CMTA-IAM JOINT RETIREE HEALTH & WELFARE TRUST
SUMMARY PLAN DESCRIPTION (SPD) WRAP
For the Insured Medical Plans for
Retirees and their Eligible Dependents

IMPORTANT NOTE
This Summary Plan Description (SPD) document, together with the Evidence of Coverage issued by the insurance company and the enrollment brochure, is your Plan Document. If the Evidence of Coverage or the enrollment brochure are not attached then the Plan Document is not complete and you should contact the Trust Fund Office for a complete Plan Document.

This Retiree Plan has been determined to be a "Retiree only Plan" meaning that is not subject to many of the group health requirements under HIPAA and the PPACA (Health Reform).

Effective September 1, 2019

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Introduction

What This Document Tells You

This Summary Plan Description (SPD) Wrap effective September 1, 2019 describes the federal mandated provisions of this Retiree Plan that are part of the CMTA-IAM Joint Retiree Health & Welfare Trust (the "Fund" or "CMTA-IAM Fund"). Your specific medical coverage is described in an Evidence of Coverage (EOC) from the insurance company and most eligibility provisions are described in your enrollment brochure that is distributed annually with your open enrollment materials.

- To determine if you are in a class of individuals who are eligible for benefits under this Plan, refer to the Eligibility information described in your enrollment brochure.
- To review your specific coverage provisions and exclusions from coverage, please refer to the Evidence of Coverage from the insurance company.
- No individual shall have accrued or vested rights to benefits under this Plan. A vested right refers to a benefit that an individual has earned the right to receive and that cannot be forfeited. Plan benefits are not vested and are not guaranteed.
- **All provisions of this document contain important information.** If you have any questions concerning eligibility or the benefits that you or your family are eligible to receive, please contact the Fund Office at their phone number and address located on the Quick Reference Chart in this document. As a courtesy to you, Fund Office staff may respond informally to oral questions; however, oral communications are not binding on the Plan and cannot be relied upon in any dispute concerning your benefits. Your most reliable method is to put your questions into writing and fax or mail those questions to the Fund Office and obtain a written response. In the event of any discrepancy between any information that you receive from the Fund Office, orally or in writing, and the terms of the Plan Document (that is, collectively, this SPD, the Evidence of Coverage, and the enrollment brochure), the terms of the Plan Document will govern your entitlement to benefits, if any.

You should review this document and share it with those members of your family who are or will be covered by the Plan.

IMPORTANT INFORMATION

CMTA-IAM Fund is committed to maintaining health care coverage for Retirees and their eligible family members at an affordable cost, however, because future conditions cannot be predicted, the Board of Trustees reserves the right to amend or terminate coverage at any time and for any reason. As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

This Plan is established under and subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA. All of the medical benefits of the

Plan are fully insured with insurance companies whose names are listed on the Quick Reference Chart in this document. The medical benefits of the plan are not described in this document and instead, are described in documents (EOCs) created by the various insurance companies.

Este folleto contiene un resumen en inglés de sus derechos y beneficios conforme al plan denominado CMTA-IAM Fund. Si usted tiene dificultades para comprender el contenido de este folleto, tenga las oficinas del Administrador del Plan: 4160 Dublin Blvd., Suite 400, Dublin, CA 94568-7756. Las horas de oficina son desde las 8:00 a.m. hasta la 5:00 p.m. de lunes a viernes. Para recibir ayuda, puede también llamar a las oficinas del Administrador del Plan, a los teléfonos (800) 635-3105.

COORDINATION OF BENEFITS WITH MEDICARE

To comply with federal Medicare coordination of benefit regulations, you must promptly furnish to the Plan Administrator, or its designee, the Social Security Number (SSN) of your eligible Dependents for which you have elected, or are electing, Plan coverage, and information on whether you or any of such dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date. Failure to provide the SSN or complete the CMS model form (form is available from the Trust Fund Office or https://www.cms.gov/MandatoryInsRep/Downloads/RevisedHICNSSNForm081809.pdf) means that claims for eligible individuals may not be processed for the affected individuals.

IMPORTANT NOTICE

You or your Dependents must promptly furnish to the Trust Fund Office information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, change in domestic partnership status, change in eligibility status of a Dependent Child, Medicare enrollment or disenrollment or the existence of other coverage.

Notify the Plan preferably within 31 days, but no later than 60 days, after any of the above noted events.

Failure to give this Plan a timely notice (as noted above) may cause your Spouse and/or Dependent Child(ren) to lose their right to obtain COBRA Continuation Coverage, or may cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability, or may cause claims to not be able to be considered for payment until eligibility issues have been resolved, or may result in a participant's liability to the Plan if any benefits are paid to an ineligible person.

For Help or Information

If you need further help, call the people listed in the following Quick Reference Chart:

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
Trust Fund Office • Eligibility for coverage • Questions about the HRA • Billing • COBRA eligibility • Premium payments	**Health Services & Benefit Administrators** 4160 Dublin Blvd., Suite 400 Dublin, CA 94568-7756 Phone (800) 635-3105 Fax (925) 588-712
Kaiser Permanente • * Kaiser Senior Advantage ($10 copay) for Medicare Retirees (California residents only) • * Kaiser Senior Advantage ($20 copay) for Medicare Retirees (California residents only) • Kaiser HMO for Non-Medicare Retirees (California residents only) • Kaiser Deductible HMO Plan for Non-Medicare Retirees (California residents only) * There is additional hearing aid and dental coverage available. However, the Medicare Retiree will have to pay 100% of the premium.	**Kaiser Permanente Health Plan** California Division 1950 Franklin Street Oakland, CA 94612 Current Kaiser HMO participants in Oregon and Hawaii may continue enrollment in these plans. However, new enrollees will not be accepted. (800) 464-4000 www.kaiserpermanente.org OR www.kp.org
Kaiser Permanente of Washington • HMO for Medicare Retirees (Washington residents only) • HMO for Non-Medicare Retirees (Washington residents only)	**Kaiser Foundation Health Plan of Washington** 601 Union Street Suite 3100 Seattle, WA 98101 (888) 901-4636 www.kp.org/wa
United Healthcare (UHC) • United Healthcare HMO Plan for Non-Medicare Retirees (California residents only) • United Healthcare Secure Horizons HMO Plan (California residents only) • United Healthcare Senior Supplement Plan (Plan C) for Medicare Retirees (residents of any state) • United Healthcare Stand-alone Prescription Drug Plan (PDP) (residents of any state)	**United Healthcare (UHC)** www.uhc.com (800) 698-0822, TTY 711

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
Health Net Medicare Advantage • Health Net Seniority Plus Plan for California residents	**Health Net Medicare Programs** PO Box 10420 Van Nuys, CA 91410-0420 (800) 275-4737 / 711
Vision Discount Plan • Discount vision program that offers immediate savings on eye care and eyewear	**VSP's Savings Pass Plan** www.vsp.com (800) 877-7195
COBRA Administrator	**See Trust Fund Office above**

Eligibility for Trust Fund-Sponsored Health Care Benefits

Who is Eligible?

Retiree

You are eligible for retiree benefits if:

- You have retired under a collective bargaining agreement with District Lodge 190 and (a) are receiving benefits from the Automotive Industries Pension Fund or IAM National Plan, or (2) are at least 55 years of age.

- You make the proper self-payments for coverage.

You may not enroll in this plan both as a retiree and as a dependent. If your coverage in the Plan is cancelled, you will be allowed to re-enroll for coverage under this Plan only once, subject to insurance carrier approval.

Dependents

If YOU qualify for benefits, the following dependents may be covered:

- Your spouse or domestic partner (if there is a registered domestic partnership with a governmental body pursuant to state law);

- Your unmarried children dependent on you for support, including:

  - Biological children;

  - Legally adopted child or a child placed for adoption. Placed for adoption means the assumption and retention by the Retiree of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement for adoption terminates upon the termination of such legal obligation;

  - Stepchildren;

  - Foster children (**Please note: Kaiser does not cover foster children,** including a foster child who (1) is claimed as an income tax deduction by the retiree, (2) is solely dependent on the retiree for support, and (3) lives in the retiree's home.);

  - A child named as an "alternate recipient" under a **Qualified Medical Child Support Order (QMCSO)** or a National Medical Support Notice.

  - An unmarried **grandchild** of the retiree under the age of 19 (proof of relationship and age will be required) who is eligible for tax-free health coverage as a "qualifying child" or "qualifying relative" under the applicable requirements of Internal Revenue Code Section 152(c) or 152(d), respectively **OR** who is claimed as a dependent on the retiree's federal income tax return for each plan year for which coverage is provided. In order to be eligible

for tax-free health coverage as a "qualifying child," the grandchild must (i) meet certain age/student limits, (ii) have the same principal place of abode as the participant for over half of the year, and (iii) not provide over half of his/her own support. To be eligible for tax-free health coverage as a "qualifying relative," the participant must provide over half of the grandchild's support, and the grandchild must not be the "qualifying child" of any person.

You can cover children up to age 19 (or to age 23, if full-time students at accredited educational institutions and dependent on you for at least half of their support).

- **Disabled Adult Child:** an unmarried child who, while eligible as a Dependent, becomes and remains incapable of engaging in self-sustaining employment because of mental or physical disability, and is solely dependent on the Retiree for support. A child meeting these qualifications shall continue to qualify as a Dependent so long as the parent remains continuously eligible as a Retiree. Satisfactory evidence of continued disability may be requested by the Fund from time to time.

Qualified Medical Child Support Orders (QMCSO)

This Plan will provide benefits in accordance with a **National Medical Support Notice**. In this document the term QMCSO is used and includes compliance with a National Medical Support Notice. According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. The QMCSO typically requires that the Plan recognize the child as a dependent even though the child may not meet the Plan's definition of dependent. A QMCSO usually results from a divorce or legal separation and typically:

- Designates one parent to pay for a child's health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
- States the period for which the QMCSO applies; and
- Identifies each health care plan to which the QMCSO applies.

1. An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any benefit option that the Plan does not otherwise provide, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.
2. If a court or state administrative agency has issued an order with respect to health care coverage for any Dependent Child of the retiree, the Plan Administrator or its designee will determine if that order is a QMCSO as defined by federal law. That determination will be binding on the retiree, the other parent, the child, and any other party acting on behalf of the child. The Plan Administrator or its designee will notify the parents and each child if an order is determined to

be a QMCSO, and if the retiree is covered by the Plan, and advise them of the procedures to be followed to provide coverage of the Dependent Child(ren).

3. **Enrollment related to a valid QMCSO:** If the Plan has determined that an order is a valid QMCSO it will accept enrollment of the alternate recipient as of the earliest possible date following the date the Plan determined the order was valid, without regard to typical enrollment restrictions.
   a. **If the retiree is already a Plan Participant**, the QMCSO may require the Plan to provide coverage for the retiree's Dependent Child(ren) and to accept contributions for that coverage from a parent who is not a Plan participant. The Plan will accept a late enrollment of the alternate recipient specified by the QMCSO from either the retiree or the custodial parent. Coverage of the alternate recipient will become effective as of the date specified on the QMCSO or if not specified, the first day of the month after the late enrollment request is received. Coverage will be subject to all terms and provisions of the Plan, including any requirements for authorization of services, as permitted by applicable law.
4. **Contributions for Coverage:** No coverage will be provided for any alternate recipient under a QMCSO unless the applicable retiree contributions for that alternate recipient's coverage are paid, and all of the Plan's requirements for enrollment and coverage of that alternate recipient have been satisfied. Contributions required for coverage under a QMCSO are the total employer contributions (if any) required for coverage of the retiree and all members of the retiree's family who are enrolled in the Plan, minus the contributions otherwise actually being paid by the retiree.
5. **Termination of Coverage:** Generally, coverage under the Plan terminates for an alternate recipient when the period of coverage required under the QMCSO ends or for the same reasons coverage terminates under the Plan for other Dependent children. This includes termination of coverage for failure to pay any required contributions. When coverage terminates, alternate recipients may be eligible for COBRA Continuation Coverage.
6. **Additional Information:** For additional information (free of charge) regarding the procedures for administration of QMCSOs, contact the Trust Fund Office at the number listed on the Quick Reference Chart.

When Does Coverage Begin?

Coverage begins upon proper self-payment on the date you have retired under a collective bargaining agreement with District Lodge 190 and (1) begin receipt of pension payments from a qualified pension plan; or (2) have reached age 55.

If you do not wish your coverage to begin on this date, you may apply at a later date. In this case, coverage would begin on the first day of the month after proper application is made to the Trust Fund Office. Application for Non-Medicare plans may be made at any time after you are eligible. Medicare Retirees should take note of the Part A and Part B enrollment requirement and the timeframes for enrolling in Part A and Part B (explained in your Enrollment Guide).

Dependents become eligible under the plan at the same time you become eligible, or on the date the dependent becomes an eligible dependent, if later.

If you and your eligible dependent(s) elect coverage and become eligible under the plan, but you later die, surviving spouse/domestic partner and/or eligible dependent child benefits will

continue after your death. Coverage may be suspended for a spouse/domestic partner if he/she becomes employed or covered under another health and welfare program; eligibility for coverage under this Plan will be resumed when the other coverage terminates. Note that Surviving Spouse coverage is an alternative to COBRA and therefore either COBRA or Surviving spouse coverage can be elected,

The spouse/domestic partner's coverage will terminate permanently on the date of remarriage. In addition, a domestic partner's coverage will terminate permanently if he or she registers a new domestic partnership.

Termination of Coverage

Retiree coverage ends on the earliest of:

- is no longer eligible to participate in the Plan; or
- the last day of the month in which the Retiree fails to make any required contributions for coverage. Failure to submit your monthly self-payment in a timely manner will be interpreted as a voluntary request to terminate your coverage; or
- the date of the Retiree's death; or
- the date Retiree coverage is discontinued under the Plan;
- the date the Retiree becomes eligible for coverage under another group health plan.

Dependent coverage ends on the earliest of the last day of the month in which:

- the Retiree's coverage ends (unless eligible for survivor benefits as outlined below); or
- your covered spouse/domestic partner or dependent child(ren) no longer meet the definition of spouse/domestic partner or dependent child(ren); or
- for dependents under a QMCSO, the expiration of the period of coverage stated in the QMCSO; or
- you cease to make any contributions required for coverage of your spouse/domestic partner or dependent child(ren); or
- the date the dependent enters the armed forces on full-time active duty; or
- you drop the dependent's coverage at open enrollment or due to a qualifying mid-year change event;
- the date of the dependent's death;
- the date dependent coverage is discontinued under the Plan;
- or the date the Plan is discontinued.

Coverage for a surviving Spouse or domestic partner ends on the last day of the month in which the spouse/domestic partner if he/she becomes employed or covered under another health and welfare program. Coverage will be resumed under this plan when the other coverage terminates. The spouse/domestic partner's coverage will terminate permanently on the date of remarriage.

Re-Entry to the Plan

As a participant in the CMTA-IAM Fund, you have many different coverage options available to you (depending on whether you are an early retiree or a retiree who is eligible for Medicare).

After coverage has been cancelled, the Board of Trustees will allow a retiree and eligible dependents to re-enter the plan on a prospective basis. However, please note:

- All re-entry will be subject to the insurance carrier permitting such re-enrollment.
- There may be instances where this will not be permitted (e.g., if you were previously terminated for cause or if you are eligible for or entitled to Medicare and Medicare will not permit re-enrollment).
- There may be applicable Medicare late enrollment penalties if you go for any period of time without coverage.

If permitted by the carrier, re-entry enrollment will become effective on the first day of the month following the date on which all properly completed enrollment documentation and any applicable self-payment are received by the Trust Fund Office. Please contact the Trust Fund Office if you have any questions.

INFORMATION ABOUT MEDICARE PART D PRESCRIPTION DRUG PLANS

Please note: This section applies only to early retirees (and dependents). If you are a Medicare eligible Retiree (or dependent), and you are covered under a Medicare Advantage Plan, this section does not apply to you. Your Medicare Advantage Plan is required under law to provide at least a standard level of coverage set by Medicare.

If you and/or your Dependent(s) are enrolled in either Part A or B of Medicare, you are also eligible for Medicare Part D prescription drug benefits. It has been determined that the prescription drug coverage under the Kaiser or United Healthcare insured medical plans for non-Medicare eligible persons offered under this Fund are "creditable." "Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

Because the medical plans noted above have prescription drug coverage as good as Medicare, you do not need to enroll in a Medicare prescription drug plan in order to avoid a late penalty under Medicare. You may, in the future, enroll in a Medicare prescription drug plan during Medicare's annual enrollment period (October 15 through December 7th of each year).

If, however you keep this Plan coverage and also enroll in a Medicare Part D prescription drug plan you will have dual prescription drug coverage and this Plan will coordinate its drug payments with Medicare. If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D premium out of your own pocket.

Note that you may not drop just the prescription drug coverage under this Plan. That is because prescription drug coverage is part of the entire medical plan. The circumstances under which you may drop or otherwise make changes to your medical plan coverage are detailed in the enrollment brochure.

For more information about creditable coverage or Medicare Part D coverage see the Plan's Notice of Creditable Coverage available from the Trust Fund Office. See also: www.medicare.gov for personalized help or call 1-800-MEDICARE (1-800-633-4227).

THIRD PARTY LIABILITY

Your HMO and/or Medicare Advantage plan may have rules concerning subrogation rights with respect to claims against third parties. Please review your Evidence of Coverage from the insurance company for more information.

Health Reimbursement Arrangement (HRA) Plan

Establishment of the HRA

The CMTA-IAM Fund permits reimbursement of certain medical care expenses on a nontaxable basis from the Health Reimbursement Arrangement (HRA) on a tax-free basis.

The HRA is intended to be a tax-exempt employer-provided plan with the intention that it qualify as a medical reimbursement plan within the meaning of Sections 105 and 106 of the Internal Revenue Code of 1986 (Code) and regulations issued thereunder, and as an HRA as defined under IRS Notice 2002-45 and shall be interpreted to accomplish that objective. The HRA is an Employee Welfare Benefit Plan under ERISA. The HRA complies with applicable federal regulations including COBRA and HIPAA Privacy and Security.

Eligibility

You are eligible to participate in the HRA if you are a covered Retiree in the CMTA-IAM Fund. Please note that the HRA cannot be used for a domestic partner who is not a qualified tax dependent.

Initial Effective Date

A Retiree will become eligible to participate in the HRA on the first day that the Retiree becomes eligible under CMTA-IAM Fund. Participation in the HRA will continue until the HRA Participant is no longer eligible as outlined below.

Accruing an HRA Balance

When you become an eligible Retiree, an HRA will be established in your name. Eligible medical care expenses incurred by you and your covered Dependents may be reimbursed from the balance in your HRA at the time a claim is submitted. This section describes how your HRA is developed and how the HRA is administered by the Fund Office.

Contributions to the HRA

The Board of Trustees will review the Fund's financial operations on an annual basis, to determine the appropriate HRA contribution amount and frequency of contribution based on the reserve level, financial projections, and financial outlook of the Plan.

Monthly self-payments are required for medical coverage under the plan. Employers contribute a portion of the cost of medical coverage for Retirees. That employer contribution is automatically loaded on a debit card that you can use for qualified medical expenses.

Nothing herein will be construed to require the CMTA-IAM Fund to maintain any trust fund or to segregate any amount for the benefit of any Retiree, and no Retiree or other person will have any claim against, right to, security or other interest in any fund, account or asset of the CMTA-IAM Fund from which any payment under the HRA may be made.

Debit Card

Eligible expenses under the Fund may be paid or reimbursed with a debit card that will be provided to you when you become eligible for benefits.

- only use the debit card to pay for eligible expenses incurred by the Employee, or his or her spouse, a tax-qualified domestic partner or eligible dependent children;
- not use the debit card for any medical expense that has already been reimbursed;
- not seek reimbursement under any other health plan for any expense paid for by the debit card; and
- acquire and maintain documentation, such as invoices and receipts, to substantiate any expenses paid for with the debit card.

The plan will limit use of the debit card to:

- physicians, dentists, vision care offices, hospitals, or other medical providers (as identified by their merchant category code);
- stores with a merchant category code for drugstores and pharmacies that comply with applicable IRS regulations;
- stores that have implemented an inventory information approval system consistent with applicable IRS regulations.

All claims for eligible expenses paid with your debit card need to be substantiated in a manner consistent with IRS guidance.

Merchant must be an IIAS or 90% vendor. An IIAS merchant has an Inventory Information Approval System (IIAS) that can automatically identify eligible medical expenses. A 90% merchant has a registered with a national organization, certifying that 90% or more of its revenue is from the sale of eligible medical items.

Unused Amounts in the HRA

If you do not incur enough expenses in a Plan Year (calendar year) to use up your HRA balance, you will not lose the unused amount in your HRA. Any unused amounts in your HRA at the end of the year will be carried over into the next calendar year. Eligible medical care expenses incurred in a previous year or in the current year can be reimbursed from the current balance in your HRA, even if all or part of the balance was carried over from the previous calendar year.

Upon termination of the Fund, the HRA Participant's coverage ceases. This means that there is no cash out, reimbursements or debits from any remaining balance in that HRA.

However, an HRA Participant may claim reimbursement of a medical care expense that was incurred during the period of coverage prior to termination of participation provided that the HRA Participant or their estate files a claim by March 31 following the close of the calendar year in which the medical care expenses were incurred.

Expenses submitted for reimbursement after your participation terminates will not be eligible for reimbursement unless COBRA is elected. Please note: when you retire, you are offered the choice between COBRA and Retiree coverage. If you elected Retiree coverage, you will have no further COBRA rights under the Plan.

Retiree Contributions

There are no Retiree or Dependent contributions permitted to the HRA.

No Funding Under a Cafeteria Plan

Under no circumstances will the benefits of the HRA be funded with salary reduction contributions, employer flex credit contributions or otherwise under a cafeteria plan.

Reimbursements

All reimbursements payable from the HRA will be paid from the general assets of the Plan. Your HRA is a notional (unfunded) bookkeeping record to track, on paper, any contributions credited to your HRA and any reimbursements made to you from the account. There are no investment income amounts earned or lost during the calendar year because the account is a notional account.

No reimbursement can be made from an HRA where the balance is zero.

Forfeitures

Amounts remaining in your HRA after your participation has ended will be forfeited, except in the event of death. In the event of your death, your participation in the HRA will end. After your death, your Dependents may elect COBRA in order to be entitled to reimbursements from your remaining HRA until the earlier of the date the HRA reaches a zero balance or the end of the COBRA Continuation Coverage.

Forfeitures will become the property of the Fund as administered by the Board of Trustees. Any HRA benefit payments that are unclaimed (e.g., uncashed benefit checks) 12 months after the period of coverage in which the medical care expense was incurred will be forfeited.

There is no cash out option, or reimbursement or debit from any remaining HRA balance for any reason including termination. The HRA is not portable.

HRA Qualified Medical Expenses

In general, Medical Care Expenses include, but are not limited to, amounts for such services as hospitalization, doctors and dentists, and prescription drugs. Such expenses also include amounts you pay for deductibles, copays, coinsurance, as well as premiums for group health plan coverage (provided premiums are not paid through salary reduction contributions under the terms of a Code Section 125 plan or any plan that provides for premium payment with pre-tax dollars), amounts paid for COBRA continuation coverage (COBRA premiums), and amounts paid for Medicare Parts B, C, and D coverage.

Medical expenses that are allowed to be reimbursed by your HRA are determined by Section 213 (d) of the Internal Revenue Code. For more detailed information, please refer to IRS Publication 502 titled, “Medical and Dental Expenses”. You can order the publication by calling (800) TAX FORM or see it online at http://www.irs.gov/pub/irs-pdf/p502.pdf. Please note that many of these expenses will have substantiation requirements – meaning that there may be other requirements for coverage to be available, sometimes including recommendation or prescription by a provider to treat a specific medical condition.

However, not all Medical Care Expenses will be considered "Eligible Medical Care Expenses" that qualify for reimbursement under the Fund. Generally, only Medical Care Expenses within the meaning of Section 213 of the Internal Revenue Code are eligible.

The HRA cannot be used to reimburse premiums for medical insurance in the individual market, federal Marketplace or state Exchange.

If you have any questions as to whether an expense is reimbursable, call the Fund Office.

Ineligible Medical and Over-the Counter Expenses

The following expenses are examples of the kinds of expenses that are not reimbursable, as they do not meet the definition of "medical care" under Code Section 213. This is not intended to be a complete list of all services that are not payable under the HRA, but an example of more commonly submitted services that are not reimbursed from the HRA. The HRA does not pay for/reimburse any item that does not constitute "medical care" as defined under Internal Revenue Code §213.

• Baby-sitting, child care, nursing services for a normal, healthy baby • Cosmetic surgery and procedures (unless it is necessary to improve a deformity) • Dancing lessons • Diaper service • Funeral expenses • Future medical care • Hair transplants • Health club or gym dues • Household help • Illegal operations and treatments • Maternity clothes • Medicines and drugs from other countries (unless FDA approved, or purchased and consumed in another country and legal in both other country and USA)	• Nonprescription drugs and medicines • Nutritional supplements • Personal use items • Swimming lessons, if only for general health improvement • Teeth whitening • Veterinary fees if not for Guide Dog or other service animal • Weight-loss program (unless for treatment of a specific disease diagnosed by a physician) • Cosmetics (including face creams/moisturizers) • Lip balm (including ChapStick® or Carmex®) • Medicated shampoos and soaps • Toiletries (including toothpaste) • Vitamins (daily), dietary supplements

Filing a Claim for Reimbursement

Each Retiree has been provided a debit card that is automatically loaded with contributions from the Board of Trustees. This debit card can be used for copays and other qualified medical expenses.

If it is necessary for you to file a claim for reimbursement, the following procedures must be followed:

a. **Claims Submission and Substantiation:** A written request to the Fund Office for reimbursement of a qualified medical expense from your HRA is considered to be a claim. In order to be reimbursed, you must provide applicable receipts, bills, invoices or other statements from the medical provider.

b. A claim for reimbursement of a qualified medical expense must be submitted to the Trust Fund Office within 12 months of the date the expense was incurred. After 12 months, the expense will no longer be eligible for reimbursement.

Inability to Locate Payee

If the Fund is unable to make payment to any Retiree or other person to whom a payment is due under the HRA because it cannot ascertain the identity or whereabouts of such Retiree or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Retiree or other person will be forfeited following a reasonable time (one year) after the date that any such payment first became due.

Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Retiree, or the allocations made to the HRA of any Retiree, or the amount of benefits paid or to be paid to a Retiree or other person, the Plan Administrator or its designee will, to the extent that it deems administratively possible and otherwise permissible under Code §105, the regulations issued thereunder or other applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Retiree or other person the credits to the HRA or distributions to which he or she is properly entitled under the HRA.

Code and ERISA Compliance

It is intended that the HRA meet all applicable requirements of the Code and ERISA, and of all regulations issued thereunder. The HRA will be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of the HRA and the Code and/or ERISA, the provisions of the Code and ERISA will be deemed controlling, and any conflicting part, clause or provision of the Plan will be deemed superseded to the extent of the conflict.

Non-Assignability of Rights

The right of any HRA Participant to receive any reimbursement under the HRA shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the HRA Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

An early Retiree (who is not eligible for Medicare and may want to become eligible for coverage on the Exchange) is permitted to permanently opt out of and waive future reimbursements from the HRA at least annually, in a time and manner determined by the trustees, and upon termination of coverage under the plan.

VISION DISCOUNT PROGRAM

As a participant in the CMTA-IAM Fund, you and your eligible Dependents have access to **VSP's Savings Pass Plan**. By using this discount program, you have access to discounts through a trusted, private-practice VSP doctor, one rate of $50 for an eye exam, special pricing on complete pairs of glasses and sunglasses, 15% savings on a contact lens exam and unlimited use on materials throughout the year. The vision discount program contracts with an independent network of vision providers who extend a discount to you for covered vision services. Covered vision expenses are noted in the following summary of the discounts and savings available.

Service	Reduced prices and Savings
Well Vision Exam every calendar year)	• $50 with purchase of a complete pair of prescription glasses. This cost is only available with the purchase of a complete pair of prescription glasses. • 20% savings off the cost of an eye exam without purchase.
Retinal Screenings	Guaranteed pricing with Well Vision exam not to exceed $39
Lenses	With purchase of a complete pair of prescription glasses: • Single vision: $40 • Lined bifocals: $60 • Lined trifocals: $75 • Polycarbonate for children $0
Lens Enhancements	Average savings of 20-25% on lens enhancements such as progressive, scratch-resistant, and anti-reflective coatings.
Frames	25% savings when a complete pair of prescription glasses is purchased.
Sunglasses	20% savings on unlimited non-prescription sunglasses from any VSP doctor within 12 months of your last Well Vision Exam.
Contact Lenses (applies only to contact lens exam, not materials. You are responsible for 100% of the contact lens material cost).	15% savings on contact lens exam (fitting and evaluation).
Laser Vision Correction	Average 15% savings off the regular price or 5% savings off the promotional price; discounts only available from contracted facilities.

Unlimited Annual Material Use

Your VSP vision savings pass can be used as often as you like throughout the year. With the best choices in eyewear, we make it easy to find the perfect frame that's right for you, your family, and your budget. Choose from great brands like Anne Klein, Bebe®, Calvin Klein, Flexon®, Lacoste, Nike, Nine West, and more.

How to Use Your VSP Vision Savings Pass

1. Find a VSP doctor at vsp.com or call (800) 877-7195.

2. At your appointment, tell your VSP doctor that you're a VSP member to save immediately on an eye exam and eyewear.
3. Take advantage of your VSP vision savings pass over and over - use is unlimited on materials

COORDINATION WITH GOVERNMENT AND OTHER PROGRAMS

Please contact the appropriate insurance company at the telephone number listed on the Quick Reference Chart to see if your Medicare Advantage Plan will coordinate benefits with any of the following programs:

- Medicaid
- Tricare
- Veterans Affairs/Military Medical Facility Services
- Motor Vehicle Coverage Required by Law
- Indian Health Services (IHS)

CLAIM FILING AND APPEAL INFORMATION

All information on how to file a claim and or on how to file most appeals of denied claims are outlined in the Evidence of Coverage from your insurance company. If you need assistance on how these guidelines work, call the telephone number of the appropriate Insurance Company listed on the Quick Reference Chart at the beginning of this document.

Please refer to your fully insured plan document(s) or Evidence of Coverage for a complete explanation of your claim appeal rights under ERISA for medical, prescription drug, and/or dental coverage. These materials, outlining the claims and appeals procedures for each of these plans are furnished automatically, without charge, as separate documents.

A review of **eligibility status** for any claim denied in whole may be submitted to the Fund Office.

The following rules apply when the Fund Office denies a claims **as to basic eligibility under the Plan** due to a determination of lack of eligibility. The following eligibility issues are examples of the type of appeal that the Fund Office reviews:

- Whether your domestic partner is eligible for coverage; and
- Whether your coverage may be terminated because your COBRA premium has not been received within the required time period.

Within 30 days of receipt of an eligibility dispute, the Fund Office will grant or deny your eligibility claim. If the Fund Office requires additional information, they will (within 30 days) advise you what additional information is required, why it is required and issue a decision within 30 days of receipt of the requested information.

If your claim for eligibility is denied, the Fund Office's notice of denial will include: (1) the specific reason for the denial; (2) specific reference to the provisions of this plan on which the denial is based; (3) any additional information that might change the decision of the Fund Office; (4) the procedures you must follow to have your claim for eligibility reviewed by the Board of Trustees.

Should the Fund Office fail to take any action on your claim of basic eligibility within 30 days of the Fund Office's receipt of your claim of basic eligibility, you may treat your claim as denied and seek review by the Board of Trustees under the following review procedures.

Review procedures

You may appeal a denial of initial eligibility or continuing eligibility within 180 days of the date you received the denial notice. To appeal, write to the Fund Office and state the reasons why you believe you were incorrectly determined to be ineligible, including any additional documentation to support your claim. You also may submit questions or comments you think are appropriate and you may review all relevant documents, including those related to how the Trustees dealt with comparable eligibility issues in the past.

The Trustees typically meet quarterly. If your appeal is received by the Fund Office at least 30 days in advance of a regularly scheduled meeting, your appeal will be considered by the Trustees at the next regularly scheduled meeting. To the extent permitted by federal regulations, consideration of your appeal may be put over to the next meeting of the Board if additional information is required. You will be notified in writing of any need for additional information.

When the Board makes a final determination on your appeal, you will be advised in writing of the determination by the Fund Office within five days of the decision.

Under a federal law known as ERISA, a participant or beneficiary whose claims for benefits has been denied, may file suit against the Plan pursuant to ERISA Section 502(a). However, prior to filing such a suit, the appeal process described above must be pursued and exhausted. Thus, following any denial of eligibility, if you disagree it is important you file a timely appeal. In all cases, your appeal must be filed no later than 180 days after you receive the initial eligibility denial. If you do not file an appeal within the required time-frame, you will have failed to exhaust your appeal rights.

If is important to understand that all benefits provided under the Fund are provided through HMO contracts and contracts of insurance. Thus, even if the Trustees eventually agree with your eligibility claim, benefits can be paid for a retroactive period only if the HMO and/or insurer agrees to accept retroactive premiums for retroactive coverage. Accordingly, it is in your best interest to promptly file all appeals related to eligibility.

The rules related to eligibility in no fashion replace the claims and appeal rules set forth in the Evidence of Coverage you receive from the insurance company when you enroll for health benefits. The Board of Trustees only deals with basic eligibility issues.

Should you have any questions related to these rules, do not hesitate to contact the Fund Office.

Using an Authorized Representative

An authorized representative may submit a claim (or later an appeal) for you if you are unable to complete it yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Trust Fund Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf.

Limitation on When a Lawsuit May Be Started

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, **until after all administrative procedures have been exhausted** (including this Plan's claim appeal review procedures described in this document) **for every issue deemed relevant by the claimant**, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision.

No lawsuit may be started more than three years after the end of the year in which services were provided.

Discretionary Authority of Plan Administrator and Designees

In carrying out their respective responsibilities under the Plan, the Plan Administrator or its delegate, other Plan fiduciaries, and the insurers or administrators of each Program of the Plan, have full discretionary authority to interpret the terms of the Plan, to resolve ambiguities, and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. The Plan Administrator also has the discretion to make all factual determinations arising under the Plan and any claims for benefits thereunder, and applying the facts to the terms of the Plan.

Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

COBRA: TEMPORARY CONTINUATION OF HEALTH CARE COVERAGE

Other Health Coverage Alternatives to COBRA (for Retirees and Dependents who are not eligible for Medicare)

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the Health Insurance Marketplace (the Marketplace helps people without health coverage find and enroll in a health plan). See your state Health Insurance Marketplace: www.coveredca.com or the federal Health Insurance Marketplace at www.healthcare.gov.

Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that other plan within 30 days of losing coverage under this Plan, even if that other plan generally does not accept late enrollees.

Entitlement to COBRA Continuation Coverage

In compliance with a federal law, the Consolidated Omnibus Reconciliation Act of 1985 (commonly called COBRA), eligible covered Dependents (called "Qualified Beneficiaries") may have the opportunity to elect a temporary continuation of their group health coverage ("COBRA Continuation Coverage") under the Plan when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law). Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

Please note: When you retired, you (the Employee) were offered a choice between electing a temporary continuation of your active group health coverage ("COBRA Continuation Coverage") or electing Retiree health coverage. As you elected the Fund's Retiree health coverage, you have no further COBRA continuation rights. However, your covered Dependent(s) may experience a COBRA Qualifying Event as described in this section.

NOTE: Domestic Partners and children of Domestic Partners are offered the ability to elect "COBRA-like" temporary continuation of benefits when coverage ends; however, Domestic Partners and children of Domestic Partners are not considered Qualified Beneficiaries and therefore may not have all the federally protected rights afforded to a Qualified Beneficiary.

This Plan provides no greater COBRA rights than what is required by law and nothing in this chapter is intended to expand a person's COBRA rights.

Who Is Entitled to COBRA Continuation Coverage, When and for How Long

Each Qualified Beneficiary **has an independent right to elect COBRA** Continuation Coverage when a Qualifying Event occurs, **and** as a result of that Qualifying Event that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. Covered retirees may elect COBRA on behalf of their spouses and covered parents/legal guardians may elect COBRA for a minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals.

1. "**Qualified Beneficiary**": Under the law, a Qualified Beneficiary is any Spouse or Dependent Child of a retiree who is covered by the Plan when a Qualifying Event occurs, and who is

therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.

A child of the covered retiree who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the retiree's period of employment, is entitled to the same rights under COBRA as an eligible dependent child.

A person who becomes the new Spouse of an existing COBRA participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA participant but is not a "Qualified Beneficiary." This means that if the existing COBRA participant dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA for him/herself.

2. **"Qualifying Event:"** Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan**. If a covered individual has a Qualifying Event but, as a result, **does not lose** their health care coverage under this Plan, then COBRA is not available.

The following chart lists the COBRA Qualifying Events, who can be a Qualified Beneficiary and the maximum period of COBRA coverage based on that Qualifying Event:

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries	
	Spouse	Dependent Child(ren)
Retiree dies.	36 months	36 months
Retiree becomes divorced or legally separated.	36 months	36 months
Dependent Child ceases to have Dependent status.	N/A	36 months
Retiree coverage is terminated or coverage is substantially reduced within one year before or after the employer files for bankruptcy reorganization under Chapter 11 of the federal Bankruptcy Act.	Varies[1]	Varies[1]

1: Employer's bankruptcy under Title 11 of the US Code may trigger COBRA coverage for certain retirees and their related Qualified Beneficiaries such as COBRA coverage for the life of the retiree. The retiree's Spouse and dependent children are entitled to COBRA for the life of the retiree and if they survive the retiree, for 36 months after the retiree's death. If the retiree is not living when the Qualifying Event occurs, but the retiree's surviving Spouse is alive and covered by the group health plan, then that surviving Spouse is entitled to coverage for life.

Failure to Elect COBRA Continuation Coverage

In considering whether to elect COBRA, you should take into account that failure to continue your coverage will affect your future rights under federal law, as noted below:

a. You can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage; and electing COBRA may help you not have such a gap; and
b. You will also lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA Continuation Coverage for the maximum time available to you.

Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage is generally 36 months measured from the date the Qualifying Event occurs.

Procedure for Notifying the Plan of a Qualifying Event (Very Important Information)

In order to have the chance to elect COBRA Continuation Coverage after a divorce, legal separation, or a child ceasing to be a "dependent child" under the Plan, **you and/or a family member must inform the Plan in writing of that event no later than 60 days after that Qualifying Event occurs.**

That written notice should be sent to the Trust Fund Office whose address is listed on the Quick Reference Chart in the front of this document. The written notice can be sent via first class mail, or be hand-delivered, and is to include your name, the Qualifying Event, the date of the event, and appropriate documentation in support of the Qualifying Event, such as divorce documents.

NOTE: If such a notice is not received by the Trust Fund Office within the 60-day period, the Qualified Beneficiary will not be entitled to choose COBRA Continuation Coverage.

Notices Related to COBRA Continuation Coverage

When **you notify the Trust Fund Office** that a Dependent Child lost Dependent status, you divorced or have become legally separated, **then** the Trust Fund Office will give you and/or your covered Dependents notice of the date on which your coverage ends and the information and forms needed to elect COBRA Continuation Coverage. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to COBRA coverage. Under the law, you and/or your covered Dependents will then have only 60 days from the date of receipt of that notice, to elect COBRA Continuation Coverage.

NOTE: If you and/or any of your covered dependents do not choose COBRA coverage within 60 days after receiving notice, you and/or they will have no group health coverage from this Plan after the date coverage ends.

The COBRA Continuation Coverage That Will Be Provided

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, that same change will apply to your COBRA Continuation Coverage.

Health Coverage Tax Credit (HCTC)

The Trade Preferences Extension Act of 2015 (Public Law 114-27), enacted June 29, 2015, extended and modified the expired Health Coverage Tax Credit or HCTC. For eligible

individuals, the HCTC allows a tax credit against the premiums paid for certain health insurance coverage through 2019. The Health Coverage Tax Credit is a tax credit that pays 72.5% of qualified health insurance premiums for eligible individuals and their families. Websites for more information: https://www.irs.gov/Credits-&-Deductions/Individuals/HCTC and https://www.irs.gov/Individuals/HCTC-Claims-FAQs.

Paying for COBRA Continuation Coverage (The Cost of COBRA)

Any person who elects COBRA Continuation Coverage must pay the full cost of the COBRA Continuation Coverage. The Fund is permitted to charge the full cost of coverage for similarly situated active employees and families plus an additional 2%.

Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time he or she becomes entitled to it. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

IMPORTANT: There will be no invoices or reminders for COBRA premium payments. You are responsible for making sure that timely COBRA premium payments are made to the Trust Fund Office.

Grace Periods

The initial payment for the COBRA Continuation Coverage is due to the Trust Fund Office **no later than 45 days** after COBRA Continuation Coverage is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect. After the initial COBRA payment, subsequent payments are due on the first day of each month, but there will be a 30-day grace period to make those payments. If payments are not made within the time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

For Monthly Payments, what if the Full COBRA Premium Payment is Not Made When Due?

If the Trust Fund Office receives a COBRA premium payment that is not for the full amount due, they will determine if the COBRA premium payment is short by an amount that is significant or not. A premium payment will be considered to be **significantly short** of the required premium payment if the shortfall exceeds the lesser of $50 or 10% of the required COBRA premium payment.

If there is a significant shortfall, then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made.

If there is not a significant shortfall, the Trust Fund Office will notify the Qualified Beneficiary of the deficient amount and allow a reasonable period of 30 days to pay the shortfall.

- If the shortfall is paid in the 30-day time period, then COBRA continuation coverage will continue for the month in which the shortfall occurred.
- If the shortfall is not paid in the 30-day time period, then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made.

Confirmation of Coverage Before Election or Payment of the Cost of COBRA Continuation Coverage

If a health care Provider requests confirmation of coverage and your Spouse or Dependent Child(ren) have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect **or** your Spouse or Dependent Child(ren) are within the COBRA election period but have not yet elected COBRA, COBRA Continuation Coverage will be confirmed, but with notice to the Health Care Provider that the cost of the COBRA Continuation Coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the COBRA Continuation Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

Notice of Unavailability of COBRA Coverage

In the event the Plan is notified of a Qualifying Event but determines that an individual is not entitled to the requested COBRA coverage, the individual will be sent, by the Trust Fund Office an explanation indicating why COBRA coverage is not available. This notice of the unavailability of COBRA coverage will be sent according to the same timeframe as a COBRA election notice.

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months (except for retirees who become entitled to COBRA because of a Chapter 11 bankruptcy reorganization proceeding on the part of their employer.)

Early Termination of COBRA Continuation Coverage

Once COBRA Continuation Coverage has been elected, it may be cut short (terminated early) on the occurrence of any of the following events:

1. The date the Fund no longer provides group health coverage to any of its Retirees;
2. The date the amount due for COBRA coverage is not paid in full on time;
3. The date the Qualified Beneficiary becomes entitled to Medicare (Part A, Part B or both) after electing COBRA;
4. The date, after the date of the COBRA election, on which the Qualified Beneficiary first becomes covered under another group health plan. IMPORTANT: The Qualified Beneficiary must notify this Plan as soon as possible once they become aware that they will become covered under another group health plan, by contacting the Trust Fund Office. COBRA coverage under this Plan ends on the date the Qualified Beneficiary is covered under the other group health plan.
5. The date the Plan has determined that the Qualified Beneficiary must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA participants under the Plan).

Notice of Early Termination of COBRA Continuation Coverage

The Trust Fund Office will notify a Qualified Beneficiary if COBRA coverage terminates earlier than the end of the maximum period of coverage applicable to the Qualifying Event that entitled the individual to COBRA coverage. This written notice will explain the reason COBRA terminated earlier than the maximum period, the date COBRA coverage terminated and any rights the Qualified Beneficiary may have under the Plan to elect alternate or conversion coverage. The

notice will be provided as soon as practicable after the Trust Fund Office determines that COBRA coverage will terminate early.

Entitlement to Convert to an Individual Health Plan after COBRA Ends

At the end of the 36-month period of COBRA Continuation Coverage, your Dependents may be allowed to enroll in an individual conversion health plan under their current insured health plan. Please contact the appropriate insurance company at the telephone number listed on the Quick Reference Chart for more information.

COBRA Questions or to Give Notice of Changes in Your Circumstances

If you have any questions about your COBRA rights, please contact the Trust Fund Office whose address is listed on the Quick Reference Chart in the front of this document.

Private Health Information

Effective April 14, 2003, a federal law, the **Health Insurance Portability and Accountability Act of 1996 (HIPAA),** as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that group health plans like the CMTA-IAM Joint Retiree Health and Welfare Trust group health plan (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**).

- The term **"Protected Health Information" (PHI)** includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.
- **PHI does not include** health information contained in employment records held by your previous contributing employer in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave and Family and Medical Leave (FMLA).

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was previously distributed to you and is also available from the Administrative Office. Information about HIPAA in this document is not intended to and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and the Plan Sponsor will not use or further disclose information that is protected by HIPAA ("protected health information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. **In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor**.

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

A. **The Plan's Use and Disclosure of PHI:** The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under the HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

   - **Treatment** is the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.
   - **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:

a. Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing employee contributions for coverage;

b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, billing, collection activities and related health care data processing, and claims auditing; and

c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review and/or retrospective review.

- **Health Care Operations** includes, but is not limited to:

a. Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, patient safety activities;

b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;

c. Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

e. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.

f. Compliance with and preparation of documents required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, Summary Annual Reports and other documents].

B. **When an Authorization Form is Needed:** Generally, the Plan will require that you sign a valid authorization form (available from the Administrative Office) in order for the Plan to use or disclose your PHI **other than** when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization.

C. **The Plan will disclose PHI to the Plan Sponsor only** upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law;
2. Ensure that any agents, including their subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules;
3. Not use or disclose the information for employment-related actions and decisions;
4. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices);
5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
6. Make PHI available to the individual in accordance with the access requirements of HIPAA;
7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
8. Make available the information required to provide an accounting of PHI disclosures;
9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA;
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
11. Notify you if a breach of your unsecured protected health information (PHI) occurs.

D. **In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained** in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI:

1. The Plan Administrator and designees,
2. Business Associates under contract to the Plan including but not limited to the Administrative Office.

E. The persons described in section D above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution

of noncompliance. **Issues of noncompliance** (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer.

If you are a minor and have concerns about the Plan releasing PHI to your parents or guardian, please contact the Privacy Officer.

F. Effective April 21, 2005 in compliance with **HIPAA Security** regulations, the Plan Sponsor will:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,
2. Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

GENERAL PROVISIONS AND INFORMATION REQUIRED BY ERISA

Name of the Plan

CMTA-IAM Joint Retiree Health and Welfare Trust

Name and Address of Employer Maintaining the Plan

The Plan is administered and maintained by the Joint Board of Trustees by contract with the firm of Associated Third Party Administrators. The Trust Fund Office is located at:

CMTA-IAM Joint Retiree Health and Welfare Trust
Health Services & Benefit Administrators
4160 Dublin Blvd., Suite 400
Dublin, CA 94568-7756
(800) 635-3105

A complete list of the employers sponsoring the Plan may be obtained by participants upon written request to the Plan Administrator (address below), and is available for examination by Plan participants.

Employer Identification Number (EIN)

94-6130509

Type of Plan and Plan Number

501 – Medical Plan

Type of Administration

Independent insurance companies (whose names and addresses are listed on the Quick Reference Chart in the front of this document) administer the fully insured health benefits of this Plan and provide payment of claims associated with these benefits.

Plan Administrator

Board of Trustees

CMTA-IAM Joint Retiree Health and Welfare Trust
4160 Dublin Blvd., Suite 400
Dublin, CA 94568-7756

Agent for Service of Legal Process

For disputes arising under the Plan, service of legal process may be made on any member of the Joint Board of Trustees or on the Plan's Legal Counsel:

Saltzman & Johnson Law Corporation

1141 Harbor Bay Parkway, Suite 100
Alameda, CA 94502

For disputes arising under those portions of the Plan insured by Kaiser, Kaiser Permanente of Washington, Health Net or United Healthcare, service of legal process may be made upon the insurance company at the address listed on the Quick Reference Chart in the front of this document or upon the supervisory official of the State Insurance Department.

Plan Trustees

The Trustees of the Plan are:

Labor Trustees	Management Trustees
James Beno IAM&AW District Lodge 190 7717 Oakport Blvd., Suite 1 Oakland, CA 94621	**Thomas A Dillon** California Metal Trades Association 851 Burlway Road, Suite 216 Burlingame, CA 94010
Donald D. Crosatto Automotive Machinists Local No. 1546 10260 MacArthur Boulevard Oakland, CA 94605	**John DiBernardo** SSA Terminals, LLC 14451 Cool Valley Ranch Road Valley Center, CA 95082-3824
Steve J. Mack Teamsters Automotive Local 853 2100 Merced Street San Leandro, CA 94577	**Ryan Thibodeau** UPS North CA District 8475 Pardee Drive Oakland, CA 94621
Rich Morales Local Union 1176 2020 Williams Street Suite A1 San Leandro, CA 94577	
Jim Schwantz District Lodge 190 Local Union no. 1101 2102 Almaden Rd., Suite 105 San Jose, CA 95125 Office: 408-723-6011	

Plan's Requirements for Eligibility and Benefits

The Plan's requirements with respect to eligibility as well as circumstance that may result in disqualification, ineligibility or denial or loss of benefits are described in a separate enrollment brochure that is available from the Trust Fund Office.

Collective Bargaining Agreements

This Plan is maintained under several collective bargaining agreements. Copies of any such agreements may be obtained by Plan participants upon written request to the Plan Administrator, and is available for examination by Plan participants.

Funding Medium

This Plan is financed by self-payments by Participants and subsidies from some contributing employers. The various retiree medical plans are all insured by a contract of insurance. There is no liability on the part of the Board of Trustees or any individual or entity to provide payment over and beyond the amounts in the Trust Fund collected and available for insured premium payments. Plan benefits are not guaranteed lifetime benefits.

The insurance companies through which benefits are provided are: Kaiser Permanente of California, Kaiser Permanente of Washington, Health Net, and United Healthcare.

Contribution Source

The majority of the contributions to the plan are self-payments made by the Retirees. There are a few employers that make contributions on behalf of the Retirees.

Plan Year

The Plan's fiscal records are kept on a Plan Year that is the twelve-month period beginning each September 1st and ending on the following August 31.

Allocation and Disposition of Assets upon Termination

In order for the Fund to carry out its obligation to provide the maximum possible benefits to all Participants within the limits of its resources, the Board of Trustees has the right to take any of the following actions, even if claims that have already accrued are affected:

- To terminate any benefits provided by this SPD/Plan Document.
- To alter or postpone the method of payment of any benefit.
- To amend or rescind any provision of these SPD/Plan Document.

In addition, the Fund may be terminated by the Board of Trustees, provided that the termination is not effective until after the mailing of such notice. In the event the Plan terminates, the Trustees, by unanimous agreement and in their full discretion, will determine the disposition of any assets remaining after all expenses of the Plan have been paid; provided that any such distribution will be made only for the benefit of former participants and for the purposes set forth in the Plan. Upon termination of the Plan, the Trustees (with full power) will continue in such capacity for the purpose of dissolution of the Plan.

Statement of ERISA Rights

As a participant in the CMTA-IAM Joint Retiree Health and Welfare Trust, 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:

1. Examine, without charge, at the Plan Administrator's office, 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 (formerly known as the Pension and Welfare Benefit Administration).
2. 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 Plan Administrator may make a reasonable charge for the copies.
3. 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

1. Continue health care coverage as required by law for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event, as described in the COBRA chapter. You and/or your Dependents may have to pay for such coverage, if it is elected. Review this summary plan description and the documents governing the plan on the rules governing your COBRA Continuation Coverage rights.
2. Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under your group health plan if you have creditable coverage from another plan. You should be provided a HIPAA Certificate of Creditable Coverage, free of charge, from your group health plan or health insurer 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 Pre-Existing Condition exclusion for 12 months (18 months for late enrollees) after your Enrollment Date in your coverage.

Prudent Actions by Plan Fiduciaries

1. 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.
2. 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

1. 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.
2. 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.

3. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court.
4. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order (QMCSO), you may file suit in Federal court.
5. 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

1. 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 (formerly known as the Pension and Welfare Benefit Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration), U.S. Department of Labor, 200 Constitution Avenue, N. W., Washington, DC 20210.
2. You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration).

Plan Amendments or Termination of Plan

CMTA-IAM Joint Retiree Health and Welfare Trust reserves the right to amend or terminate this Plan, or any part of it, at any time without advance notice to participants.

- Amendments to the Plan may be made in writing by the Board of Trustees (or its designee) and become effective on the written approval of the Board of Trustees, or on such other date as may be specified in the document amending the Plan.
- The Plan or any coverage under it may be terminated by the Board of Trustees, and new coverages may be added by its Board of Trustees. Upon termination, discontinuance or revocation of participation in the Plan all elections and reductions in compensation related to the Plan will terminate.

Statement of the Fund's Rights

A. CMTA-IAM Joint Retiree Health and Welfare Trust makes no representation that prior employment with it represents lifetime security or a guarantee of continued benefits.

B. CMTA-IAM Joint Retiree Health and Welfare Trust, as Plan Sponsor, intends that the terms of this Plan described in this document, including those relating to coverage and benefits, are legally enforceable, and that each plan is maintained for the exclusive benefit of participants, as defined by law.

C. Any written or oral statement other than a written statement signed by the Board of Trustees that is contrary to the provisions of this subchapter **is invalid**, and no retiree should rely on any such statement.

No Liability for Practice of Medicine

The Plan, Plan Administrator or any of their designees are not engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any Health Care Provider. Neither the Plan, Plan Administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any Health Care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Newborns' & Mothers' Health Protection Act (Newborns' Act)

Hospital Length of Stay for Childbirth: Under federal law, group health plans, like this Plan, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan may pay for a shorter stay if the attending physician (e.g., Physician, or health care practitioner), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans 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. In addition, the plan may not, under federal law, require that a Physician or other Health Care Practitioner 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. Please direct any questions to your insurance company.

Information You or Your Dependents Must Furnish to the Plan (Very Important Information)

In addition to information you must furnish in support of any claim for Plan benefits under this Plan, you or your covered Dependents must furnish information you or they may have that may affect eligibility for coverage under the Plan. If you fail to do so, you or your covered Dependents may lose the right to obtain COBRA Continuation Coverage or to continue coverage of a Dependent Child who has a physical or mental disability.

Submit such information in writing to the Trust Fund Office at the address shown in the Quick Reference Chart in the front of this document. The information needed and timeframes for submitting such information are outlined below.

Type of Information Needed	Date Information is to be Submitted to the Plan
• Change of name or address or the existence of other health care coverage for any covered person.	As soon as possible but not later than 60 days after the change or addition of other coverage.

• Marriage, divorce, legal separation, addition of a new Dependent, death of any covered person.	Within 31 days
• Covered child ceases to be a Dependent as defined by this Plan (*e.g.* over the limiting age of the Plan, loses student status, etc.)	Within 60 days of the date the child is no longer considered a Dependent.

Headings, Font and Style do not Modify Plan Provisions

The headings of chapters and subchapters and text appearing in bold or CAPITAL LETTERS and font and size of sections, paragraphs and subparagraphs are included for the sole purpose of generally identifying the subject matter of the substantive text for the convenience of the reader. The headings are not part of the substantive text of any provision, and they should not be construed to modify the text of any substantive provision in any way.

DEFINITIONS

Dependent: Any of the following individuals: Dependent Child(ren) or Spouse or domestic partner as those terms are defined in the enrollment chapter.

Subrogation: This is a technical legal term for the right of one party to be substituted in place of another party in a lawsuit. See the Third Party Liability chapter for an explanation of how the Plan may use the right of subrogation to be substituted in place of a covered individual in that person's claim against a third party who wrongfully caused that person's injury or illness, so that the Plan may recover medical benefits paid if the covered individual recovers any amount from the third party either by way of a settlement or judgment in a lawsuit.

You, your: When used in this document, these words refer to the retiree who is covered by the Plan. They do **not** refer to any Dependent of the retiree.