NORTHERN CALIFORNIA PIPE TRADES TRUST FUNDS FOR UA LOCAL 342

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TO: ACTIVE AND RETIRED PARTICIPANTS

RE: ANNUAL NOTIFICATIONS / IMPORTANT INFORMATION ABOUT THE PLAN

This Notice includes annual notices the Plan is required to provide you under the Patient Protection and Affordable Care Act ("ACA") and other Federal Laws. It also includes other reminders of various Plan rules. **This is for informational purposes only. No action is necessary.**

A. ACA Grandfathered Health Plan Statement

The Board of Trustees believes the Northern California Pipe Trades Health and Welfare Plan (hereafter "Plan") is a "Grandfathered Health Plan" under the ACA. As permitted by the ACA, a Grandfathered Health Plan can preserve certain basic health coverage that was already in effect when that ACA was enacted. Being a Grandfathered Health Plan means that your Plan is not required to include certain consumer protections of the ACA that apply to other plans (known as Non-Grandfathered Plans); for example, requiring the provision of preventive health services without any cost sharing. However, Grandfathered Health Plans must comply with certain other consumer protections in the ACA, such as the elimination of annual and lifetime limits on the Plan's essential health benefits. (For a definition of what constitutes as Essential Health Benefits, please visit *www.healthcare.gov/glossary/essential-health-benefits*.)

Questions regarding which protections apply and which protections do not apply to a Grandfathered Health Plan and what might cause a plan to change from Grandfathered Health Plan status can be directed to the Employee Benefits Security Administration, U.S. Department of Labor (DOL) at 866/444–3272 or *www.dol.gov/ebsa/healthreform*. This website has a table summarizing which protections do and do not apply to Grandfathered Health Plans. Implementation of the ACA's provision began with the July 1, 2011 Plan Year.

B. ACA Availability of Summary of Benefits and Coverage ("SBC")

Group Health Plans, Insurers, and Health Maintenance Organizations ("HMOs") are responsible for providing an SBC annually to all eligible participants as well as to all future eligible new Participants and their Dependents upon initial and special enrollment, as well as 60 days prior to a mid-year material modification of the SBC. The SBC provides a summary of what the Plan covers and what it costs and allows you to compare the Plan's benefit options (currently Kaiser Permanente HMO, Blue Shield of California HMO, or Blue Shield of California PPO) offered to you and/or your eligible Dependents. You have the right to request and receive within seven (7) business days an SBC for the Plan's benefits offered through Kaiser Permanente and Blue Shield of California. If you would like to receive a copy of the SBC and/or more details about your coverage, please contact Kaiser Permanente at 800/464-4000 or Blue Shield of California at 855/256-9404.

C. ACA Notice of Non-Discrimination

The Plan is required by the ACA to provide you with a Notice of Non-Discrimination about your rights under the law. This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a written grievance (including an appeal) in person or by mail, fax, or email with the Plan's Civil Rights Coordinator at the contact below. If you have questions on the Plan's grievance procedures or need help filing a grievance, please contact the Plan's Civil Rights Coordinator, Kim Biagi at 1855 Gateway Blvd., Suite 350 Concord, CA 94520-8445, Telephone: (925) 356-8921, Fax: (925) 356-8938, E-mail: *tfo@ncpttf.com*.

You can also file a grievance with Kaiser Permanente by calling (800) 278-3296 or Blue Shield by calling (855) 256-9404. For information about Kaiser or Blue Shield's grievance procedures please refer to your Kaiser or Blue Shield Evidence of Coverage booklet.

D. ACA No Pre-Existing Condition Exclusions for Any Person

Under the ACA, you and your eligible Dependents cannot be denied coverage, charged higher premiums, subjected to an extended waiting period, or have benefits modified because of a pre-existing condition (i.e., medical or mental condition that existed prior to enrolling in the health plan). Your Plan (including Kaiser and Blue Shield) does not impose any pre-existing condition exclusions.

E. ACA Individual Mandate and Minimum Essential Coverage

The ACA establishes a minimum value standard of benefits for a health plan and requires you and your dependents to have health coverage that qualifies as minimum essential coverage. Subject to certain exceptions, failure to have minimum essential health coverage will subject you to an Internal Revenue Service ("IRS") penalty. The minimum value standard is 60% (actuarial value) and Grandfathered Health Plans (such as this Plan) are considered minimum essential coverage. **As such, if you are covered under the Northern California Pipe Trades Health and Welfare Plan you meet the individual mandate**, **since this Plan provides minimum essential coverage and meets the minimum value standard for the benefits it provides (exceeds 60%).**

Around March 2017, depending on which Plan option you are enrolled in, Kaiser Permanente or Blue Shield of California will be required to send you a statement (known as Form 1095-B) about the coverage you and/or your dependents are enrolled in. This information is intended to help you meet your individual mandated requirement and to assist you in reporting your health coverage when you file your income tax return. Kaiser Permanente and Blue Shield of California are also required to file this Form with the IRS. If you did not receive such statement yet, please contact Kaiser or Blue Shield.

F. ACA Notice of Rescission of Coverage Restrictions

Under the ACA, the Plan and Insurers (such as Kaiser Permanente and Blue Shield of California) cannot retroactively cancel or terminate your coverage, except in cases of fraud, intentional misrepresentation of material fact, or failure to pay premiums. However, a retroactive cancellation of coverage is not considered a rescission if (1) it only has prospective effect, (2) is initiated by the covered individual, (3) due to delay in administrative record-keeping, (4) attributed to a failure to timely pay required premiums or contributions toward the cost of coverage, or (5) termination of coverage retroactive to a divorce, if the Plan does not cover former spouses. Plans and Insurers that rescind coverage must give affected individuals at least 30 days advance notice.

G. Availability of the Notice of Privacy Practices

The Board of Trustees of the Plan has adopted a Notice of Privacy Practices. The Notice of Privacy Practices describes the ways that the Plan uses and discloses your medical information, your rights, and the Plan's legal responsibility regarding your medical information. You may obtain a copy of the Notice on the Plan's website at *www.ncpttf.com* or by contacting the Trust Fund Office to request a paper copy of the Notice at any time. The Notice is also automatically provided to you at least once every three years or when there is a material change to the Notice.

H. Newborns and Mothers Health Protection Act

Under Federal Law, Group Health Plans, Health Insurance Issuers, and HMOs (such as Kaiser Permanente and the Blue Shield of California HMO option) may not generally, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or Issuer (Kaiser Permanente or Blue Shield of California) may pay for a shorter stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

In addition, under Federal Law, Plans and Issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. A Plan or Issuer may not, under Federal Law, require that a physician or other Health Care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification.

For information on precertification or if you have any questions about your Plan's coverage as it relates to childbirth or a newborn child, you may contact your selected Health Plan (Kaiser Permanente or Blue Shield of California) directly. The toll free number for Kaiser Permanente is 800/464-4000 and Blue Shield of California is 855/256-9404.

I. One (1) Year Limitation Period for Filing a Lawsuit

Under the Plan's Claims and Appeals rules, no lawsuit may be brought against the Plan and/or the Board of Trustees and/or any Individual Trustee more than one (1) year after services were provided, or benefits were partially or totally denied, or an adverse benefit determination was issued. In addition, you must first utilize the Plan's Appeal Procedures before commencing a lawsuit, if any, against the Plan and/or the Board of Trustees and/or any Individual Trustee. Any outside entity providing services for the Plan (e.g., Kaiser Permanente, Blue Shield of California, Delta Dental of California, Principal Life Insurance Company, Vision Service Plan ("VSP") has their own claims and appeals procedures, and you would need to contact them for more information.

If you are enrolled in Kaiser Permanente, Blue Shield of California, Delta Dental of California and/or Vision Service Plan, please refer to the applicable Evidence of Coverage Documents for its appeal and grievance procedures.

J. Same-Sex Spouses are Covered under the Plan

The Plan will treat same-sex spouses in the same manner as it treats opposite-sex spouses. If you have a same-sex spouse, you may enroll that spouse for coverage under the Plan in the same manner and under the same rules as an opposite-sex spouse. Please refer to Article VI of the Restated Summary Plan Description ("SPD")/Plan Document for more information about enrollment procedures.

K. Premium Assistance under Medicaid and the Children's Health Insurance Program ("CHIP")

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, the State you reside in may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs. **NOTE: California is NO LONGER a state that provides premium assistance to help pay for Medicaid or CHIP coverage; however, the Medi-Cal Program will continue to provide health, dental, and vision benefits to California's low-income, uninsured children. Information is available at *www.coveredca.com/medi-cal/*.**

If you or your Dependents are already enrolled in Medicaid or CHIP and you live in a State that provides premium assistance, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office at **877/KIDS NOW** or ***www.insurekidsnow.gov*** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

If it is determined that you or your Dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under the plan documents you may enroll in your employer plan if you are not already enrolled. The employer cannot stop you from enrolling. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at *www.askebsa.dol.gov* or by calling toll-free 866/444-EBSA (3272).

To find out if the State you reside in provides assistance in paying your employer health plan premiums or for more information on eligibility, visit the Plan website at *www.ncpttf.com* for a list of participating States.

To see if any more States have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, you can also contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

L. Women's Health and Cancer Rights Act of 1998

Under Federal Law, Group Health Plans, Insurers, and HMOs (such as Kaiser Permanente and the Blue Shield of California HMO option) that provide medical and surgical benefits in connection with a mastectomy must provide benefits for reconstructive surgery, in consultation with the attending physician and patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed; and
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient.

This coverage is subject to the Plan's annual deductibles, coinsurance, and co-payment provisions (consistent with those established for other benefits under the Plan). This Plan complies with these requirements. If you have any questions about whether your Plan covers mastectomies or reconstructive surgery, you may contact your selected Health Plan (Kaiser Permanente or Blue Shield of California) directly. The toll free number for Kaiser Permanente is 800/464-4000 and Blue Shield of California is 855/256-9404.

M. Retiree Returning to Covered Employment

If you are retired and considering returning to work, you must submit a written request for a determination to the Board of Trustees of the Northern California Pipe Trades Pension Plan on whether your contemplated employment would be considered "Prohibited Employment" under Plan rules. (**Please refer to the Northern California Pipe Trades Pension Plan Suspension of Retirement Benefits Notice**.)

If you return to any type of "Prohibited Employment" your monthly Retirement Benefits will be suspended. If you are eligible for Retiree Health and Welfare Benefits, your Retiree Health and Welfare Benefits will also be suspended. (**Please refer to the Northern California Pipe Trades Pension Plan Suspension of Retirement Benefits Notice**.)

However, the Plan will permit you the loss of Retiree Health and Welfare Benefits under these circumstances one (1) time without forfeiting your right to Retiree Health and Welfare Benefits. Any subsequent termination of a Retiree's Health and Welfare coverage will result in a permanent termination of Retiree Health and Welfare Benefits. Please refer to Article XIII, Section A.9 of the SPD for more details.

In the event of a Temporary Special Needs Provision and/or a period of Full Employment, special Plan provisions would apply. Please refer to the most current Temporary Special Needs Provision or Full Employment Notice that can be found on our website at www.ncpttf.com.

N. Medicare Coordination – You are Required to Enroll

Medicare is our country's federal health insurance program for people who worked at least ten years in Medicare-covered employment who are age 65 or older, for people under age 65 with certain disabilities, and for people of any age who have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). If you are receiving Social Security Disability Income ("SSDI") benefits, you generally become eligible for Medicare

coverage 24 months after your SSDI benefits begin. **ALERT**: If you are not a citizen or permanent U.S. resident, you may not be eligible for certain or all of the medical coverage under the Plan.

Under the Medicare program, the hospital insurance portion is called Medicare Part A, and the medical insurance portion, such as for the cost of physicians, is called Medicare Part B. Medicare Part A is financed by payroll taxes, and if you are eligible to receive, it is based on your own or your spouse's employment. You do not pay a premium. Medicare Part B is partly financed by monthly premiums paid by individuals enrolled for Medicare Part B coverage. Most working people are entitled to Medicare Part A and Part B–when they reach age 65 because either they or a spouse paid Medicare taxes while working. Failure to timely notify the Trust Fund Office of your Medicare entitlement may result in penalties.

The Plan coordinates benefits with Medicare as if you are covered under both Medicare Part A (hospital benefits) and Part B (medical benefits). This means you must enroll in **both Medicare Part A and Part B**, as soon as you are eligible for Medicare. If you do not enroll in Medicare (Part A and Part B), the Plan will not make up for the portion of expenses that Medicare would have paid, and you will be required to pay an additional Retiree Health and Welfare Premium, currently $275 per month.

Medicare's prescription drug plan (**Medicare Part D**) is available to Medicare beneficiaries and is part of your coverage if you are enrolled in the Retiree Health and Welfare Plan. If you earn a higher income (above $85,000 for individuals or above $170,000 for married couples), Federal Law requires that you pay an additional premium for your Medicare Part D coverage to the Social Security Administration.

This additional premium is called the Income-Related Monthly Adjustment Amount (also known as "IRMAA"). The premium is based on your modified adjusted gross income as reported on your IRS tax return from two years prior (thus, the fee in 2017 will be based on your adjusted gross income on your 2015 tax return). If you must pay a higher premium, Medicare will send you a letter with your premium amounts and the reason for their determination.

For more information on Medicare Part D or IRMAA, please call Medicare at 800/MEDICARE (800/633-4227) or visit *www.medicare.gov.* TTY users should call 877/486-2048. If you have any questions, please contact the Trust Fund Office at 925/356-8921 ext. 246 or toll free at 800/780-8984 ext. 246.

O. HIPAA Group Special Enrollment Rights

Under Federal Law, if you declined enrollment for yourself and/or your Dependents (including your spouse) because of having other sufficient group health coverage, you may be able to enroll yourself and/or your Dependents in this Plan, if you or your Dependents lose eligibility for that other coverage. However, you must request enrollment within 30 days after you or your Dependents' other coverage ends.

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement of adoption, you may be able to enroll yourself and your Dependents within 30 days after the birth, adoption, placement for adoption, or marriage provided you complete and submit an Enrollment/Change Form along with any other Plan required documentation (e.g. certified marriage certificate, certified birth certificate, Court Adoption Order) to the Trust Fund Office.

The Plan will also allow a special enrollment opportunity if you and/or your eligible Dependents either: (1) lose Medicaid or CHIP coverage because you are no longer eligible, or (2) become eligible for a State's premium assistance program under Medicaid or CHIP. For these enrollment opportunities you will have 60 days from the date of the Medicaid/CHIP eligibility change to request enrollment in the Plan.

To request special enrollment information, please contact the Trust Fund Office.

P. Important Reminder to Provide the Plan with Taxpayer Identification Number or Social Security Number of Each Enrollee in the Plan

Employers and the Plan are required by law to collect the Taxpayer Identification Number (TIN) or Social Security Number (SSN) of each Plan Participant and provide that number on reports (known as Forms 1094-B, 1095-B, 1094-C and 1095-C) that will be provided to the IRS each year. Employers and the Plan are required to make at least three consecutive attempts to gather missing TINs/SSNs.

If a Dependent does not yet have a SSN, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for an SSN is FREE.

If you have not yet provided the SSN (or other TIN) for each of your Dependents that you have enrolled in the Plan, please contact the Trust Fund Office.

P. Other Plan Reminders

Please periodically update your Beneficiary Designation Form when you have a change in your life circumstances. The Beneficiary Designation Form is available at *www.ncpttf.com* or you may contact the Trust Fund Office.

It is your responsibility to notify the Trust Fund Office of changes to your address and/or changes in your life circumstances (e.g. divorce, legal separation, dependent child ceases to be an eligible dependent). You will be required to complete the appropriate Enrollment/Change Form or Change Request Form, both of which are available at *www.ncpttf.com*.

Please note, no benefits will be paid by the Plan for fraudulent premiums, claims or services made by a Participant, Dependent, or any other person, for any other reasons, including, but not limited to enrolling ineligible Dependents, failing to notify the Plan that a previously eligible Dependent no longer qualifies as a Dependent, failure to timely enroll in Medicare or failure to notify the Trust Fund Office of you or your Dependent's eligibility to enroll in Medicare. If payment is made on behalf of any person for fraudulent claims, the Participant and any person on whose behalf a fraudulent claim was submitted will be responsible for repaying the Plan.

As a reminder, the following classifications are only permitted to enroll in the Plan's Kaiser Permanente HMO option:

- Residential Employees and their eligible Dependents;
- Tradesmen and Servicemen Employees and their eligible Dependents;
- Shortline Helper, and MLA Helper Employees, and their eligible Dependents; and
- U.A. National Distribution Agreement Employees, and their eligible Dependents.

Below is a list of Contacts for your convenience:

Provider/Contact	Type of Benefit	Website	Phone Number
Kaiser Permanente	Medical & RX	www.kaiserpermanente.org	800/464-4000 800/777-1370 (toll-free)
Blue Shield of California	Medical & RX	www.blueshieldca.com	855/256-9404
Delta Dental of California	Dental	www.deltadentalins.com	800/765-6003
Vision Service Plan	Vision	www.vsp.com	800/877-7195 800/428-4833 (toll-free)
Kaufmann & Goble	Health Reimbursement Account	www.kandg.com	855/512-1170

If you have any questions, please contact the Trust Fund Office at 925/356-8921 ext. 246 or toll free at 800/780-8984 ext. 246.

Respectfully submitted,
Fund Manager
On Behalf of the Board of Trustees