of-pocket expenses which you incur and pay resulting from these required copayments. The reimbursements will be for expenses paid in excess of \$300 for an individual and \$600 for a family, up to your annual out-of-pocket maximum.

Summary of benefits begins on the next page.
Spanish-language benefit summaries begin on page 93.
Tablas de ventajas en español estan en la página 93.

A note regarding the Benefit Summaries on the following pages

The benefit tables which are included with this booklet summarize the general benefit rates, limitations, and conditions for particular kinds of care for the medical benefit options currently available under the Plan. The tables are summaries only, and do not describe in full any of the medical benefit options of the Plan. The tables are not intended to supersede the formal Evidence of Coverage (EOC) documents of the HMOs or other plan providers, which are binding contracts. If there is any discrepancy between a table and the EOC, the EOC prevails.

You are eligible only for the benefits of the medical benefits option in which you have properly enrolled, and only if you satisfy the conditions of payment of that option. Your dependents are eligible for benefits only of the medical benefits provider you elected, and only if they are properly enrolled. For more detailed information about the benefits available under any of the options available under the Plan, the conditions of treatment and/or payment, and the claims review and adjudication procedures, please refer to the Evidence of Coverage documents of the provider. A participant or beneficiary may inspect, without cost at the Trust Fund Office, the Evidence of Coverage document of any benefit option available to him or her, or request in writing a copy of the same, subject to a reasonable copying charge in certain cases.

MEDICAL COVERAGE OPTIONS FOR ACTIVE EMPLOYEES

Kaiser Permanente Deductible Plan (HMO) – Benefit Summary- Active Employees

The Services described below are covered only if all of the following conditions are satisfied:

- the Services are determined by Kaiser to be Medically Necessary;
- the Services are provided, prescribed, authorized, or directed by a Kaiser Plan Physician and you receive the Services from Kaiser Plan Providers inside Kaiser's Northern California Region Service Area (your Home Region), except where specifically noted to the contrary in the Evidence of Coverage (EOC) for authorized referrals, hospice care, Emergency Care, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services.

Annual Out-of-Pocket Maximum for Certain Services

For Services subject to the maximum, you will not pay any more Cost Share during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:

For self-only enrollment (a Family of one Member)\$3,000 per calendar year
 For any one Member in a Family of two or more Members\$3,000 per calendar year
 For an entire Family of two or more Members.....\$6,000 per calendar year

Annual Deductible\$300 per individual/\$600 per family
Annual or Lifetime Maximum None

Professional Services	You pay
Most primary care consultations, exams and treatment.....	\$20 per visit
Specialist care consultations, exams and treatment	\$40 per visit
Routine physical maintenance exams.....	No charge
Well-child preventive exams (through age 23 months).....	No charge
Family planning counseling and consultations.....	No charge
Scheduled prenatal care exams	No charge
Routine eye exams with a Plan Optometrist.....	No charge
Urgent care consultations, exams and treatment	\$20 per visit
Most physical, occupational and speech therapy.....	\$20 per visit*
Outpatient Services	You pay
Outpatient surgery & certain other outpatient procedures.....	20% copayment*
Allergy injection (including allergy serum)	No charge after deductible
Most immunizations (including the vaccine).....	No charge
Most X-rays and lab tests	\$10 per encounter
MRIs, CT, Pet scans.....	20% copayment up to \$50 maximum
Covered individual health education counseling.....	No charge
Covered health education programs	No charge

Kaiser - Active Employees (continued)

Hospitalization Services	You pay
Room and board, surgery, anesthesia, X-rays, lab tests and drugs	20% copayment*
Emergency Health Coverage	You pay
Emergency department visits	20% copayment*
Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient (see Hospitalization Services for inpatient Cost Sharing).	
Ambulance Services	You pay
Ambulance services.....	\$150 per trip*
Prescription Services	You pay
Covered outpatient items in accord with Kaiser's drug formulary guidelines:	
Most generic items from a Kaiser pharmacy	\$10 for up to a 30-day supply
Most generic refills for Kaiser's mail order service.....	\$20 for up to a 100-day supply
Most brand-name items from a Kaiser pharmacy.....	\$30 for up to a 30-day supply
Most brand name refills from Kaiser's mail order service.....	\$60 for up to a 100-day supply
Most specialty items at a Kaiser pharmacy.....	\$30 for up to a 30-day supply
Durable Medical Equipment (DME)	You pay
DME items as described in the EOC	20% copayment
Mental Health Services	You pay
Inpatient psychiatric hospitalization	20% copayment*
Individual outpatient mental health evaluation and treatment	\$20 per visit
Group outpatient mental health treatment	\$10 per visit
Substance Use Disorder Treatment	You pay
Inpatient detoxification.....	20% copayment*
Individual outpatient mental health evaluation and treatment	\$20 per visit
Group outpatient mental health treatment	\$5 per visit
Home Health Services	You pay
Home health care (up to 100 visits per calendar year)	No charge

Kaiser - Active Employees (continued)

Other	You pay
Skilled nursing facility care (up to 100 days per benefit period).....	20% copayment*
Prosthetic and orthotic devices as described in the EOC.....	No charge
Covered services for diagnosis and treatment of infertility.....	50% copayment
Hospice care	No charge
Chiropractic Services (limited to 20 visits per 12-month period).....	\$15 per visit
This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to Kaiser's EOC. Please note that Kaiser provides all benefits required by law (for example, diabetes testing supplies).	

* Subject to satisfaction of the annual deductible.

Blue Shield of California Access+ HMO – Benefit Summary - Active Employees **(Facility Deductible 30-30%/2000)**

This Summary of Benefits shows the amount you will pay for Covered Services. It is only a summary and is part of the contract for health care coverage called the Evidence of Coverage (EOC).¹

Access+ HMO Network. This Blue Shield plan uses a specific network of health care providers. Providers in this network are called Participating Providers.³ You must select a Primary Care Physician from this network to provide your primary care and help you access services, but there are some exceptions. Please review the EOC for details. You can find Participating Providers at blueshieldca.com.

General Features

Calendar Year Medical Deductible ²	\$2,000 per individual \$4,000 per family
Calendar Year Out-of-Pocket Maximum ⁴	\$3,500 per individual \$7,000 per family
Lifetime Benefit Maximum	None

Covered Services When Using a Participating Provider^{3,5}

You Pay

Office Visits - Primary care, specialist and other practitioner	\$30 per visit copayment
Access+ Specialist Benefits (self-referral)	\$45 per visit copayment
Outpatient X-ray, pathology and laboratory	No charge
Preventive Health Benefits ⁶	No charge
Outpatient Services (Hospital Benefits - Facility Services)	
Outpatient surgery at an Ambulatory Surgery Center	20% copayment
Outpatient surgery in a hospital	30% copayment
Outpatient Service for treatment of illness or injury, radiation therapy, chemotherapy and necessary supplies	No charge
Hospitalization Benefits (Hospital Benefits - Facility Services)	
Inpatient Non-Emergency Facility Services	30% copayment
Inpatient Physician Services	No charge
Emergency Room Facility Services (Copayment waived if admitted).....	\$150 copayment per visit
Emergency Room Physician Services	No charge
Urgent Care Services	\$30 per visit
Ambulance Services	\$100/transport
Prosthetics/Orthotics	No charge
Durable Medical Equipment	
Breast pump	No charge
Other Durable Medical Equipment.....	50% of allowed charges
Mental Health Benefits	
Inpatient Hospital Services	\$30% copayment
Outpatient Mental Health Services	\$30 per visit

Blue Shield - Active Employees (continued)

Covered Services When Using a Participating Provider^{3,5}

You Pay

Substance Use Disorder Benefits	
Inpatient Hospitalization	30% copayment
Physician-Outpatient Visits	\$30 per visit copayment
Partial Hospitalization/Day Treatment	No charge
Home Health Services	
Home Health Care Agency Services (up to 100 visits per year)	\$30 per visit
Medical Supplies	No charge
Skilled Nursing Facility (up to 100 days per Member per Benefit Period)	30% copayment
Hospice Program Services	No charge
Pregnancy and Maternity Care Office Visits ⁶	No charge
Family Planning and Infertility Benefits	
Counseling and Consulting.....	No charge
Infertility Services	50% of allowed charges
Tubal Ligation	No charge
Vasectomy	No charge
Rehabilitation Benefits (Physical, Occupational & Respiratory Therapy)	\$30 per visit
Speech Therapy	\$25 per visit
Hearing Aids	\$2000 allowance every 24 months
Allergy Testing and Treatments.....	\$30 per visit copayment
Allergy Serum.....	50% copayment
Diabetes Care Benefits	
Devices, Equipment and Non-Testing Supplies	20% of allowed charges
Diabetes Self-Management Training	\$30 per visit
Dialysis Services	No charge

Prescription Services

You Pay

Contraceptive drugs and devices	No charge
	\$15 formulary generic (Tier 1)
	\$30 formulary brand name (Tier 2)
Retail Pharmacy for up to a 30 day supply	\$45 non-formulary brand name (Tier 3)
	\$30 formulary generic (Tier 1)
	\$60 formulary brand name (Tier 2)
Mail Order for up to a 90 day supply	\$90 non-formulary brand name (Tier 3)
	20% copayment up to \$200 copayment maximum per prescription retail and
Tier 4 drugs	\$400 per prescription mail order
	20% copayment up to \$200 copayment maximum per prescription
Specialty drugs at Specialty Network Pharmacies	

Notes:**1 Evidence of Coverage (EOC):**

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this benefit Plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time. Defined terms are in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

2 Calendar Year Deductible (CYD):

A Deductible is the amount you pay each Calendar Year before Blue Shield pays for Covered Services under the benefit Plan. Some Covered Services received from Participating Providers are paid by Blue Shield before you meet any Calendar Year medical Deductible.

Family Coverage has an individual Deductible within the Family Deductible. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year.

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met. You will pay the Copayment or Coinsurance applicable to Participating Providers for Covered Services received from Other Providers. However, Other Providers do not have a contract to provide health care services to Members and so are not Participating Providers. Therefore, you will also pay all charges above the Allowable Amount. This out-of-pocket expense can be significant.

4 Calendar Year Out-of-Pocket Maximum (OOPM):

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges above a Benefit maximum.

Essential health benefits count towards the OOPM.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the medical Calendar Year Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year.

5 Separate Member Payments When Multiple Covered Services are received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit Copayment in addition to an allergy serum Copayment when you visit the doctor for an allergy shot.

6 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

Benefit Plans may be modified to ensure compliance with State and Federal requirements.

MEDICAL COVERAGE OPTIONS FOR RETIREES UNDER AGE 65

Kaiser Permanente Health Plan (HMO) – Benefit Summary

The Services described below are covered only if all of the following conditions are satisfied:

- the Services are determined by Kaiser to be Medically Necessary;
- the Services are provided, prescribed, authorized, or directed by a Kaiser Plan Physician and you receive the Services from Kaiser Plan Providers inside Kaiser's Northern California Region Service Area (your Home Region), except where specifically noted to the contrary in the Evidence of Coverage (EOC) for authorized referrals, hospice care, Emergency Care, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services.

Annual Out-of-Pocket Maximum for Certain Services

For Services subject to the maximum, you will not pay any more Cost Share during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:

For self-only enrollment (a Family of one Member)\$1,500 per calendar year
 For any one Member in a Family of two or more Members\$1,500 per calendar year
 For an entire Family of two or more Members.....\$3,000 per calendar year

Deductible or Lifetime Maximum None

Professional Services	You pay
Most primary and specialty care visits:	\$20 per visit
Routine physical maintenance exams.....	No charge
Well-child preventive exams (through age 23 months).....	No charge
Family planning counseling and consultations.....	No charge
Scheduled prenatal care exams.....	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations and treatment	\$20 per visit
Most physical, occupational and speech therapy.....	\$20 per visit
Outpatient Services	You pay
Outpatient surgery & certain other outpatient procedures.....	\$20 per procedure
Allergy injection (including allergy serum)	\$3 per visit
Most immunizations (including the vaccine).....	No charge
Most X-rays and lab tests	No charge
Covered individual health education counseling.....	No charge
Covered health education programs	No charge
Hospitalization Services	You pay
Room and board, surgery, anesthesia, X-rays, lab tests and drugs.....	\$250 per admission

Kaiser - Early Retirees (continued)

Emergency Health Coverage	You pay
Emergency department visits	\$100 per visit
Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient (see Hospitalization Services for inpatient Cost Share.)	
Ambulance Services	You pay
Ambulance services.....	No charge
Prescription Services	You pay
Covered outpatient items in accord with Kaiser's drug formulary guidelines:	
Most generic items from a Kaiser pharmacy	\$10 for up to a 30-day supply
Most generic refills for Kaiser's mail order service.....	\$20 for up to a 100-day supply
Most brand-name items from a Kaiser pharmacy	\$20 for up to a 30-day supply
Most brand name refills from Kaiser's mail order service	\$40 for up to a 100-day supply
Most specialty items at a Kaiser pharmacy	\$20 for up to a 30-day supply
Durable Medical Equipment (DME)	You pay
DME items as described in the EOC	No charge
Mental Health Services	You pay
Inpatient psychiatric hospitalization	\$250 per admission
Individual outpatient evaluation and treatment	\$20 per visit
Group outpatient treatment.....	\$10 per visit
Substance Use Disorder Treatment	You pay
Inpatient detoxification.....	\$250 per admission
Individual outpatient evaluation and treatment	\$20 per visit
Group outpatient treatment.....	\$5 per visit
Home Health Services	You pay
Home health care (up to 100 visits per calendar year)	No charge

Kaiser - Early Retirees (continued)

Other	You pay
Hearing aids (every 36 months)	Amount in excess of \$500 Allowance per aid
Skilled nursing facility care (up to 100 days per benefit period).....	\$250 per admission
Prosthetic and orthotic devices as described in the EOC.....	No charge
Hospice care	No charge
This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to Kaiser's EOC. Please note that Kaiser provides all benefits required by law (for example, diabetes testing supplies).	

Blue Shield of California Access+ HMO – Benefit Summary - Retirees Under Age 65 **(Facility Coinsurance 20-20%)**

This Summary of Benefits shows the amount you will pay for Covered Services. It is only a summary and is part of the contract for health care coverage called the Evidence of Coverage (EOC).¹

Access+ HMO Network. This Blue Shield plan uses a specific network of health care providers. Providers in this network are called Participating Providers.³ You must select a Primary Care Physician from this network to provide your primary care and help you access services, but there are some exceptions. Please review the EOC for details. You can find Participating Providers at blueshieldca.com.

General Features

Calendar Year Medical Deductible ²	None
Calendar Year Out-of-Pocket Maximum ⁴	\$2,500 per individual \$5,000 per family
Lifetime Benefit Maximum	None

Covered Services Using a Participating Provider^{3,5}

You Pay

Office Visits - Primary care and specialist	\$20 per visit copayment
Access+ Specialist Benefits	\$35 per visit copayment
Outpatient X-ray, pathology and laboratory	No charge
Preventive Health Benefits ⁶	No charge
Outpatient Services (Hospital Benefits - Facility Services)	
Outpatient surgery at an Ambulatory Surgery Center.....	10% copayment
Outpatient surgery in a hospital	25% copayment
Outpatient Service for treatment of illness or injury, radiation therapy, chemotherapy and necessary supplies	No charge
Hospitalization Benefits (Hospital Benefits - Facility Services)	
Inpatient Non-Emergency Facility Services	\$100 per admission plus 20% copayment
Inpatient Physician Services	No charge
Emergency Room Facility Services (Copayment waived if admitted)...	\$150 copayment per visit
Emergency Room Physician Services	No charge
Urgent care center services.....	\$20 per visit copayment
Ambulance Services	\$100 per transport
Prosthetics/Orthotics	No charge
Durable Medical Equipment	
Breast pump	No charge
Other Durable Medical Equipment	50% of allowed charges
Mental Health Services	
Inpatient Hospital Services	\$100 per admission plus 20% copayment
Outpatient Mental Health Services	\$20 per visit copayment

Blue Shield - Early Retirees (continued)

Substance Use Disorder Benefits	\$100 per admission plus 20% copayment
Inpatient Hospitalization	
Outpatient Visits	\$20 per visit copayment
Home Health Services	
Home Health Care Agency Services (up to 100 visits per year)	\$20 per visit copayment
Medical Supplies	No charge
Skilled Nursing Facility Services (up to 100 visits per Member per Calendar Year)	20% copayment
Hospice Program Services	No charge
Pregnancy and Maternity Care Office Visits ⁶	No charge
Family Planning and Infertility Benefits	
Counseling and Consulting	No charge
Infertility Services	50% of allowed charges
Tubal Ligation	No charge
Vasectomy	No charge
Rehabilitation Benefits (Physical, Occupational & Respiratory Therapy)	\$20 per visit copayment
Speech Therapy	\$20 per visit copayment
Hearing Aids	\$2000 allowance every 24 months
Allergy Testing and Treatments	\$20 per visit copayment
Allergy Serum.....	50% copayment
Diabetes Care Benefits	
Devices, Equipment and Non-Testing Supplies	20% of allowed charges
Diabetes Self-Management Training	\$20 per visit
Dialysis Services	No charge

Prescription Services

You Pay

Contraceptive drugs and devices	No charge
	\$10 formulary generic (Tier 1)
	\$20 formulary brand name (Tier 2)
Retail Pharmacy for up to a 30 day supply	\$35 non-formulary brand name (Tier 3)
	\$20 formulary generic (Tier 1)
	\$40 formulary brand name (Tier 2)
Mail Order for up to a 90 day supply	\$70 non-formulary brand name (Tier 3)
	20% copayment up to \$200 copayment maximum per prescription retail and \$400 per prescription mail order
Tier 4 drugs	
Specialty Drugs at Specialty Pharmacies	20% copayment up to \$200 copayment maximum per prescription

Notes:

1 Evidence of Coverage (EOC):

The Evidence of Coverage (EOC) describes the Benefits, limitations, and exclusions that apply to coverage under this benefit Plan. Please review the EOC for more details of coverage outlined in this Summary of Benefits. You can request a copy of the EOC at any time. Defined terms are in the EOC. Refer to the EOC for an explanation of the terms used in this Summary of Benefits.

Blue Shield - Early Retirees (continued)

2 Calendar Year Deductible:

A Deductible is the amount you pay each Calendar Year before Blue Shield pays for Covered Services under the benefit Plan.

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met. You will pay the Copayment or Coinsurance applicable to Participating Providers for Covered Services received from Other Providers. However, Other Providers do not have a contract to provide health care services to Members and so are not Participating Providers. Therefore, you will also pay all charges above the Allowable Amount. This out-of-pocket expense can be significant.

4 Calendar Year Out-of-Pocket Maximum (OOPM):

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges above a Benefit maximum.

Essential health benefits count towards the OOPM.

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year.

5 Separate Member Payments When Multiple Covered Services are received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit Copayment in addition to an allergy serum Copayment when you visit the doctor for an allergy shot.

6 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

Benefit Plans may be modified to ensure compliance with State and Federal requirements.

MEDICAL COVERAGE OPTIONS FOR RETIREES AGE 65 AND OLDER

Retirees age 65 and older must enroll in Medicare Parts A and B, and may choose between the two options for medical coverage below. To choose Kaiser, you must live within Kaiser's service area.

Kaiser Permanente Senior Advantage (HMO) With Part D (a Medicare Advantage plan)

Annual Out-of-Pocket Maximum for Certain Services

For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:

For self-only enrollment (a Family of one Member)\$1,500 per calendar year
 For any one Member in a Family of two or more Members\$1,500 per calendar year
 For an entire Family of two or more Members.....\$3,000 per calendar year

Deductible or Lifetime Maximum None

Professional Services	You pay
Most primary and specialty care visits	\$20 per visit
Annual Wellness Visit and Welcome to Medicare Exam.....	No charge
Routine eye exams with a Plan Optometrist.....	No charge
Urgent care consultations, evaluations and treatment	\$20 per visit
Physical, occupational and speech therapy.....	\$20 per visit
Outpatient Services	You pay
Outpatient surgery & certain other outpatient procedures.....	\$20 per procedure
Allergy injection (including allergy serum).....	\$3 per visit
Most immunizations (including vaccine)	No charge
Most X-rays, annual mammograms and lab tests	No charge
Manual manipulation of the spine	\$20 per visit
Hospitalization Services	You pay
Room and board, surgery, anesthesia, x-rays, lab tests and drugs	\$250 per admission
Emergency Health Coverage	You pay
Emergency department visits.....	\$50 per visit
Ambulance Services	You pay
Ambulance services.....	No charge

Kaiser - Retirees Age 65 and Older (continued)

Prescription Services	You pay
Covered outpatient items in accord with Kaiser's drug formulary guidelines: Most generic items from a Kaiser pharmacy	\$10 for up to a 30-day supply; \$20 for a 31- to 60-day supply; or \$30 for a 61- to 100-day supply
Most generic refills for Kaiser's mail order service.....	\$10 for up to a 30-day supply or \$20 for a 31- to 100-day supply
Most brand-name items from a Kaiser pharmacy	\$20 for up to a 30-day supply; \$40 for a 31- to 60-day supply; or \$60 for a 61- to 100-day supply
Most brand name refills from Kaiser's mail order service.....	\$20 for up to a 30-day supply or \$40 for a 31- to 100-day supply
Durable Medical Equipment (DME)	You pay
Covered DME for home use	No charge
Mental Health Services	You pay
Inpatient psychiatric hospitalization	\$250 per admission
Individual outpatient mental health evaluation and treatment	\$20 per visit
Group outpatient mental health treatment	\$10 per visit
Substance Use Disorder Treatment	You pay
Inpatient detoxification.....	\$250 per admission
Individual outpatient evaluation and treatment	\$20 per visit
Group outpatient treatment.....	\$5 per visit
Home Health Services	You pay
Home health care (part-time, intermittent)	No charge

Kaiser - Retirees Age 65 and Older (continued)

Other	You pay
Eyeglasses or contact lenses every 24 months	Amount in excess of \$150 Allowance
Hearing aids (every 36 months)	Amount in excess of \$500 Allowance per aid
Skilled nursing facility care (up to 100 days per benefit period).....	No charge
External prosthetic devices, orthotic devices, and ostomy and urological Supplies	No charge
Ostomy and urological supplies	No charge
This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For more information, please refer to Kaiser's EOC.	

UnitedHealthCare – AARP Medicare Supplement Insurance Plan N (a Medigap or Medicare Supplement Plan)

MEDICARE PART A: HOSPITAL SERVICES PER BENEFIT PERIOD FOR 2019*

Service	Period	Medicare Pays	Plan N Pays	You Pay
Hospitalization* (Semiprivate room and board, general nursing, misc. services and supplies)	First 60 days	All but \$1,364	\$1,364	\$0
	Days 61-90	All but \$341/day	\$341/day	\$0
	Days 91 & later while using 60 lifetime reserve days	All but \$682/day	\$682/day	\$0
	After lifetime reserve is used, an additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
	Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care*	First 20 days	All approved amounts	\$0	\$0
	Days 21-100	All but \$170.50/day	Up to \$170.50/day	\$0
	Days 101 & later	\$0	\$0	All costs
Blood	First 3 pints	\$0	3 pints	\$0
	Additional amounts	100%	\$0	\$0
Hospice Care		All but very limited copayment for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** When your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

UnitedHealthcare - AARP Medicare Supplement Insurance Plan N (continued)

MEDICARE PART B: MEDICAL SERVICES PER CALENDAR YEAR FOR 2019

Service	Period	Medicare Pays	Plan N Pays	You Pay
Medical Expenses (Treatment in or out of the hospital and outpatient hospital treatment)	First \$185* of approved amounts	\$0	\$0	\$185 deductible
	Remainder of approved amounts	Generally 80%	Balance, other than copayment	\$20 per office visit; up to \$50 per emergency room visit**
	Preventive Benefits for Medicare-covered services	Generally 75% or more of Medicare-approved amounts	Balance, other up to \$20 per office visit	Up to \$20 per office visit
Excess Charges	Amounts above approved amounts	\$0	\$0	All costs
Blood	First 3 pints	\$0	All costs	\$0
	Next \$140 of approved amounts	\$0	\$0	\$185 deductible
	Remainder of approved amounts	80%	20%	\$0
Clinical Laboratory Services	Test for diagnostic services	100%	\$0	\$0

* Once you have been billed \$185 of Medicare-approved amounts, your Part B deductible is met for the calendar year.

** The emergency room copayment is waived if you are admitted to the hospital and the visit is covered as a Medicare Part A expense.

PARTS A AND B

Service	Period	Medicare Pays	Plan N Pays	You Pay
Home Health Care	Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable Medical Equipment	First \$185 of approved amounts	\$0	\$0	\$185 deductible
	Remainder of approved amounts	80%	20%	\$0

UnitedHealthcare - AARP Medicare Supplement Insurance Plan N (continued)

BENEFITS NOT COVERED BY MEDICARE

Service	Period	Medicare Pays	Plan N Pays	You Pay
Foreign Travel (Necessary emergency care services)	First \$250 each calendar year	\$0	\$0	\$250
	Remainder of approved amounts	\$0	80% to a lifetime max. of \$50,000	20% and amounts over the max.

For other benefits available under the AARP Medicare Supplement Insurance Plan N, see your enrollment kit or call 1-800-392-7537.

INFORMATION ABOUT PARTICULAR MEDICAL BENEFITS

Maternity Benefits Under the Newborn and Mothers Health Protection Act

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

Mastectomy Benefits Under the Women's Health and Cancer Rights Act

In accordance with Federal law, women who have had a medically necessary mastectomy are entitled to coverage for:

1. all stages of reconstruction of the breast on which the mastectomy was performed; and
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prostheses; and
4. treatment of any physical complication of mastectomy, including lymphedemas.

The care covered under these rules is subject to the standard co-payment or co-insurance requirements which apply to other medical and hospital coverage provided by the plan in which the patient is enrolled.

Preventive Services

Benefits will be provided for the following preventive services: (a) evidence-based items or services that have in effect a rating of A or B in the current commendations of the United States Preventive Services Task Force with respect to the individual involved; (b) immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Centers for Disease Control and Prevention with respect to the individual involved; (c) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and (d) with respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

DENTAL BENEFITS

The Plan provides coverage for dental care through Delta Dental Plan of California, for covered active employees, Individual Employers, and non-bargaining unit participants, and their Eligible Dependents.

Eligible retirees may elect retiree dental coverage for themselves and their Eligible Dependents by paying the applicable charge. Retiree coverage is provided through Cigna Dental.

The Delta Dental plan is a fee-for-service plan. It has contracts with over 90% of the dentists in California. The Delta Dental plan sets both the total fee for any service, and the portion that you have to pay, up to the maximum benefit for a plan year. Dental benefits are not provided to retired participants, unless they elect and pay for such coverage through Cigna Dental, or to those active participants who elect Limited Coverage or who are on Self-Payment. Booklets are provided by Delta from time to time; see the latest Delta booklet for this Plan for more information about the benefits currently in effect.

Briefly, the Delta Dental Plan in effect as of the publication of this booklet provides for payment of 80% of covered charges for each eligible participant for Basic Dental and Prosthodontic care, and 50% of covered charges for Orthodontic care, subject to the Service Limitations and Exclusions. Benefits are limited to \$2,500 annually. Lifetime payments for Orthodontic Benefits are limited to \$2,000 per person. The table below summarizes the dental benefits available under the Plan:

BENEFITS	COPAYMENT
Professional Services provided by a Delta Dental PPO Dentist	
Diagnostic and Preventive	No charge
Other Basic Services	20%
Prosthodontics	20%
Crowns and Cast Restorations	20%
Othodontics	50%

How to Use Your Program

During your first appointment, tell your dentist that you are a participant in the U. A. Local No. 159 Health and Welfare Plan, Delta Dental Group No. 01513, and give the participating employee's Social Security number for identification purposes. Dependents should also use the participant's group number and Social Security number.

Be sure to advise your dentist of all programs under which you have dental coverage and have the dentist complete the Dual Coverage portion of the Attending Dentist's Statement, so that you will

receive all benefits to which you are entitled. For further information, contact the Delta Benefit Services Department.

Predeterminations

After an examination, your dentist will talk to you about treatment you may need. The cost of treatment is something you may want to consider. If the service is extensive and involves crowns or bridges, or if the service will cost more than \$300, your dentist should request a predetermination.

A predetermination does not guarantee payment. It is an estimate of the amount Delta Dental will pay if you are eligible and meet all the requirements of your plan at the time the treatment you have planned is completed.

In order to receive predetermination, your dentist must send a claim form listing the proposed treatment. Delta Dental will send your dentist a Notice of Predetermination which estimates how much you will have to pay. After you review the estimate with your dentist and decide to go ahead with the treatment plan, your dentist returns the form to Delta Dental for payment when treatment has been completed.

Reimbursement Provisions

A Delta Dental Dentist will file the claim for you. You do not have to file a claim or pay Delta Dental's co-payment for covered services if provided by a Delta Dental Dentist.

If the covered service is provided by a dentist who is not a Delta Dental Dentist, you are responsible for filing the claims and paying your dentist. Claims should be filed with Delta Dental of California at P.O. Box 997330, Sacramento, CA 95899-7330 and Delta Dental will reimburse you. However, if for any reason Delta Dental fails to pay a dentist who is not a Delta Dental Dentist, you may be liable for that portion of the cost.

Claims Appeal Procedure

If you have any questions about the services received from a Delta Dental Dentist, you may call or write Delta Dental. Delta Dental will provide notifications if any dental services or claims are denied, in whole or part, stating the specific reason or reasons for denial. If you have any question or complaint regarding the denial of dental services or claims, the policies, procedures and operations of Delta Dental, or the quality of dental services performed by a Delta Dental Dentist, you may call us toll-free at 800-765-6003, contact us on our website at: deltadentalins.com or write us at P.O. Box 997330, Sacramento, CA 95899-7330, Attention: Customer Service Department. For a complete description of Delta Dental's appeal procedures, see the Delta Dental Evidence of Coverage, or call Delta at 800-765-6003.

VISION CARE BENEFITS

Vision Care Benefits are provided to all covered active employees (except those who elect Limited Coverage or who are on Self-Payment), Individual Employers and non-bargaining unit employees, and Eligible Dependents of the above. Benefits are provided on an insured basis by Vision Service Plan. Benefits are also provided to retirees and their Eligible Dependents, if they are enrolled in either Kaiser or Blue Shield through this Local 159 Plan. Benefits for retirees and their Eligible Dependents are provided through VSP if they reside within the service area of the Plan. The following is a brief outline of the benefits available under the VSP contract, and is not to be accepted or construed as a substitute for the provisions of the contract. For a complete description of VSP's benefits, limitations, exclusions and appeals procedures, see the VSP Evidence of Coverage

BENEFITS PROVIDED

Participating Providers: The Plan provides benefits when you go to an Ophthalmologist, Optician, or Optometrist who is on the Vision Service Plan panel of participating providers, for the following services and supplies:

Benefits	Copayment
Examination	No charge. One examination is covered every 12 months.
Lenses	No charge. One pair of single vision, lined bifocal or lined trifocal lenses is covered every 24 months
Frame	Covered up to the Plan allowance of \$150 per frame for a wide selection of frames, up to \$170 for featured frame brands. One frame is covered every 24 months.
Contact Lenses*	Benefits are limited to \$130 per pair. One pair is covered, in lieu of a frame and lenses, every 24 months.

* If contact lenses are medically necessary, they are a fully covered benefit. A report from the eye care specialist is required.

Non-Participating Providers: If covered services and/or materials are provided by a non-participating Ophthalmologist, Optician, or Optometrist, charges will be paid, but not to exceed the following Schedule of Allowances:

Benefits	Allowances
Exam	\$ 45.00
Lenses (per pair): Single Vision..... Bifocal..... Trifocal..... Lenticular	\$ 30.00 \$ 50.00 \$ 65.00 \$100.00
Contact Lenses (per pair): Medically necessary..... Elective	\$210.00 \$105.00
Frame	\$ 70.00 (wholesale price)

Benefit frequencies and deductibles are the same as listed under the participating provider section.

How to Use Vision Service Plan

1. Find a participating doctor. If you want to confirm that your doctor participates in VSP, or you want to find a VSP doctor, call VSP at (800) 877-7195, or go to the VSP website, www.VSP.com.
2. Call the participating VSP doctor's office for an appointment. Be sure to tell them that you are a VSP member. You must provide the participating employee's Social Security number and the name of the group, which is the U. A. Local No. 159 Health and Welfare Trust Fund. The doctor then obtains an authorization from VSP.
3. Go to your appointment. If eye wear is necessary, the doctor will order it from a VSP-contracted laboratory. You are responsible for deductibles, co-payments and any additional charges for cosmetic options or non-covered services or supplies. The doctor will bill you for these charges, and will submit the necessary claim forms to VSP for the covered charges.

Limitations and Exclusions

Some brands of frames may not be covered or may be subject to additional limitations. You may obtain details regarding frame brand availability from your VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

VSP covers visual needs rather than cosmetic materials. If you select cosmetic options, such as anti-reflective coatings, color coatings, blended lenses, or oversized lenses, VSP will cover the basic cost of the allowed lenses or frames, and you will be responsible for the additional costs for the options, unless the extra is defined as a plan benefit.

For a complete description of VSP's limitations and exclusions, see the VSP Evidence of Coverage, or call VSP's Customer Care Division at (800) 877-7195.

Complaints and Appeals

If you have a complaint regarding VSP service or claim payment, you may contact the VSP Customer Service Department toll free, at 800-877-7195, or in writing at 3333 Quality Drive, Rancho Cordova, CA 95670.

For a complete description of VSP's appeals procedures, see the VSP Evidence of Coverage, or call VSP's Customer Care Division at (800) 877-7195.

HEARING BENEFITS

The Plan provides hearing benefits, including examinations and hearing aids, on a self-funded basis, administered by the Trust Fund Office, to members enrolled in an HMO which does not cover hearing aids. These benefits are provided to active and retired employees and their Eligible Dependents.

Under the Plan's hearing coverage, one hearing examination is covered every twelve months, and one device is covered every three years. 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. The table below summarizes the hearing benefits available under the Plan.

Benefits	Copayment
Examination and devices	Your copayment is 20% of the billed charge, after payment of a \$100 deductible per individual per year, up to a maximum Plan payment of \$800 per device, and \$1600 in any 36 month period.

INSURANCE BENEFITS

The Plan provides life insurance and accidental death and dismemberment insurance through CIGNA Group Insurance. Life insurance benefits are provided for all active employees, Individual Employers, and non-bargaining unit employees, and their eligible dependents (as described below). Life insurance benefits are also provided to active employees who elect Limited Coverage, and to active employees on subsidized Self-Payment. Accidental death and dismemberment benefits are provided for employees only, not dependents.

Life Insurance for Active Employees and Dependents Only (Policy #FLX961752)

Employee Benefits

This Plan insures an eligible employee in the amount of \$50,000 payable in full to the designated beneficiary in the event of death from any cause, on the job or off, while insured.

The amount of insurance is reduced after your age 65, as follows:

Age 65-69:	65% of life insurance benefit;
Age 70-74:	45% of life insurance benefit;
Age 75-79:	30% of life insurance benefit;
Age 80 and over:	20% of life insurance benefit.

Terminal Illness Benefit: The Plan pays 50% of the life insurance benefit in effect on the date the employee is determined by the Insurance Company to be terminally ill, subject to a maximum benefit of \$25,000. The remainder of the life insurance benefit is paid upon the death of the employee.

Dependent Benefits

The Plan includes life insurance for dependents. If an insured dependent dies, the amount of insurance then in effect on the life of that dependent will be paid to the employee as beneficiary.

Spouse or Domestic Partner to Age 70 \$10,000

Terminal Illness Benefit: The Plan pays 50% of the life insurance benefit in effect on the date the spouse or domestic partner is determined by the Insurance Company to be terminally ill. The remainder of the life insurance benefit is paid upon the death of the spouse or domestic partner.

Children (6 months of age until 19th birthday, unless extended) \$5,000

Children under 6 months of age.....\$500

Life insurance coverage is extended for children after their 19th birthday, if:

- (a) they are full-time students and primarily supported by the Employee, until their 25th birthday; and
- (b) they are primarily supported by the Employee and incapable of self-sustaining employment by reason of physical or mental disability.

Continuation of Insurance

If an employee is no longer in active service, he or she may be eligible to continue life insurance, subject to certain rules. See the CIGNA policy for the complete rules.

Accidental Death & Dismemberment - Active Employees Only (Policy #OK961836)

An eligible employee is insured for \$50,000 against death or dismemberment in an accident, on the job or off.

- If an employee is killed in an accident, or dies within 365 days as a result of accident, the beneficiary will be paid \$50,000, in addition to the \$50,000 to be paid under the life insurance benefit, or
- If an employee accidentally suffers the loss of two or more hands or feet, or the sight of both eyes or one hand or one foot and sight in one eye, or loss of speech and hearing (in both ears), or quadriplegia, or coma, within 365 days of the accident, the benefit is \$50,000, or
- If an employee accidentally suffers the loss of one hand, or one foot, or the sight of one eye, or the loss of speech, or the loss of hearing in both ears, or paraplegia, within 365 days of the accident, the benefit is \$25,000, or
- If an employee accidentally suffers the loss of four fingers of the same hand, or one thumb and one index finger of the same hand, or all of the toes of the same foot, or uniplegia, within 365 days of the accident, the benefit is \$12,500.

The amount of insurance is reduced after your age 65, as follows:

Age 70-74:	65% of insurance benefit;
Age 75-79:	45% of insurance benefit;
Age 80-84:	30% of insurance benefit;
Age 85 and over:	15% of insurance benefit.

Exclusions

See the CIGNA policy for a complete list of exclusions which apply to this accidental death and dismemberment coverage.

SUPPLEMENTAL BONUS BENEFIT

The Health and Welfare Trust Fund provides a Supplemental Bonus Benefit to qualified employees who are working in Residential Plumbing. This benefit is paid once a year, based on contributions made for this purpose under the Master Labor Agreement during the Plan's "determination year" (ending September 30). Benefits are generally paid in December.

In order to be eligible for the Supplemental Bonus Benefit, you must meet all four of the following qualifications, with respect to the current determination year:

1. You are a Building Trades Journeyman or Building Trades Apprentice and you worked in Residential Plumbing.
2. You did not voluntarily leave work in Residential Plumbing for higher paid work under a U.A. agreement.
3. You did not perform any plumbing or pipefitting work during the Determination Year for employers who do not contribute to the Plan under a U.A. agreement.
4. You did not have any ownership interest in the contributing employer for which you worked.

The amount of benefits a qualified employee receives is determined by dividing the total contributions made for this benefit by the number of hours of Residential Plumbing work performed by all qualifying employees, and multiplying that number times the number of hours of Residential Plumbing work performed by the individual employee.

You do not have to file a claim to receive benefits. The Trust Fund Office determines who is qualified and the amount of Residential hours that each qualified employee worked, and distributes benefits. If you believe you are entitled to benefits, but did not receive them, or you believe you were entitled to additional benefits, you may appeal the action of the Trust Fund Office concerning this benefit to the Board of Trustees.

SUMMARY OF CLAIMS AND APPEALS RULES

The Health and Welfare Plan provides for claims and appeals for all matters under the discretion of the Board of Trustees. There are different procedures, depending on whether the claim or appeal involves: 1) a specific treatment or a medical, dental, vision, or hearing benefit, or 2) eligibility for benefits under the Plan or other matters not related to a specific treatment or benefit.

APPEALS TO YOUR HMO OR PLAN PROVIDER

If you are denied benefits by an HMO or plan provider on any grounds under the HMO or provider's sole discretion, such as whether a particular medical treatment is medically necessary, your only appeal is directly to the HMO or provider under the HMO's or provider's own appeal rules, and not to the Plan's Board of Trustees. The Trust Fund Office or the Local Union may be able to assist you with an appeal to an HMO provider, but the final responsibility for such appeals is yours.

GENERAL RULES ABOUT APPEALS TO THE BOARD OF TRUSTEES:

- The Plan's appeals procedures are the only recourse for matters under the discretion of the Board of Trustees.
- For matters under the Board of Trustees' discretion, failure to appeal an adverse action about your Plan benefits is deemed a waiver of all objections to the action.
- The decision of the Board of Trustees on any matter within their discretion is final and binding on all parties affected by the action in question.

Claims and Appeals Procedures for Specific Treatments or Benefits, Disability Status, or for Self-Administered Benefits

These procedures apply to all decisions under the discretion of the Board of Trustees, concerning specific treatments or benefits, based on your eligibility under the Plan, including disability status.

For example, the Plan's appeal procedures do apply if you are denied pre-authorization for a medical treatment, or are denied medical treatment, or you have been sent a bill by a Plan provider, on the grounds that you are ineligible for Plan benefits, or you have been denied disability status. If you believe that you were wrongly denied medical, dental, vision or HMO-provided hearing care on eligibility grounds, you may submit a claim for eligibility for benefits by contacting the Trust Fund Office. Your authorized representative or, if the situation is urgent, your doctor, may also contact the Trust Fund Office to submit a claim.

The Plan's claims and appeals procedures also apply if you are requesting a benefit that is administered by the Trust Fund Office, such as the self-funded hearing benefit or reimbursement of out-of-pocket costs.

The Trust Fund Office will notify you of its action on your claim within the following times, unless they notify you that they need more information or more time:

- Urgent Care: 72 hours

- Non-Urgent Care: 15 days
- If you have already received the care: 30 days

If you disagree with the action of the Trust Fund Office on a claim, you may appeal to the Board of Trustees by sending a letter to the Trust Fund Office, within 180 days of receiving the denial of benefits. Be sure to provide any information or documents that you want the Trustees to consider. The Board of Trustees will conduct an independent review of your appeal. If your appeal will be heard at a meeting of the Board of Trustees, you and/or your authorized representative may be permitted to appear, and you may be permitted to present witnesses. If you file an appeal, contact the Trust Fund Office for more information about the procedure for your appeal.

The Trustees will notify you in writing of their decision on your appeal before the following deadlines, unless they notify you that they need more information or an extension:

- Urgent Care: 72 hours
- Non-Urgent Care: 30 days
- If you have already received the care: 5 days after the next meeting of the Board of Trustees, unless you submit the appeal less than 30 days before the meeting, in which case you will be notified within 5 days after the meeting after the next meeting.

Appeals Procedures Regarding Eligibility and Other Matters

If you disagree with the decision of the Trust Fund Office or other Plan representative on an eligibility determination not related to specific care, or on any other Plan question, the appeal procedure starts when you send a letter of appeal to the Trust Fund Office. When you submit your appeal, you should submit any other information or documents that you want the Trustees to consider. Your appeal must be submitted within 60 days from when you received notification of the action or decision you are appealing. Otherwise, you will be deemed to have waived all objections to the prior decision. After you submit your appeal, the Trustees will determine whether additional information is needed, and whether a personal appearance is required. For further information about the procedures for your appeal, contact the Trust Fund Office.

The Board will decide your appeal at their next regular meeting, unless it is not received in time to have your appeal reviewed. The Trust Fund Office will notify you of the Board's action. Please note that the Board's final action on an appeal is binding on all parties affected by the appeal.

These appeals procedures also apply to Supplemental Bonus Benefits. The claims procedures do not apply because no claim is necessary for a qualified employee to receive that benefit.

For full claims and appeal procedures and rules, see Section VIII of the Formal Plan Rules.

GENERAL INFORMATION ABOUT THE PLAN

This Plan is the U. A. Local No. 159 Health and Welfare Plan, a group health plan. The Plan is sponsored and administered by the Board of Trustees of the U. A. Local No. 159 Health and Welfare Trust Fund. The Plan Year ends on June 30. The federal EIN of the Trust Fund is 94-6430804, and the Plan Number is 502.

The Board of Trustees is assisted in the administration of the Plan by a contract administrator, Health Services & Benefit Administrators, Inc. (the "Trust Fund Office"). The mailing address and contact information for the Board of Trustees are as follows:

U. A. Local Union No. 159 Trust Funds
c/o HS&BA
4160 Dublin Blvd., Suite 400
Dublin, CA 94568
Phone: (866) 295-6402
Fax: (925) 833-7301

The Board is also assisted in the administration of the Plan by U. A. Local No. 159, and has hired health maintenance organizations and other providers to provide benefits or claims services under insurance contracts or service agreements. Their names and phone numbers appear on page ii.

Medical coverage, dental benefits, vision benefits, life insurance, and accidental death and dismemberment benefits are provided on an insured basis. Hearing benefits are provided on a self-funded basis, if not covered by a participant's HMO.

The Board of Trustees consists of three representatives of employees, from U. A. Local No. 159, and three representatives of employers and the signatory employer associations.

The current members of the Board are:

LABOR TRUSTEES	EMPLOYER TRUSTEES
Mr. Thomas Lawson U. A. Local No. 159 1308 Roman Way Martinez, CA 94553 (925) 229-0400	Mr. Alex Hall No. Cal. Mechanical Contractors Assoc. 78 Cernon Street, Suite D Vacaville, CA 95688 (510) 679-3862
Mr. Nick Goodwin U. A. Local No. 159 1308 Roman Way Martinez, CA 94553 (925) 229-0400	William Cawley, III Benicia Plumbing, Inc. 265 W. Channel Court Benicia, CA 94510 (800) 746-2930
Mr. Robert Sewell U. A. Local No. 159 1308 Roman Way Martinez, CA 94553 (925) 229-0400	Mr. Michael Lescure Lescure Company 2301 Arnold Industrial Way Concord, CA 95420 (925) 283-2528

The Plan's legal counsel and agent for service of process is:

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

Legal process may also be served on the Plan or Trust Fund by service on any of the Trustees or at the Trust Fund Office.

The Plan Consultant and Actuary is:

Michael Kaplan
Rael & Letson
35 N. Lake Avenue, Suite 810
Pasadena, CA 91101

The Plan is funded by contributions from employers who are signatory to, or members of an employer association which is signatory to, a collective bargaining agreement with U. A. Local No. 159, including the Northern California Mechanical Contractors Association, Industrial Contractors, UMIC, Inc., and the Plumbing, Heating, Cooling Contractors of the Greater Bay Area. The Plan is also funded in some cases by monthly payments by participants and dependents. The Plan is maintained pursuant to, and the amount of contributions required of signatory employers is

determined by, the collective bargaining agreement. The amount of monthly payments of participants and dependents for whom such payments are required is determined by the Board of Trustees.

A complete list of employers and employee organizations sponsoring the Plan, and copies of any document governing the Plan, including the Trust Agreement, insurance and HMO contracts, and collective bargaining agreements calling for contributions to the Plan, may be obtained by participants and beneficiaries upon written request to the Trust Fund Office, or may be inspected by participants and beneficiaries at the Trust Fund Office, or the Local Union, during normal business hours. A participant or beneficiary may also request in writing information as to whether a particular employer, employer association, or labor organization is a plan sponsor, and if so, the sponsor's address. There may be a charge for copies of Plan documents.

The Plan's reserve assets are currently invested in Vanguard mutual funds.

YOUR RIGHTS UNDER FEDERAL LAW

As a participant in the U. A. Local No. 159 Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor, which is 90 Seventh Street, Suite 11-300, San Francisco, CA 94103, Telephone: (415) 625-2481, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

YOUR RIGHTS UNDER COBRA

The U. A. Local No. 159 Health and Welfare Plan provides for continuation of coverage for a limited period, for qualified employees, retirees, and dependents, subject to payment of a monthly premium ("COBRA continuation coverage"). The COBRA premium rates will be higher than the self-pay rates for qualified employees who are employed under the labor agreement or available for such employment, or for qualified surviving spouses. Employees who may qualify for the more favorable self-payment rate, as well as those individuals who qualify for COBRA continuation coverage under the following regulations, should check with the Trust Fund Office as to the proper monthly premium. Your rights to elect COBRA continuation coverage are briefly summarized below, and appear in the Formal Rules under the Section entitled "COBRA Continuation Coverage." A more complete explanation is also available from the Trust Fund Office on request, and is provided whenever a person receives a COBRA election.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

This section contains important information about your rights to COBRA continuation coverage, which is a temporary extension of health coverage you may elect when you lose your regular coverage under the U. A. Local No. 159 Health and Welfare Plan ("the Plan") due to a qualifying event. The following pages will serve as an initial notice to you regarding your rights under COBRA.

This notice explains, in general:

- what COBRA continuation coverage is;
- what Qualifying Events trigger the eligibility for COBRA continuation coverage;
- when COBRA continuation coverage may become available to you and your family and for how long; and
- what you need to do to protect the right to receive it.

1. What is COBRA Continuation Coverage?

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." Specific examples of Qualifying Events are listed in Section 2 below.

After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary". You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for the coverage on their own. COBRA coverage is also coordinated with other forms of extended coverage, so your period of COBRA coverage may or may not be reduced by periods of other extended coverage. (See Section 4, C.)

2. What Qualifying Events Might Trigger the Eligibility for COBRA Coverage?

If you are an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following Qualifying Events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because any of the following Qualifying Events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his/her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced from your spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- The child stops being eligible for coverage under the Plan as a "dependent child," after reaching the Plan's limiting age for dependents (see page 8.)

3. When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. You and your dependents' right to receive COBRA continuation coverage is contingent upon timely notifying the Plan of a Qualifying Event, promptly returning the COBRA election form and making all required payments.

A. The Employer's Duty to Give Notice of Some Qualifying Events

When the Qualifying Event is the end of employment or reduction of hours of employment, the employer must notify the Plan Administrator within 30 days of the Qualifying Event. The Employer Report Form submitted to the Trust Fund Office each month is sufficient to constitute such a notice.

Upon the death of the employee, the employer or the employee's dependent has 30 days to notify the Plan Administrator.

If the Qualifying Event is the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan will usually be automatically notified.

IMPORTANT:

B. The Qualified Beneficiary's Duty to Give Notice of Other Qualifying Events

The duty to give notice of all other Qualifying Events falls on the Qualified Beneficiaries. The employee, the spouse or dependent children of the employee must notify the Plan Administrator within 60 days after any of the following Qualifying Events occurs:

- (a) a divorce or a child's loss of dependent status under the Plan;
- (b) occurrence of a second Qualifying Event entitling certain Qualified Beneficiaries to an extension of the COBRA maximum coverage period to up to 36 months (see Section 4, A (b)); and
- (c) when a Qualified Beneficiary who is entitled to 18 months of COBRA has been determined by the SSA to be disabled at any time during the first 60 days of COBRA coverage (see Section 4, A (a)).

You must include the following information in your notice to the Plan Administrator:

- (a) the nature of the Qualifying Event that has caused the loss of coverage under the Plan;
- (b) the date when the Qualifying Event occurred;
- (c) your name and signature; and
- (d) the date when the notice was signed.

You must deliver this notice, either by mail, or in person, to the address provided in Section 6.

4. How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Please inform the Plan Administrator immediately if you acquire any new dependents through marriage, having children born, adopted or placed with you for adoption.

A. Length of COBRA Coverage: 18 Months and May be Extended

Generally, when the Qualifying Event is (1) the end of employment or (2) reduction of the employee's hours of employment, COBRA continuation coverage lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

(a) Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

(b) Second Qualifying Event extension of 18-month period of continuation coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the Plan. The 36-month period is measured from the date of the first Qualifying Event.

This extension may be available to the spouse and any dependent child receiving continuing coverage if the employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced, or if the dependent child loses dependent status, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

B. Length of COBRA Coverage: A Total of 36 Months

When the Qualifying Event is (1) the death of the employee, (2) the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), (3) divorce from the employee, or (4) a dependent child's loss of dependent status, the Qualified Beneficiary may elect COBRA continuation coverage for up to a total of 36 months.

C. Coordination with Other Coverage

The period of time for which an employee or his/her dependent is eligible for COBRA coverage is not reduced by any period of time in which the employee or his/her dependent was covered under his/her Hour Bank, but will be reduced for any period of coverage provided at less cost than COBRA coverage, including Special Disability Coverage or Self-Pay Coverage.

5. Where Can You Get More Information?

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the office identified in Section 6. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, you may also contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area at: 90 Seventh Street, Suite 11-300, San Francisco, CA 94103, Telephone: (415) 625-2481. Or visit the EBSA website at www.dol.gov/ebsa.

6. Plan Administrator's Contact Information

HS&BA
4160 Dublin Blvd., Suite 400
Dublin, CA 94568
Phone: (866) 295-6402
Fax: (925) 833-7301

IMPORTANT: Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

APPENDIX 1

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.

APPENDIX 2
SPANISH-LANGUAGE BENEFIT SUMMARIES

OPCIONES de cobertura médica para empleados activos

Kaiser Permanente Plan de deducible (HMO) – Resumen de Beneficios - Empleados Activos

Los servicios que se describen a continuación sólo están cubiertos si todas las condiciones siguientes se han cumplido:

- los servicios son determinados por Kaiser que es médicamente necesario;
- los servicios son proporcionados, recetados, autorizados o dirigidos por un médico del plan de Kaiser y recibe los servicios de proveedores del plan de Kaiser dentro de la zona de Kaiser norte de California región de servicio (su región nacional), excepto cuando se indique específicamente lo contrario en la Evidencia de Cobertura (EOC) para obtener referencias autorizadas, cuidados paliativos, atención de emergencia, posterior a la estabilización de atención, fuera de la zona de atención urgente, y servicios de ambulancia de emergencia.

Anual fuera de bolsillo máximo de determinados servicios

Para los servicios sujetos al máximo, usted no tendrá que pagar más de los costos durante un año calendario si los co-pagos y co-seguro que paga por esos servicios se suman a una de las siguientes cantidades:

Para la inscripción de solamente un miembro (una familia de un solo miembro) ... \$3,000 por año calendario

Para cualquier miembro de una familia de dos o más miembros \$3,000 por año calendario

Para toda una familia de dos o más miembros \$6,000 por año calendario

Deducible Anual \$300 por persona / \$600 por familia

Máximo Anual o Maximo de por vida Ninguna

Servicios profesionales	Tu pagas
La mayoría de las consultas de atención primaria, exámenes y tratamiento	\$20 por visita
Consultas de atención especializada, exámenes y tratamiento	\$40 por visita
Exámenes físicos de rutina de mantenimiento	No hay cobro
Exámenes preventivos de rutina para niños (hasta la edad de 23 meses)	No hay cobro
Asesoramiento sobre planificación familiar y consultas	No hay cobro
Programados exámenes prenatales	No hay cobro
Los exámenes de rutina con un optometrista de plan	No hay cobro
Consultas de atención de urgencia, exámenes y tratamientos	\$20 por visita
La mayor parte de terapia física, ocupacional y del lenguaje	\$20 por visita *
Servicios Ambulatorios	Tu pagas
La cirugía ambulatoria y otros procedimientos ambulatorios	20% co-pago *
Inyección para la alergia (incluyendo suero para alergia)	No hay cobro después del deducible
La mayoría de inmunizaciones (incluyendo vacunas)	No hay cobro
La mayoría de las radiografías y pruebas de laboratorio	\$10 por encuentro
Imágenes de resonancia magnética, TAC, TEP	20% de co-pago hasta \$50 máximo
Consejería de educación de salud individual	No hay cobro
Programas cubiertas de educación sanitaria	No hay cobro

Kaiser - Empleados Activos (continuación)

Servicios de hospitalización	Tu pagas
Alojamiento y comida, cirugía, anestesia, radiografías, pruebas de laboratorio y medicamentos	20% co-pago*
Cobertura de Emergencia	Tu pagas
Visitas a emergencia	20% co-pago*
Nota: Reparto de los costos no se aplica si es admitido directamente al hospital como paciente interno (véa Servicios de hospitalización para reparto de costos).	
Servicios de Ambulancia	Tu pagas
Los servicios de ambulancia	\$150 por viaje*
Servicios de Medicamentos Recetados	Tu pagas
Artículos para pacientes externos cubiertos de acuerdo con las directrices del formulario de medicamentos de Kaiser: La mayoría de los elementos genéricos de una farmacia de Kaiser	\$10 para un suministro de hasta 30 días
La mayoría de los recambios genéricos para el servicio de pedidos por correo de Kaiser.....	\$20 para un suministro de hasta 100 días
La mayoría de los artículos de marca en una farmacia de Kaiser	\$30 para un suministro de hasta 30 días
La mayoría de las recargas de marca de servicio de pedidos por correo de Kaiser	\$60 para un suministro de hasta 100 días
La mayoría de los artículos de la especialidad en una farmacia de Kaiser	\$30 para un suministro de hasta 30 días
Equipo médico duradero (DME)	Tu pagas
Artículos de DME como se describe en la EOC	20% co-pago
Servicios de Salud Mental	Tu pagas
Hospitalización psiquiátrica para pacientes internos	20% co-pago*
Evaluación y tratamiento de salud mental para individual ambulatorio.....	\$20 por visita
Tratamiento de salud mental ambulatoria con grupo	\$10 por visita
Tratamiento de Trastorno por uso de Sustancias	Tu pagas
Desintoxicación hospitalaria	20% co-pago*
Evaluación de la salud mental y tratamiento para individual ambulatorio.....	\$20 por visita
Tratamiento de salud mental ambulatoria en grupo	\$5 por visita

Otros Servicios de Salud	Tu pagas
Atención médica a domicilio (hasta 100 visitas por año calendario)	No hay cobro
Cuidado de enfermería especializada (hasta 100 días por período de beneficios)..	20% co-pago*
Prótesis y dispositivos ortopédicos como se describe en el EOC	No hay cobro
Los servicios cubiertos para el diagnóstico y tratamiento de la infertilidad	50% co-pago
Cuidado de hospicio	No hay cobro
Servicios quiroprácticos (limitados a 20 visitas por período de 12 meses)	\$15 por visita
Este es un resumen de las preguntas más frecuentes acerca de los beneficios. Esta tabla no explica los beneficios, reparto de costos, fuera de su bolsillo máximos, exclusiones o limitaciones, ni una lista de todos los beneficios y las cantidades Costo de Acciones. Para una explicación completa, consulte la EOC de Kaiser. Tenga en cuenta que Kaiser ofrece todos los beneficios requeridos por la ley (por ejemplo, la diabetes suministros de pruebas).	

* Sujeto a la satisfacción del deducible anual.

Blue Shield of California Access + HMO - Resumen de Beneficios - Empleados Activos (Deducible de Instalaciones 30-30% / 2000)

Este Resumen de Beneficios muestra la cantidad que pagará por los servicios cubiertos. Es sólo un resumen y es parte del contrato de cobertura de atención de salud llamada la Evidencia de Cobertura (EOC).¹

Acceso a la red HMO+. Este plan de Blue Shield utiliza una red específica de proveedores de atención médica. Proveedores en esta red se llaman Proveedores Participantes.³ Debe seleccionar un médico de atención primaria de esta red para proporcionar la atención primaria y ayudarlo acceder los servicios, pero hay algunas excepciones. Por favor revise el COE para más detalles. Puede encontrar proveedores participantes en blueshieldca.com.

Características generales

Deducible Medico por año calendario ²	\$2,000 por persona \$4,000 por familia
Maximo fuera de bolsillo por año calendario ⁴	\$3,500 por persona \$7,000 por familia
Beneficio máximo de por vida	Ninguna

Los servicios cubiertos cuando se utiliza un Proveedor Participante ^{3,5}

Tu pagas

Las visitas al consultorio - La atención primaria, especializada y otro profesional	\$30 por consulta co-pago
Access + Beneficios de Especialista (auto-referencia)	\$45 por visita co-pago
Para pacientes ambulatorios de rayos X, patología y laboratorio	No hay cobro
Beneficio de Salud Preventiva ⁶	No hay cobro
Servicios para pacientes ambulatorios (Beneficios de Hospital – Servicios de Instalaciones)	
Cirugía ambulatoria en un centro de cirugía ambulatoria	20% co-pago
La cirugía ambulatoria en un hospital	30% co-pago
Servicio ambulatorio para el tratamiento de una enfermedad o lesión, la radioterapia, la quimioterapia y suministros necesarios	No hay cobro
Beneficios de hospitalización (Beneficios de Hospital – Servicios de Instalaciones)	
Servicios de centro de hospitalización no son de emergencia	30% co-pago
Servicios médicos para pacientes hospitalizados	No hay cobro
Servicios de sala de emergencias (Co-pago no se aplica si es admitido)	\$150 de co-pago por visita
Sala de Emergencia Servicios para médicos	No hay cobro
Servicios de atención urgente	\$30 por consulta
Servicios de ambulancia	\$100 / transporte
Prótesis / Ortopedia	No hay cobro
Equipo médico duradero	
Extractor de leche	No hay cobro
Otro Equipo médico duradero	50% de los cargos permitidos
Beneficios para la salud mental	
Servicios para pacientes hospitalizados	Co-pago del 30%
Servicios Ambulatorios de Salud Mental	\$30 por consulta

Blue Shield - Empleados Activos (continuación)

Los servicios cubiertos cuando se utiliza un Proveedor Participante ^{3,5}

Tu pagas

Beneficios para Trastorno por uso de Sustancias	
Hospitalización.	30% co-pago
Visitas al médico para pacientes ambulatorios-.....	\$30 por visita
Hospitalización Parcial / Tratamiento al Día	No hay cobro
Servicios de Salud en el Hogar	
Agencia de servicios de atención médica a domicilio (hasta 100 visitas por año)	\$30 por visita
Suministros médicos	No hay cobro
Centro de enfermería especializada (hasta 100 días por miembro por período de beneficios)	30% co-pago
Servicios o Programa de cuidados paliativos	No hay cobro
Visitas de Embarazo y Maternidad ⁶	No hay cobro
Beneficios de planificación familiar y la infertilidad	
Asesoramiento y consulta	No hay cobro
Servicios de infertilidad	50% de los cargos permitidos
Ligadura de trompas	No hay cobro
Vasectomía	No hay cobro
Beneficios de rehabilitación (física, ocupacional y terapia respiratoria)	\$30 por consulta
Terapia de lenguaje	\$25 por visita
Audífonos	\$Subsidio el año 2000 cada 24 meses
Pruebas y tratamientos para alergias	\$30 por consulta co-pago
Suero para alergia.....	50% co-pago
Beneficios de Cuidado de la diabetes	
Dispositivos, equipos y suministros que no son para pruebas.....	20% de los cargos permitidos
Entrenamiento para el control de la diabetes	\$30 por consulta
Servicios de diálisis	No hay cobro

Servicios de Medicamentos Recetados

Tu pagas

Medicamentos y dispositivos anticonceptivos	No hay cobro
	\$15 formulario genérico (Nivel 1)
	\$30 Nombre de marca del formulario (Nivel 2)
	\$45 de marca fuera del formulario (Nivel 3)
Farmacia de venta al por hasta 30 días de suministro	
	\$30 de formulario genérico (Nivel 1)
	\$60 de marca del formulario (Nivel 2)
	\$90 de marca fuera del formulario (Nivel 3)
Pedido por correo para un suministro de hasta 90 días	
	20% de co-pago hasta \$200 co-pago máximo por menor prescripción y \$400 por la prescripción de pedidos por correo
Nivel 4 drogas	

Medicamentos de especialidad en las farmacias de la red especializada	20% de co-pago hasta \$200 co-pago máximo por receta
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Notas:

1 Evidencia de cobertura (EOC):

La Evidencia de cobertura (EOC) describe los beneficios, limitaciones y exclusiones que se aplican a la cobertura de este plan de beneficios. Por favor revise el COE para más detalles de la cobertura se describen en este resumen de beneficios. Puede solicitar una copia de la EOC en cualquier momento. los términos definidos están en el EOC. Consulte la EOC para una explicación de los términos utilizados en este resumen de beneficios.

2 deducible por año calendario (CYD):

Un deducible es la cantidad que paga cada año calendario antes de Blue Shield paga por los servicios cubiertos por el plan de beneficios.

Algunos servicios cubiertos recibidos de los proveedores participantes son pagados por Blue Shield antes de reunirse deducible cualquier año calendario médica.

La cobertura de la familia tiene un deducible individual dentro de la familia de deducible. Esto significa que el deducible se reunió por un individuo con cobertura familiar que cumple con el deducible individual antes de la reunión de la familia del deducible familiar dentro de un año calendario.

3 Uso de los Proveedores Participantes:

Los proveedores participantes tienen un contrato de prestación de servicios de atención médica a los miembros. Cuando recibe servicios cubiertos de un proveedor participante, sólo es responsable por el co-pago o co-seguro, una vez que cualquier calendario se ha cumplido deducible del año.

Usted pagará el co-pago o coaseguro aplicable a los proveedores participantes por los Servicios Cubiertos recibidos de otros proveedores. Sin embargo, otros proveedores no tienen un contrato de prestación de servicios de atención médica a los miembros y así no participan proveedores. Por lo tanto, también tendrá que pagar todos los cargos por encima de la cantidad permitida. Este gasto fuera de bolsillo puede ser significativo.

4 Maxima fuera de bolsillo por año calendario (OOPM):

Su pago después de que llegue el año calendario OOPM. Va a seguir pagando todos los cargos por encima de un máximo beneficio. beneficios para la salud esenciales cuentan para el OOPM.

Deducibles cuentan para el OOPM. Cualquier cantidad que paga que cuentan como el calendario médico del deducible por año también contará para el año calendario fuera de bolsillo máximo.

cobertura de la familia tiene un OOPM individuo dentro de la familia OOPM. Esto significa que el OOPM se reunieron para una persona con cobertura familiar que se encuentra con el OOPM individual antes de la Familia satisfacer la OOPM familia dentro de un año calendario.

5 Pagos separados para miembros cuando se recibe servicios múltiples:

Cada vez que reciba múltiples servicios cubiertos, usted podría tener pagos por separado (co-pago o co-seguro) por cada servicio. Cuando esto sucede, usted puede ser responsable de múltiples co-pagos o co-seguros. Por ejemplo, usted puede deber un co-pago por visita al consultorio, además de un co-pago suero para alergias cuando se visita al médico para una inyección para la alergia.

6 Servicios de Salud Preventiva:

Si sólo recibe servicios de salud preventiva durante una visita al consultorio del médico, no hay co-pago o co-seguro por la visita. Si recibe servicios de salud preventivos y otros servicios cubiertos durante la visita al consultorio del médico, es posible que tenga un co-pago o co-seguro por la visita.

Planes de beneficios pueden ser modificados para asegurar el cumplimiento con los requisitos estatales y federales.

OPCIONES de cobertura para los jubilados menores de 65 años

Kaiser Permanente Plan de Salud (HMO) - Resumen de beneficios

Los servicios que se describen a continuación sólo están cubiertos si todas las condiciones siguientes:

- los servicios son determinados por Kaiser que es médicamente necesario;
- los servicios son proporcionados, recetados, autorizados o dirigidos por un médico del plan de Kaiser y recibe los servicios de proveedores del plan de Kaiser dentro de la zona de Kaiser norte de California región de servicio (su región nacional), excepto cuando se indique específicamente lo contrario en la Evidencia de Cobertura (EOC) para obtener referencias autorizadas, cuidados paliativos, atención de emergencia, posterior a la estabilización de atención, fuera de la zona de atención urgente, y servicios de ambulancia de emergencia.

Anual fuera de bolsillo máximo de determinados servicios

Para los servicios sujetos al máximo, usted no tendrá que pagar más participación en los costos durante un año calendario si los co-pagos y co-seguro que paga por esos servicios se suman a una de las siguientes cantidades:

Para la inscripción de solamente un miembro (una familia de un solo miembro) ... \$1,500 por año calendario

Para cualquier miembro de una familia de dos o más miembros \$1,500 por año calendario

Para toda una familia de dos o más miembros \$3,000 por año calendario

Máximo deducible o de por vida Ninguna

Servicios profesionales	Tu pagas
La mayoría de las visitas de atención primaria y especializada:	\$20 por visita
Exámenes físicos de rutina	No hay cobro
Exámenes preventivos de rutina para niños (hasta la edad de 23 meses)	No hay cobro
Asesoramiento sobre planificación familiar y consultas	No hay cobro
Programados exámenes prenatales	No hay cobro
Los exámenes de rutina con un optometrista de plan	No hay cobro
Consultas de atención de urgencia, evaluaciones y tratamiento	\$20 por visita
La mayor parte de terapia física, ocupacional y de lenguaje	\$20 por visita
Servicios para pacientes ambulatorios	Tu pagas
La cirugía ambulatoria y otros procedimientos ambulatorios.....	\$20 por procedimiento
Inyección para la alergia (incluyendo suero para alergia)	\$3 por visita
La mayoría de las inmunizaciones (incluyendo vacunas).....	No hay cobro
La mayoría de las radiografías y pruebas de laboratorio	No hay cobro
Consejería de educación de salud individual.....	No hay cobro
Programas cubiertas de educación sanitaria	No hay cobro
Servicios de hospitalización	Tu pagas
Alojamiento y comida, cirugía, anestesia, radiografías, pruebas de laboratorio y medicamentos	\$250 por admisión

Kaiser - prejubilados (continuación)

Cobertura de salud de emergencia	Tu pagas
Visitas a urgencias..... Nota: Reparto de los costos no se aplica si es admitido directamente al hospital como paciente interno (Vea Servicios de hospitalización para reparto de costos)	\$100 por visita
Servicios de Ambulancia	Tu pagas
Los servicios de ambulancia.....	No hay cobro
Servicios de Medicamentos Recetados	Tu pagas
Artículos para pacientes externos cubiertos de acuerdo con las directrices del formulario de medicamentos de Kaiser:	
La mayoría de los elementos genéricos de una farmacia de Kaiser.....	\$10 para un suministro de hasta 30 días
La mayoría de los recambios genéricos para el servicio de pedidos por correo de Kaiser	\$20 para un suministro de hasta 100 días
La mayoría de los artículos de marca en una farmacia de Kaiser.....	\$20 para un suministro de hasta 30 días
La mayoría de las recargas de marca de servicio de pedidos por correo de Kaiser	\$40 para un suministro de hasta 100 días
La mayoría de los artículos de la especialidad en una farmacia de Kaiser	\$20 para un suministro de hasta 30 días
Equipo médico duradero (DME)	Tu pagas
Artículos de DME como se describe en la EOC.....	No hay cobro
Servicios de salud mental	Tu pagas
Hospitalización psiquiátrica para pacientes internos	\$250 por admisión
Evaluación y tratamiento de salud mental para individual ambulatorio	\$20 por visita
Tratamiento ambulatorio en grupo	\$10 por visita
Trastorno por uso de Sustancias	Tu pagas
Desintoxicación hospitalaria	\$250 por admisión
Evaluación ambulatoria individual y el tratamiento	\$20 por visita
tratamiento ambulatorio en grupo.....	\$5 por visita

Kaiser - prejubilados (continuación)

Otros Servicios de Salud	Tu pagas
Atención médica a domicilio (hasta 100 visitas por año calendario).....	No hay cobro
Audífonos (cada 36 meses)	Cantidad en exceso de \$500 Dieta por la ayuda
Cuidado de enfermería especializada (hasta 100 días por período de beneficios)	\$250 por admisión
Prótesis y dispositivos ortopédicos como se describe en el EOC	No hay cobro
Cuidado de hospicio	No hay cobro
Este es un resumen de las preguntas más frecuentes acerca de los beneficios. Esta tabla no explica los beneficios, reparto de costos, fuera de su bolsillo máximos, exclusiones o limitaciones, ni una lista de todos los beneficios y las cantidades Costo de Acciones. Para una explicación completa, consulte la EOC de Kaiser. Tenga en cuenta que Kaiser ofrece todos los beneficios requeridos por la ley (por ejemplo, la diabetes suministros de pruebas).	

Blue Shield of California Access + HMO - Resumen de Beneficios - Los jubilados menores de 65 años (Coaseguranza de Instalaciones 20-20%)

Este Resumen de Beneficios muestra la cantidad que pagará por los servicios cubiertos. Es sólo un resumen y es parte del contrato de cobertura de atención de salud llamada La Evidencia de Cobertura (EOC) ^{0,1}

Acceso a la red HMO+. Este plan de Blue Shield utiliza una red específica de proveedores de atención médica. Proveedores en esta red se llaman Proveedores Participantes.³ Debe seleccionar un médico de atención primaria de esta red para proporcionar la atención primaria y ayudarlo acceder los servicios, pero hay algunas excepciones. Por favor revise el COE para más detalles. Puede encontrar proveedores participantes en blueshieldca.com.

Características generales

Deducible médico por año calendario ²	Ninguna
Maximo fuera de bolsillo por año calendario ⁴	\$2,500 por persona \$5,000 por familia
Beneficio máximo de por vida	Ninguna

Los servicios cubiertos cuando se utiliza un Proveedor Participante ^{3,5}

Tu pagas

Las visitas al consultorio - La atención primaria y especializada	\$20 por visita co-pago
Access + Beneficios de Especialista	\$35 por visita co-pago
Para pacientes ambulatorios de rayos X, patología y laboratorio	No hay cobro
Beneficio de Salud Preventiva ⁶	No hay cobro
Servicios para pacientes ambulatorios (Beneficios de Hospital – Servicios de Instalaciones)	
Cirugía ambulatoria en un Centro de Cirugía Ambulatoria	10% co-pago
La cirugía ambulatoria en un hospital	25% co-pago
Servicio ambulatorio para el tratamiento de una enfermedad o lesión, la radioterapia, la quimioterapia y suministros necesarios	No hay cobro
Beneficios de hospitalización (Beneficios de Hospital – Servicios de Instalaciones)	
Paciente interno (no de emergencia) Servicio de Instalacion	\$100 por admisión más el 20% co-pago
Servicios médicos para pacientes hospitalizados	No hay cobro
Servicios de sala de emergencias (co-pago no se aplica si es admitido) ...	\$150 de co-pago por visita
Sala de Emergencia (Servicios para médicos)	No hay cobro
Servicios de atención urgente	\$20 por visita co-pago
Servicios de ambulancia	\$100 por el transporte
Prótesis / Ortopedia	No hay cobro
Equipo médico duradero	
Extractor de leche	No hay cobro
Otro equipo médico duradero	50% de los cargos permitidos
Servicios de salud mental	
Servicios para pacientes hospitalizados	\$100 por admisión más el 20% co-pago
Servicios Ambulatorios de Salud Mental	\$20 por visita co-pago

Blue Shield - prejubilados (continuación)

Beneficios para trastorno por uso de sustancias	\$100 por admisión más el 20% co-pago
Hospitalización.....	\$20 por visita co-pago
Visitas al médico para pacientes ambulatorios.....	
Servicios de Salud en el Hogar	
Agencia de servicios de atención médica a domicilio (hasta 100 visitas por año)	\$20 por visita co-pago
Suministros médicos	No hay cobro
Servicios de enfermería especializada (hasta 100 visitas por miembro por año calendario)	20% co-pago
Servicios o programa de cuidados paliativos	No hay cobro
Visitas de Embarazo y Maternidad ⁶	No hay cobro
Beneficios de planificación familiar y la infertilidad	
Asesoramiento y consulta	No hay cobro
Servicios de Infertilidad	50% de los cargos permitidos
Ligadura de trompas	No hay cobro
Vasectomía	No hay cobro
Beneficios de rehabilitación (física, ocupacional y terapia respiratoria)	\$20 por visita co-pago
Terapia del lenguaje	\$20 por visita co-pago
Audífonos	\$Subsidio el año 2000 cada 24 meses
Pruebas y tratamientos de alergia	\$20 por visita co-pago
Suero para alergia	50% co-pago
Beneficios de Cuidado de la diabetes	
Dispositivos, equipos y suministros que no son para pruebas	20% de los cargos permitidos
Entrenamiento para el control de la diabetes	\$20 por visita
Servicios de diálisis	No hay cobro

Servicios de Medicamentos Recetados

Tu pagas

Medicamentos y dispositivos anticonceptivos	No hay cobro
	\$10 formulario genérico (Nivel 1)
	\$20 Nombre de marca del formulario (Nivel 2)
Farmacia de venta al por hasta 30 días de suministro	\$35 Nombre de la marca fuera del formulario (Nivel 3)
	\$20 formulario genérico (Nivel 1)
	\$40 de marca del formulario (Nivel 2)
Pedido por correo para un suministro de hasta 90 días	\$70 de marca fuera del formulario (Nivel 3)
	20% de co-pago hasta \$200 co-pago máximo por menor prescripción y \$400 por la prescripción de pedidos por correo
Nivel 4 drogas	
Medicamentos especializados en farmacias especializadas	20% de co-pago hasta \$200 co-pago máximo por receta

Blue Shield - prejubilados (continuación)

notas:

1 Evidencia de cobertura (EOC):

La Evidencia de cobertura (EOC) describe los beneficios, limitaciones y exclusiones que se aplican a la cobertura de este plan de beneficios. Por favor revise el COE para más detalles de la cobertura se describen en este resumen de beneficios. Puede solicitar una copia de la EOC en cualquier momento. los términos definidos están en el EOC. Consulte la EOC para una explicación de los términos utilizados en este resumen de beneficios.

2 Deducible por año calendario:

Un deducible es la cantidad que paga cada año calendario antes de Blue Shield paga por los servicios cubiertos por el plan de beneficios.

3 Uso de los Proveedores Participantes:

Los proveedores participantes tienen un contrato de prestación de servicios de atención médica a los miembros. Cuando recibe servicios cubiertos de un proveedor participante, sólo es responsable por el co-pago o co-seguro, una vez que cualquier calendario se ha cumplido deducible del año.

Usted pagará el co-pago o coaseguro aplicable a los proveedores participantes por los Servicios Cubiertos recibidos de otros proveedores. Sin embargo, otros proveedores no tienen un contrato de prestación de servicios de atención médica a los miembros y así no participan proveedores. Por lo tanto, también tendrá que pagar todos los cargos por encima de la cantidad permitida. Este gasto fuera de bolsillo puede ser significativo.

4 Maxima fuera de bolsillo por año calendario (OOPM):

Su pago después de que llegue el año calendario OOPM. Va a seguir pagando todos los cargos por encima de un máximo beneficio. beneficios para la salud esenciales cuentan para el OOPM.

cobertura de la familia tiene un OOPM individuo dentro de la familia OOPM. Esto significa que el OOPM se reunieron para una persona con cobertura familiar que se encuentra con el OOPM individual antes de la Familia satisfacer la OOPM familia dentro de un año calendario.

5 Pagos miembro separado cuando recibe servicios cubiertos múltiples:

Cada vez que reciba múltiples servicios cubiertos, usted podría tener pagos por separado (co-pago o co-seguro) por cada servicio. Cuando esto sucede, usted puede ser responsable de múltiples co-pagos o co-seguros. Por ejemplo, usted puede deber un co-pago por visita al consultorio, además de un co-pago suero para alergias cuando se visita al médico para una inyección para la alergia.

6 Servicios de Salud Preventiva:

Si sólo recibe servicios de salud preventiva durante una visita al consultorio del médico, no hay co-pago o co-seguro por la visita. Si recibe servicios de salud preventivos y otros servicios cubiertos durante la visita al consultorio del médico, es posible que tenga un co-pago o co-seguro por la visita.

Planes de beneficios pueden ser modificados para asegurar el cumplimiento con los requisitos estatales y federales.

OPCIONES de cobertura para jubilados mayores de 65 años

Jubilados mayores de 65 años deben inscribirse en Medicare Partes A y B, y pueden escoger entre las dos opciones para la cobertura médica a continuación. Para elegir Kaiser, debe vivir dentro del área de servicio de Kaiser.

Kaiser Permanente Senior Advantage (HMO) en la parte D (un plan Medicare Advantage)

Anual fuera de bolsillo máximo de determinados servicios

Para los servicios sujetos al máximo, usted no tendrá que pagar más la compartición de costos durante un año calendario si los co-pagos y co-seguro que paga por esos servicios se suman a una de las siguientes cantidades:

Para la inscripción de auto-solamente (una familia de un solo miembro) \$1,500 por año calendario

Para cualquier miembro de una familia de dos o más miembros \$1,500 por año calendario

Para toda una familia de dos o más miembros \$3,000 por año calendario

Máximo deducible o de por vida Ninguna

Servicios profesionales	Tu pagas
La mayoría de las consultas de atención primaria y de especialidades.....	\$20 por visita
Visita anual de bienestar y examen Bienvenido a Medicare	No hay cobro
Los exámenes de rutina con un optometrista de plan	No hay cobro
Consultas de atención de urgencia, evaluaciones y tratamiento	\$20 por visita
La terapia física, ocupacional y de lenguaje.....	\$20 por visita
Servicios para pacientes ambulatorios	Tu pagas
La cirugía ambulatoria y otros procedimientos ambulatorios.....	\$20 por procedimiento
Inyección para la alergia (incluyendo suero para alergia)	\$3 por visita
La mayoría de inmunizaciones (incluyendo vacunas)	No hay cobro
La mayoría de los rayos X, mamografías anuales y pruebas de laboratorio	No hay cobro
Manipulación manual de la columna vertebral.....	\$20 por visita
Servicios de hospitalización	Tu pagas
Alojamiento y comida, cirugía, anestesia, radiografías, pruebas de laboratorio y medicamentos	\$250 por admisión
Cobertura de salud de emergencia	Tu pagas
Visitas a urgencias.....	\$50 por visita
Servicios de ambulancia	Tu pagas
Los servicios de ambulancia.....	No hay cobro

Kaiser - Los jubilados mayores de 65 años (continuación)

Servicios de Medicamentos Recetados	Tu pagas
Artículos para pacientes externos cubiertos de acuerdo con las directrices del formulario de medicamentos de Kaiser: La mayoría de los elementos genéricos de una farmacia de Kaiser..... La mayoría de los recambios genéricos para el servicio de pedidos por correo de Kaiser La mayoría de los artículos de marca en una farmacia de Kaiser La mayoría de las recargas de marca de servicio de pedidos por correo de Kaiser	\$10 para un suministro de hasta 30 días; \$20 para un suministro de 31 a 60 días; o \$30 para un suministro de 61- a 100 días \$10 para un suministro de hasta 30 días o \$20 para un suministro de 31 a 100 días \$20 para un suministro de hasta 30 días; \$40 para un suministro de 31 a 60 días; o \$60 para un suministro de 61- a 100 días \$20 para un suministro de hasta 30 días o \$40 para un suministro de 31 a 100 días
Equipo médico duradero (DME)	Tu pagas
DME cubierto para uso doméstico	No hay cobro
Servicios de salud mental	Tu pagas
Hospitalización psiquiátrica para pacientes internos Evaluación y tratamiento de salud mental para individual ambulatorio Tratamiento de salud mental ambulatoria en grupo.....	\$250 por admisión \$20 por visita \$10 por visita
Tratamiento de Trastorno por uso de Sustancias	Tu pagas
Desintoxicación hospitalaria Evaluación y tratamiento para individual ambulatorio Tratamiento de salud mental ambulatorio en grupo.....	\$250 por admisión \$20 por visita \$5 por visita
Otros Servicios de Salud	Tu pagas
Atención médica a domicilio (a tiempo parcial, intermitente).....	No hay cobro

Kaiser - Los jubilados mayores de 65 años (continuación)

Otros Servicios de Salud	Tu pagas
Anteojos o lentes de contacto cada 24 meses	Cantidad en exceso de \$150 Provisión
Audífonos (cada 36 meses)	Cantidad en exceso de \$500 Dieta por la ayuda
Atención de enfermería especializada (Hasta 100 días por periodo de beneficios)	No hay cobro
Los dispositivos externos de prótesis, dispositivos ortopédicos, y ostomía y urológicos Suministros.....	No hay cobro
Ostomía y suministros urológicos	No hay cobro
Este es un resumen de las preguntas más frecuentes acerca de los beneficios. Esta tabla no explica los beneficios, reparto de costos, fuera de su bolsillo máximos, exclusiones o limitaciones, ni una lista de todos los beneficios y las cantidades Costo de Acciones. Para una explicación completa, consulte la EOC de Kaiser.	

Suplemento de Medicare de AARP plan N (un plan complementario de Medigap o Medicare) - UnitedHealthCare

MEDICARE PARTE A: SERVICIOS DE HOSPITAL POR PERIODO DE BENEFICIO PARA 2019*

Servicio	Período	Medicare paga	Plan N Paga	Tu pagas
Hospitalización* (Habitación semiprivada y comida, enfermería general, Misc. Servicios y suministros)	Primeros 60 días	Todos menos \$1,364	\$1.364	\$0
	Días 61-90	Todos menos \$341 / día	\$341 /día	\$0
	Días 91 o más, mientras usa 60 días de reserva de por vida	Todos menos \$682 / día	\$682 /día	\$0
	Después se utilizar reserva de por vida, un adicional de 365 días	\$0	100% de los gastos elegibles de Medicare	\$0 **
	Después de los 365 días adicionales	\$0	\$0	todos los costos
Centro de enfermería y atención especializada*	Primeros 20 días	Todas las cantidades aprobadas	\$0	\$0
	Días 21-100	Todos menos \$170.50/ día	Hasta \$170.50 /día	\$0
	Días 101 o mas	\$0	\$0	todos los costos
Sangre	Las primeras 3 pintas	\$0	3 pintas	\$0
	Cantidades adicionales	100%	\$0	\$0
Cuidado de hospicio		Todos menos co-pago muy limitado para medicamentos ambulatorios y cuidado de relevo para pacientes hospitalizados	co-pago /co-seguro de Medicare	\$0

* Un período de beneficios comienza el primer día en que reciba el servicio como un paciente hospitalizado en un hospital y termina después de haber estado fuera del hospital y no haya recibido atención especializada en cualquier otro centro durante 60 días seguidos.

** Cuando sus beneficios hospitalarios de Medicare Parte A se han agotado, el asegurador toma el lugar de Medicare y pagará cualquier cantidad que Medicare hubiera pagado por un período adicional de 365 días según lo provisto en la política de "Beneficios de la central." Durante este tiempo, el hospital se le prohíbe a facturarle el equilibrio basado en la diferencia entre los cargos facturados y la cantidad que Medicare hubiera pagado.

UnitedHealthcare - Suplemento a Medicare de AARP plan N (continuación)

MEDICARE PARTE B: SERVICIOS MÉDICOS POR AÑO CALENDARIO PARA 2019

Servicio	Período	Medicare paga	Plan N Paga	Tu pagas
Gastos médicos (Tratamiento en o fuera del hospital y hospital para pacientes ambulatorios)	Primeros \$185 de la cantidad aprobada	\$0	\$0	\$185 deducible
	El resto de cantidades aprobadas	Generalmente 80%	El saldo, aparte de el co-pago	\$20 por visita al consultorio; hasta \$50 por visita a la sala de emergencia**
	Beneficios preventivos para los servicios cubiertos por Medicare	Generalmente 75% o más de los cobros aprobados por Medicare	El saldo, hasta \$20 por visita al consultorio	Hasta \$20 por visita al consultorio
Tarifas por exceso	Las cantidades por encima de los montos aprobados	\$0	\$0	todos los costos
Sangre	Las primeras 3 pintas	\$0	todos los costos	\$0
	Siguiente \$140 de los montos aprobados	\$0	\$0	\$185 deducible
	El resto de cantidades aprobadas	80%	20%	\$0
Servicios de Laboratorio Clínico	Prueba para servicios de diagnóstico	100%	\$0	\$0

* Una vez que le hayan facturado \$185 de los cobros aprobados por Medicare, el deducible para Parte B se cumple para el año calendario.

** El co-pago para la sala de emergencia co-pago no se aplica si es admitido al hospital y la visita está cubierto como un gasto de Medicare Parte A.

Partes A y B

Servicio	Período	Medicare paga	Plan N Paga	Tu pagas
Home Health Care	Servicios que son médicamente necesarios de atención especializada y suministros médicos	100%	\$0	\$0
Equipo médico duradero	Primeros \$185 de los cobros aprobados	\$0	\$0	\$185 deducible
	El resto de cantidades aprobadas	80%	20%	\$0

UnitedHealthcare - Suplemento a Medicare de AARP plan N (continuación)

Los beneficios no están cubiertos por Medicare

Servicio	Período	Medicare paga	Plan N Paga	Tu pagas
Viaje al extranjero (servicios de emergencia que son necesarios)	Primeros \$250 cada año calendario	\$0	\$0	\$250
	El resto de los montos aprobados	\$0	80% a un máximo de por vida. \$50.000	20% y las cantidades más de la max.

Para otros beneficios disponibles bajo el Suplemento de Medicare de AARP plan de seguro N, consulte a su paquete de inscripción o llame al 1-800-392-7537.