

**U.A. LOCAL 467**  
**HEALTH AND WELFARE TRUST FUND**  
**SUMMARY PLAN DESCRIPTION**  
**for**  
**RESIDENTIAL CLASSIFICATIONS**



**April 2008**

### **LIMITATION UPON RELIANCE ON BOOKLET AND STATEMENTS**

You are not entitled to rely upon oral statements of Employees of the Trust Fund Office, a Trustee, an Employer, any Union officer, or any other person or entity. As a courtesy to you, the Trust Fund Office may respond orally to questions; however, oral information and answers are not binding upon the Plan and cannot be relied upon in any dispute concerning your benefits.

If you wish an interpretation of the Plan you should address your request in writing to the Board of Trustees at the Trust Fund Office. To make their decision, the Trustees must be furnished with full and accurate information concerning your situation.

You should further understand that, from time to time, there may be an error in a statement that you receive or a payment that has been made which may be corrected upon an audit or review. The Board of Trustees reserves the right to make corrections whenever any error is discovered.

### **CAUTION - FUTURE PLAN AMENDMENTS**

Future amendments to the Plan may have to be made from time to time to comply with new laws or amendments passed by Congress, rulings by federal agencies or courts, and other changes deemed necessary or prudent by the Board of Trustees. You will be notified if there are important amendments to the Plans. Before you decide to retire, you may want to contact the Trust Fund Office to determine if there have been Plan amendments or other developments that may affect your situation.

## **AUTHORIZED SOURCE OF INFORMATION**

United Administrative Services (“UAS”), the administrative office of the Health and Welfare Trust Fund, is the only authorized source of information concerning the administration of the Trust and the interpretation of the Plan provisions affecting the rights and duties of any Employee, retiree, or other person. All other sources, including without limitation, any Individual Trustee or officers and representatives of the Local Union, individual Employer or Employer Association (whether a Trustee or not) are completely unauthorized, and statements and opinions from them are not to be relied upon. Employees, retirees and other persons desiring information about the administration of the Trust, or a ruling as to their particular rights and duties under the Plans of the Trust, must request the same in writing from the Trust Fund Office.

Only the Board of Trustees has the authority to make final and binding interpretations of the Plan. Any person who believes he or she is adversely affected by a determination of the Trust Fund Office may appeal it to the Board of Trustees. An appeal must be submitted in writing to the Trust Fund Office within 180 days of the receipt of the notice of the adverse determination, or all objections to that determination are considered waived.

As a courtesy to you, the Plan representatives may respond informally to oral questions; however, oral information and answers are not binding upon the Board of Trustees or the Plan and cannot be relied on in any dispute concerning your benefits.

### **BENEFITS ARE NOT VESTED!**

**Plan rules and benefits may change from time to time. Your benefits under the Plan are not vested. The Board of Trustees may reduce or eliminate or change any benefits provided under the Plan (or any insurance policy, HMO or other entity) at any time. Participants may also be required to make new or additional contributions for benefits provided by the Plan.**

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## **A. INTRODUCTION**

This booklet contains a Summary Plan Description and gives the Rules and Regulations of your Health and Welfare Plan. This document is considered the Plan document for this Plan. The pages which follow give you an explanation of the coverages which are available to members of residential classifications and their eligible dependents.

Medical and prescription drug coverage is provided by the Kaiser Foundation Health Plan. The Trust Fund has a contract with Delta Dental Plan of California to provide dental benefits, and a contract with Vision Service Plan to provide vision benefits. Separate pamphlets describing these programs in detail may be obtained from your Local Union office or United Administrative Services, the Fund Manager. Highlights of these programs are contained in this booklet.

If you have any questions regarding this Health and Welfare Plan, please contact the Contract Administrator, United Administrative Services, 1120 South Bascom Avenue, P. O. Box 5057, San Jose, California, 95150; telephone (408) 288-4400. The Administrator is the only authorized source of information concerning the administration of the Trust and interpretation of the Plan with respect to the rights and responsibilities of any Employee, Retiree or dependent. Statements of opinion from any other source are not binding upon the Plan and are not to be relied upon.

Any information regarding specific benefit coverage should be obtained in writing from United Administrative Services, the Contract Administrator. Plan provisions cannot be modified or altered by oral representations by any party.

## **B. ELIGIBILITY**

### **1. RULES OF ELIGIBILITY**

Each Employee covered under this Plan shall have a reserve of hours account consisting of hours worked (up to a maximum of 450 hours) for individual employers under a Collective Bargaining Agreement with Local 467 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada A.F. L.-C.I.O. (U.A. Local 467)

Every Employee covered shall become eligible for Employee and dependent benefits the first of the month following the month the Employee's reserve of hours account has first been credited with four hundred and fifty (450) or more hours within any period of twelve (12) consecutive calendar months or less.

Once eligible, an Employee and his dependents continue to be eligible for benefits so long as he has at least 150 hours in his reserve of hours account, also known as an hour bank. The reserve of hours account is charged 150 hours for each calendar month the Employee remains eligible. If the Employee works more than the required 150 hours in any one calendar month, his reserve of hours account is credited with the excess; but if he works less than the required 150 hours, his reserve of hours account is debited by the difference. No Employee shall be credited with more than 450 hours in his reserve of hours account at any one time.

The reserve of hours account of any Employee who accepts employment from any contractor not a party to a Collective Bargaining Agreement with U.A. Local No. 467, or who connives with any employer paying into the fund less than the full contract rate of contribution for each hour worked by him or her, shall be terminated forthwith and the Employee and dependents shall not again be eligible except upon compliance with the requirements of the plan hereof for initial eligibility.

## **2. TERMINATION OF ELIGIBILITY**

A member's eligibility under this Plan will terminate at the time of occurrence of any of the following events:

- a. At the end of the month in which his or her reserve of hours account falls below 150 hours and he or she is no longer eligible under the continuance of eligibility provisions.
- b. On the last day of the month for which any required contribution is not paid.
- c. On the day the Plan is terminated.
- d. On the day he or she enters full-time active duty in the Armed Forces of the United States.

## **3. CANCELLATION OF BANK HOURS**

The Reserve of Hours account of any Employee who accepts employment of any duration in the type of work covered by a Collective Bargaining Agreement from an employer not signatory or otherwise party to any such Agreement or engages in business for his own account without being signatory or otherwise party to such Agreement shall be terminated as of the date of commencement of such employment. The Employee shall not again be eligible for any benefits or for any of the rights incident to eligibility until he has ceased such employment and re-established eligibility under the Plan.

A dependent child's eligibility will terminate when the child marries, reaches the maximum limiting age or when the Member's eligibility terminates. Eligibility of the Member's spouse terminates when his eligibility terminates or upon decree of final dissolution of marriage or legal separation. Termination of eligibility for a Member's spouse or dependent children is subject to the continuation coverage rights (COBRA) as described starting on page 14.

## **4. REINSTATEMENT OF ELIGIBILITY WITHIN 12 MONTHS**

An Employee whose eligibility has been terminated because his bank of hours has fallen below 150 hours will be reinstated as of the first day of the calendar month following any calendar month within the next 12 calendar months in which his bank of hours has again totaled 150 hours or more.

## **5. SELF PAYMENT WHEN UNEMPLOYED OR HOUR BANK IS BELOW 150 HOURS**

A Participant who becomes unemployed and whose reserve of hours account falls below 150 hours may continue to be eligible for Employee and dependent benefits as follows:

By paying each month into the Fund the amount determined by the Board of Trustees to be just and equitable.

The payment is to be made on or before the twentieth (20th) day of the calendar month following the calendar month in which the Employee's reserve of hours account first fell below 150 hours.

No such Employee may continue his eligibility by such payments unless he remains continuously registered for employment on the out of work list of the Local Union and does not refuse more than three offers of dispatch within any period of twelve (12) consecutive calendar months.

The Health and Welfare Plan provisions for continuation of coverage for a limited period by the Participant making self payments is governed by Federal Legislation known as "COBRA". COBRA requires group health plans to offer Employees and their families temporary extension of health benefits ('continuation coverage') at group rates under certain circumstances known as qualifying events in which health coverage would otherwise terminate. The main qualifying events are unemployment, death, divorce and attainment of the maximum age for dependent children. Such payments shall be made at the office of the Contract Administrator.

## 6. DEPENDENT ELIGIBILITY

Eligible dependents include the following:

- a. Spouse. Lawful spouse of an eligible Employee or eligible retiree.
- b. Children. Unmarried children (including any stepchild entirely supported by the Employee or retiree) of an eligible Employee or eligible retiree, who have not reached their nineteenth (19th) birthday. This includes a legally adopted minor child of an eligible Employee.
- c. Children Who Are Students. Unmarried dependent children of an eligible Employee or eligible retiree, age nineteen (19) but less than twenty-four (24), if they are full time students at an accredited educational institution and receiving at least 50% of their support from the Employee or retiree (and were covered by the Plan when they were age 18).
- d. Disabled Children. Unmarried dependent children, age nineteen (19) or over, of an eligible Employee or eligible retiree, who are incapable of support because of physical or mental incapacity that commenced prior to reaching age nineteen (19). A physician's certificate as to such incapacity must be submitted within six (6) months following the nineteenth (19th) birthday. This benefit is applicable only up to the month of the 23<sup>rd</sup> birthday.

A person who is an eligible dependent of an Employee shall become eligible for benefits when the Employee becomes eligible for benefits, or upon becoming an eligible dependent, if later, except that an otherwise eligible dependent who is Medicare-eligible shall be eligible only if he or she enrolls in Medicare Parts A and B.

**IT IS FRAUD IF YOU ENROLL A DEPENDENT(S) THAT DOES NOT MEET THE PLAN DEFINITION OF DEPENDENT OR YOU FAIL TO NOTIFY THE TRUST FUND OFFICE ONCE A DEPENDENT NO LONGER MEETS THE PLAN DEPENDENT DEFINITION. IT IS YOUR RESPONSIBILITY TO TIMELY NOTIFY THE TRUST FUND OFFICE OF ANY SUCH CHANGE. YOU WILL BE REQUIRED TO REPAY THE PLAN FOR ANY OVERPAYMENTS OR IMPROPER PAYMENTS MADE FOR A PERSON WHO DID NOT QUALIFY AS A DEPENDENT. YOU WILL BE RESPONSIBLE FOR REIMBURSING THE PLAN ANY ATTORNEYS FEES AND COSTS INCURRED BY THE PLAN TO RECOVER SUCH FUNDS.**

## 7. TERMINATION OF DEPENDENT ELIGIBILITY

Under the following conditions and subject to COBRA, a dependent will not be eligible:

- a. Lack of Eligibility. Eligibility of all of an Employee's dependents ends upon termination of eligibility of the Employee.
- b. Divorce or Legal Separation. A spouse ceases to be eligible upon the first day of the month following the entry of an order of dissolution of marriage to, or legal separation from, the Employee.
- c. Maximum Age of Child. A dependent child's eligibility shall terminate on the first day of the month following the month when the child marries or reaches the applicable maximum limiting age, or on the day that the child enters military service.

## 8. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

The Participant must timely provide the Trust Fund Office with a copy of any court order that establishes the Participant's legal obligation to maintain coverage on a Dependent Child including a QMCSO.

A QMCSO recognizes an eligible child's right to receive Plan benefits as a beneficiary of an eligible Plan Participant. The child, to be covered for benefits by this Plan, must meet Plan requirements for an eligible Dependent child including age requirements.

The steps that will be followed to establish and determine whether a court order would qualify as a QMCSO are:

- a. The Participant must provide the Plan Office with a copy of the court order and/or QMCSO.
- b. Within thirty (30) days after receipt of the QMCSO, the Plan Office or the Plan's legal counsel will notify the Participant and/or child support agency in writing if the court order and/or QMCSO is acceptable to the Plan.
- c. If the Plan determines that the court order and/or QMCSO is not acceptable, or if additional information is required, the Participant will be notified in writing by the Plan or the Plan's legal counsel.
  - (i) If a QMCSO is denied. The notice will describe the reasons for denial. There is a right to appeal a denial. A summary of the Plan's appeal procedures will be included in the notice of denial. In most instances however, you will simply be asked to revise the order in such a way that it is a proper QMCSO.
  - (ii) If additional information is required. The notice will describe what is needed. There will be sixty (60) days to respond. If you do not respond within the sixty (60) days, the request for the QMCSO will be deemed canceled.

## 9. PARTICIPANT IN ACTIVE MILITARY SERVICE

- a. If a Participant is called to active military duty for a period of 30 days or longer, the Participant may elect either of the following options:
- (i) to have his Reserve Hour Bank frozen as of the first day of the month following the commencement of active service, which will terminate all eligibility for the Employee and any dependents; or
  - (ii) to continue the eligibility of the Employee's dependents using the Employee's Reserve Hour Bank, until it is depleted.
- b. Eligibility Rules for USERRA:

To qualify for re-employment rights under the Uniformed Service Employees Reemployment Rights Act ("USERRA"), including certain limited health care benefits (summarized below), a covered Employee must meet the following requirements:

- (i) Purpose of Leave. The Employee had to leave civilian employment for the purpose of entering a "uniformed service." Uniformed services includes the Army, Navy, Air Force, Marine Corp, Coast Guard, National Guard (full time duty), Commissioned Corps of Public Health Service and anyone else designated as Covered by the President of the United States during time of war or National Emergency.
  - (ii) Employee Provide Prior Notice of Service. An Employee leaving for uniformed service has to provide prior notice that his absence will be due to uniformed service. Written notice is not required. You are strongly urged to notify the Union Dispatch Office so that the uniformed service may be noted on the dispatch rolls, your Employer, and the Plan Office so the Plan is aware of your situation.
  - (iii) Assert Military Rights for no More than Five Years (with certain exceptions).
  - (iv) Honorably Discharged. You must have been honorably discharged from the military service.
  - (v) Return to Covered Employment Within Specified Period. You must return to your same Employer or another Employer that contributes to the Plan within a specified period of time, depending upon the length of time of your military service.
- c. USERRA Rights to Certain Health Care Benefits Under the Plan
- (i) If Absent for Less than 31 Days, One Month of Coverage. If you are absent from covered employment for less than 31 days, you may elect to continue your coverage with this Plan at the expense of the Plan.
  - (ii) Absent for More than Thirty Days. If you are absent from covered employment as a result of military service for more than 30 days, you

may elect to purchase COBRA-like coverage for up to 24 months (the first month of which is free). After that first 30 days you will be required to pay a premium which is 102% of the Plan's cost of the coverage. Typical rights under COBRA are for 18 months, rather than the longer 24 month periods for veterans. USERRA's continuation requirements are similar but not identical to COBRA's requirements. Your absence for service in the uniformed services will trigger rights under both statutes, and you are entitled to protection under the law that provides the most favorable benefit.

- (iii) Twenty Four Months of Continuation Coverage. The Participant and/or any dependents will be eligible to pay for Continuation Coverage for up to 24 consecutive months. Coverage under the Participant's Hour Bank will recommence after discharge from active military duty if the Employee returns to work for a contributing Employer or becomes available to work for a contributing Employer as shown by registration on the Union's out-of-work list provided the Employee returns to work or registers within 90 days of discharge.

## C. BENEFITS

### 1. SUMMARY OF KAISER MEDICAL AND HOSPITAL SERVICES

Your Kaiser Permanente Group number is: 937

#### Professional Services:

Primary and specialty care visits	\$20
Routine physical exams	\$20
Physical therapy visits	\$20
Well-child preventive visits (0-23 months)	\$15
Scheduled prenatal care visits	\$15
Family planning visits	\$20
Hearing exams	\$20

#### Outpatient Services

Outpatient surgery	\$20
Allergy injection visits	\$3
Allergy testing visits	\$20
Vaccines (immunizations)	No Charge
Laboratory and X-ray	No Charge

#### Inpatient Hospitalization:

Room and board, surgery, anesthesia, X-rays, lab tests and drugs	\$100 per admission
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#### Emergency Care:

Emergency department visits (waived if admitted to hospital)	\$50
Ambulance	\$50 per trip
Complication of pregnancy	No Charge

#### Prescription Drug Benefit:

Obtained at Kaiser Permanente Pharmacies

Generic Drug	\$10
Brand Drug	\$25

For a more complete description of Kaiser Foundation Health Plan Benefits, refer to your separate Kaiser Health Plan Booklet.

### 2. SUMMARY OF DENTAL BENEFITS – DELTA DENTAL

Dental benefits are provided through a contract with Delta Dental Plan of California. These benefits are provided to all Participants and eligible dependents. A separate booklet is available from your Local Union Office or the Trust Fund Office which will explain the Plan's dental benefits in detail.

When you use a Delta Dental Participating Dentist, you pay the designated portion of the covered charges, and payment will be made directly to the dentist by Delta Dental. Delta Dental Participating Dentists have agreed with Delta Dental not to charge you for any amount above the agreed charges for covered services and supplies, or for any sums owing by Delta

Dental under this Plan. This rule does not apply to non-Delta dentists, so you will be responsible for any charges by a non-Delta dentist that the Plan does not pay.

After you have satisfied the lifetime deductible requirement of the first \$100 of covered expenses for each eligible member of your family, benefits are payable at the indicated percentage of the remaining usual, customary and reasonable fee:

Diagnostic and Preventative Benefits	80%
Other Basic Benefits	80%
Crowns, Jackets and Cast Restorations	80%
Prosthodontic Benefits	80%

For a more complete description of benefits refer to your Delta Dental Group Summary Plan Description.

**There are certain procedures not covered by Delta Dental. Thus, you should refer to the list of exclusions in the Delta Dental booklet.**

Delta Dental insures the benefits payable through the Plan. This means that the final decision on whether or not to pay a claim is up to Delta. To object to their initial decision on a claim, you must appeal under Delta's own procedures. If you have questions about a claim, you may call Delta at the following toll-free customer service number:

Delta Dental Customer Service  
(888) 335-8227 (toll free)  
or go to its website at [www.deltadentalca.org](http://www.deltadentalca.org)

It is to your advantage to select a dentist who is a Delta Participating Dentist, since his fees will have been accepted in advance by Delta. A lower percentage of the Dentist's fees may be covered by this Program if you select a Dentist who is not a Delta Participating Dentist. During your first appointment with the Dentist, it is very important to advise your Dentist of the following information:

Group Number: 79-0002  
Employee's Social Security Number  
Name of Group Plan: U.A. Local Union No. 467  
Health and Welfare Plan for Residential Tradesmen.

### **3. SUMMARY OF VISION BENEFITS – VISION SERVICE PLAN (VSP)**

Vision benefits are provided through a contract with Vision Service Plan (VSP). These benefits are provided to all Participants and eligible dependents.

VSP supplies brochures which may be obtained at the Trust Fund Office or the Local Union office. Your VSP-participating optometrist can obtain eligibility and benefits information by phoning VSP directly and providing the Participant's name and social security number.

**Summary of Vision Care Benefits:**

Copayment \$15

Schedule of Benefits (VSP Provider)

Exam	Covered up to VSP allowances every 12 months
Lenses	Covered up to VSP allowances every 12 months
Frames	Covered up to VSP allowances every 24 months
Contact Lenses (necessary)	Exam and materials covered every 24 months
Contact Lenses (elective)	Covered up to \$120 every 24 months; in lieu of lenses and frames

Schedule of Benefits (Non-VSP Provider)

Exam	Up to \$45
Lenses	
Single Vision	Up to \$45
Bifocal	Up to \$65
Trifocal	Up to \$85
Lenticular	Up to \$125
Frames	Up to \$47
Contact Lenses (necessary)	Up to \$210
Contact Lenses (elective)	Up to \$105

## **D. MISCELLANEOUS RULES**

### **1. DEFINITIONS**

Except for terms which are specifically defined herein, all terms shall be presumed to have the meaning, if any, given in the U. A. Local No. 467 Health and Welfare Trust Fund Trust Agreement, as amended. Wherever a single-gender pronoun is used herein, it shall be presumed to refer to Employees of either gender, so that it shall be understood that all covered Employees have equal rights to benefits under the Plan.

### **2. COST OF PLAN**

The entire cost of the Plan is paid by the Board of Trustees of U.A. Local No. 467 Health and Welfare Trust Fund from contributions made to the Trust Fund by Individual Employers pursuant to Collective Bargaining Agreements and from monthly payments required of certain classes of Participants. In no event shall the Plan be construed to require payment of benefits in excess of funds collected by the Trust Fund from these sources.

### **3. AMENDMENT AND TERMINATION OF PLAN**

It is the intention of the Board of Trustees that this Plan continue indefinitely. However, the Board reserves the right to amend the Plan as they, in their exclusive discretion, find to be proper, and if they find it necessary or appropriate under the circumstances then in effect, to terminate the Plan or any portion thereof, for any or all Participants and dependents.

### **4. RESERVATION OF POWER TO INTERPRET**

This booklet (except for benefits provided through health maintenance organizations) contains what is intended as a complete description of all available benefits for current Employees and retirees, and their eligible dependents. In case of any question as to the meaning of any portion of this Plan, the Trustees reserve the power to interpret this booklet, the Plan and any portion thereof, and, in the event of conflict between the summary plan description and this formal plan text, this formal plan text is controlling.

### **5. IDENTIFICATION CARD**

Each covered Employee or Individual Employer will receive an identification card which will assist in establishing coverage under the Plan when entering a hospital or requiring other medical care.

### **6. COORDINATION OF BENEFITS**

This Plan coordinates benefits for any claim in accordance with the coordination rules of the National Association of Insurance Commissioners, as in effect at the time of the claim (including the "birthday rule" for payment of claims for dependent children of parents with coverage under different Plans). Under this provision, duplication of benefits is eliminated but recognition is given to the coverage provided by all Plans under which protection is provided.

This Plan, if primary, will pay its regular benefits in full or, if secondary, will pay a reduced amount which, when added to the benefits payable by other group Plans, does not exceed 100% of Usual, Customary, and Reasonable charges, as defined herein.

### **7. THIRD PARTY RECOVERY**

If the Covered Person is injured as a result of the act or omission of another person or party, Plan benefits are available provided:

- a. Exclusion of Claims Caused by Third Party. The Plan does not cover any illness, injury, disease or other condition for which a third party is or may be liable or legally responsible, by reason of negligence, an intentional act or breach of any legal obligation on the part of that third party.

As a condition precedent to receiving Plan benefits, a Participant is required immediately (within thirty days) to notify the Plan Office if any claims incurred under the Plan are the result of an accident, injury, disease or other condition for which a third party is or may be liable or legally responsible, by reason of negligence, an intentional act or breach of any legal obligation on the part of that third party.

Charges incurred by a Participant or dependent for which a Third Party is or may be responsible are not covered charges under any benefits provided in this Plan; however, payments may be advanced to an otherwise eligible Participant or beneficiary, if the conditions of this section are met.

- b. The Covered Person agrees to reimburse to the Plan immediately any amounts recovered by way of a judgment, settlement or otherwise (including receipt of proceeds under any uninsured motorists coverage or other insurance including the Participant's own or family or other insurance coverage.) arising out of any claims for damages by the individual or his assignees, representatives, heirs, parents or legal guardians, to the extent of the payments made or to be made by the Plan for which the third party may be responsible. Any Covered Person who accepts payments from the Plan agrees that by doing so he is making a present assignment of his rights against such third party to the extent of the payments made by the Plan.

The Plan may require that any Covered Person execute an Agreement to Reimburse and/or Assignment of Recovery in such form or forms as the Plan may require. Any Covered Person who refuses to execute an Agreement to Reimburse and/or Assignment of Recovery in a form satisfactory to the Plan shall not be eligible for Plan benefit payments related to the injury involved. Any Covered Person who receives benefits and later fails to reimburse the Plan as set forth above shall be ineligible for any future Plan benefit payments until the Plan has withheld an amount equal to the amount which the Covered Person has failed to reimburse, including reasonable interest on such unpaid funds.

- c. By accepting payments from the Plan, any Covered Person agrees that the Plan may intervene in any legal action brought against the third party or any insurance company, including the Covered Person's own carrier for uninsured motorist coverage. By accepting payments from the Plan, any Covered Person further agrees that a lien shall exist in favor of the Plan upon that portion of the total recovery which is due to the Plan for benefits paid. The lien may be filed with the third party, the third party's agents, or the court. The Covered Person shall do nothing to prejudice the Plan's rights as described above without the Plan's written consent.
- d. If the Covered Person settles or compromises a third party liability claim in such a manner that the Plan is reimbursed in an amount less than its lien, or which results in a third party or its insurance carrier being relieved of any future liability for medical costs, then the Covered Person shall receive no further

benefits from the Trust in connection with the medical condition forming the basis of the third party liability claim unless the Board of Trustees or its duly authorized representative has previously approved the settlement or compromise, in writing, as one which is not unreasonable from the standpoint of the Trust. The Plan may offset any future claims incurred by the Participant and/or his family members against amounts owed to the Plan as a result of this Section.

## **8. RIGHTS OF STATES**

- a. Payment of benefits with respect to a Participant shall be made in accordance with any assignment of rights made by or on behalf of such Participant or beneficiary of a Participant as required by a state plan for medical assistance approved under title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of that Act.
- b. In enrolling an individual as a Participant or beneficiary or in determining or making any payments for benefits of an individual as Participant or beneficiary, the fact that the individual is eligible for, or is provided, medical assistance under a state plan for medical assistance under title XIX of the Social Security Act shall not be taken into account.
- c. To the extent that payment has been made under a state plan for medical assistance approved under title XIX of the Social Security Act in any case in which the Plan has a legal liability to make payments for items or service constituting such assistance, payment for benefits under the Plan shall be made in accordance with any state law which provides that the state has acquired rights with respect to a Participant to such payment for such items or services.

## **E. ERISA INFORMATION**

### **1. DESCRIPTION OF COLLECTIVE BARGAINING AGREEMENTS**

The Plan is Maintained pursuant to the terms of the Collective Bargaining Agreement between U.A. Local Union No. 467 and Employer Associations and Individual Employers.

This Agreement provides that employer parties will make the required contributions to this Plan for the purpose of enabling the Employees working under the Collective Bargaining Agreement to participate in the Trust Fund. Copies of these Agreements and lists of the Individual Employers who are bound either by virtue of membership in any one of these organizations, or by individual signature, may be obtained from the office of the Contract Administrator. A reasonable amount may be charged for copies if you desire them.

### **2. SOURCE OF CONTRIBUTIONS AND DISBURSEMENT OF BENEFITS**

This Plan is funded through employer contributions, the amounts of which are specified in the underlying Collective Bargaining Agreements. Payments made to the Fund on behalf of Employees are based on hours worked. The office of the Contract Administrator will provide, upon written request, information if an Employer is contributing to this Plan on behalf of Participants working under the Collective Bargaining Agreement, together with his address.

### **3. ENTITIES USED FOR ACCUMULATION OF ASSETS AND PAYMENT OF BENEFITS**

Benefits are provided from the Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered Participants and defraying reasonable administrative expenses.

### **4. CLAIMS AND APPEALS PROCEDURE**

Both the Kaiser and Delta Dental materials contain a claims and appeal procedure that must be followed. You should read those provisions carefully so that you are aware of the timelines and DEADLINES for filing claims and appeals. Those documents govern the appropriate time period to file. After completing the claims and appeals procedures, if you are still not satisfied with the result, you have only two years in which to file a lawsuit against the Plan, Board of Trustees, or any other fiduciary, person or entity involved with the decision to deny your benefit request (or which involved any other adverse action).

## **F. POTENTIAL LOSS OF BENEFITS**

You or your beneficiary could lose your benefits or have payments delayed in at least the following circumstances:

### **1. INADEQUATE OR IMPROPER EVIDENCE**

The Plan grants the Board of Trustees the power to deny, suspend or discontinue benefits to a Participant who fails to submit at the request of the Trust Fund Office any information or proof of coverage reasonably required to administer the Plan.

### **2. WORK IN NON-COVERED EMPLOYMENT (MISCONDUCT)**

Your eligibility for benefits under the Plan and your Hour Bank will be cancelled if you work in the type of employment for which Employers contribute to this Plan, for an Employer who does not contribute to a health and welfare trust fund affiliated with a local union of the United Association, or you go into business in the plumbing or pipefitting industry without being signatory to an agreement with a local union of the United Association, or in other words, if you work non-union. If this occurs, the only coverage for which you may be eligible is COBRA (and COBRA is not available in certain situations), unless you requalify for coverage as a new Employee by working 450 hours of covered employment after your misconduct.

### **3. SUBROGATION THIRD PARTY CLAIMS**

The Plan does not cover any illness, injury, disease or other condition or claim for which a third party may be liable or legally responsible.

### **4. COORDINATION OF BENEFITS**

If dependents are covered by more than one Plan, this Plan may not be responsible for many claims.

### **5. WORK-RELATED INJURIES**

The Plan is not responsible for paying any claims incurred as a result of a work-related injury. This is so even though you fail to file a claim with workers compensation.

**6. RIGHT TO RECOVER CLAIMS PAID OR OFFSET FUTURE CLAIMS**

The Plan has the right to recover any amounts improperly paid. The Plan may offset any amounts owed to the Plan against any claims that you and/or a dependent incur in the future.

**7. PLAN EXCLUSION/CO-PAYMENTS**

The Plan and any HMO or PPO contains exclusions and exceptions for coverage. You should be aware of the Plan's limitations, exclusions, co-payments and other facets of the Plan in which you may not receive full payment on a claim or reimbursement or for which there is a co-payment.

**8. FAILURE TO COMPLETE APPLICATION**

Benefits may not be payable until a completed application and other forms required by the Trust Fund Office are received by the Trust Fund Office.

**9. ONE YEAR CLAIM RULE**

Claims have to be submitted and paid within 12 months.

**10. INCOMPLETE INFORMATION/FALSE STATEMENT/FRAUD**

If you fail to provide request information or give false information to verify disability, age, beneficiary information, marital status or other vital information, coverage under the Plan or benefits provided may be postponed or cancelled.

If you make a false statement to the Plan or other officials regarding the payment of benefits or other issues related to the Plan, you will be liable to the Plan for any benefits paid in reliance on such false statements or information, and any attorney fees and costs incurred in effecting recovery or which were incurred as a result of the false statement or information. This includes but is not limited to costs incurred by the Trust Fund Office, reasonable attorney fees, and interest charges. The Plan may deduct any such fees and costs from any benefits otherwise payable to you, your estate or a beneficiary.

The Board of Trustees reserves the right to suspend or terminate coverage for you and your dependents or any other person claiming eligibility through your participation if you or that person received benefits knowing that he is not entitled to benefits or coverage. If participation is suspended, the Board will determine the length of suspension. The Board may cancel your Hour Bank. The Board reserves the rights of recovery and offset of benefits provided elsewhere in the Plan.

**11. PLAN TERMINATION**

If the Plan terminates, benefits will no longer be provided.

**G. COBRA CONTINUATION COVERAGE**

**1. ELIGIBILITY FOR COBRA**

A federal law, known as the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), requires that group health Plans such as this Plan offer covered Employees and their dependents the opportunity to elect to pay a monthly premium for a temporary extension of health coverage (called "COBRA Continuation Coverage" or "COBRA") in certain instances (called "qualifying events") where coverage under the Plan would otherwise end. To receive

this continuation coverage the Employee, spouse and/or dependent(s) must make timely monthly payments directly to the Plan.

When you no longer have sufficient hours in your Reserve Hour Bank, your COBRA coverage will run concurrently with any continuation of coverage described beginning on page 4. In other words, your COBRA eligibility is reduced by the number of months of subsidized coverage.

Even if you do not elect COBRA continuation coverage, your spouse and each of your eligible dependents have a separate right to elect it. You, your spouse and all of your eligible dependents should read this section of your benefit booklet.

A qualifying event is any of the following:

- a. The death of the Participant;
- b. The Participant's termination of employment which includes resignation, layoff, firing (except for gross misconduct), retirement, strike or lockout;
- c. A reduction in the Participant's hours;
- d. The divorce or legal separation of the Participant and his spouse; or
- e. A child no longer meets the definition of a dependent.

To receive this COBRA coverage, a Participant and/or his eligible dependents must file a timely application following the qualifying event and make monthly self-payments to the Trust Fund Office in an amount determined by the Board of Trustees.

## 2. COBRA RULES

- a. Upon payment of the required monthly premium set by the Board of Trustees you and/or your dependent(s) may elect COBRA continuation coverage as follows:

- (i) Termination of Employment or Reduction in Hours. A Participant or dependent may elect COBRA for medical benefits and prescription drug coverage only (core), or medical, dental and vision coverage (core and non-core benefits) for a period of **up to 18 months** if you lose your health coverage because of termination of your Covered Employment or a reduction in hours (including having used all hours in your Reserve Hour Bank), unless such termination is due to your Gross Misconduct, which does not require a criminal conviction. This 18 month period is reduced by the number of months of subsidized self-payment described above.

By electing COBRA continuation coverage, you will be electing to maintain benefits on behalf of your eligible dependents. If you do not elect COBRA continuation coverage, each of your dependents may independently elect such coverage on behalf of himself or herself and eligible dependents if applicable and pay the required premium.

- (ii) Disability-Extended Coverage for 29 Months. For an additional premium and subject to certain notice provisions, an Employee or other eligible dependent may elect continuation coverage for an additional 11 months if the Employee or eligible dependent is determined by the Social Security Administration to be totally disabled and permanently disabled as of the date of the Employee's termination of employment or reduction in hours (i.e., the qualifying event which invoked COBRA coverage) or within

sixty days of the COBRA coverage. You pay 150% of the applicable premium for the additional 11 months of coverage. To qualify for this special extended COBRA eligibility, you must report the Social Security disability determination to the Trust Fund Office before the initial 18 months of COBRA coverage expires (and within 60 days after receipt of the Social Security determination). This disability extension ends immediately if the disabled individual recovers.

- b. Thirty-Six Month COBRA Coverage for Dependents. Your dependent spouse or child who would otherwise lose health coverage is eligible for continuation coverage for up to 36 months because of the following qualifying events:
  - (i) the death of the Employee;
  - (ii) divorce or legal separation of the Employee and spouse; or
  - (iii) a child ceases to meet the Plan's definition of dependent.
  
- c. Multiple Qualifying Events. An 18-month period of COBRA continuation coverage may be extended for up to 36 months for your spouse or dependent child if a second qualifying event occurs (such as if you die, divorce, or your child no longer qualifies for coverage) within the first 18-month period. In no event, however, will such coverage extend beyond 36 months from the date coverage was first lost due to the initial qualifying event.

#### **EXAMPLE**

An Employee's spouse is on COBRA continuation coverage due to the Employee's termination of employment. The Employee dies after 12 months of coverage during the 18-month period. His death is a second "qualifying event" and entitles the spouse to the remaining balance of 24 months (36 months maximum minus the 12 months that has already been covered).

**The period of coverage under this section is reduced by any period in which the Employee or dependent was provided coverage by the Plan at lower cost than coverage under this section pursuant to the subsidized self-pay provisions of the Plan.**

### **3. ELECTION OF COBRA COVERAGE**

Within 60 days after the Trust Fund Office is informed in writing of an event entitling you and/or your spouse or dependent children to COBRA coverage, the Trust Fund Office will provide you with information concerning the coverage available and its cost. You and/or your dependent must elect COBRA coverage within 60 days after your coverage under the Plan ends or the date you receive the election form, whichever is later. Anyone electing COBRA coverage must pay for it retroactive to the date he or she lost coverage under the Plan. Payment for this retroactive coverage is due within 45 days after the date COBRA coverage is first elected. After this first premium, there is a 30 day grace period for making future COBRA payments. No benefit claim will be honored unless the required payment has been received for the period in which the claim was incurred.

If you elect COBRA, you will be entitled to the same health coverage that is provided to active Employees or family members in the Plan. Therefore, if there are any changes to the Plan for active Employees, your benefits will also change.

You have the option of electing one of the following COBRA Plans and paying the designated premiums:

- a. Core Coverage. Provides coverage for medical and prescription drugs only.
- b. Full Coverage: Core and Non-core. Provides coverage for medical, prescription drugs, dental and vision.

**The premiums for COBRA will increase each year**

#### **4. YOUR OBLIGATION TO NOTIFY THE TRUST FUND OFFICE**

You are required to notify the Trust Fund Office if you become divorced or legally separated and/or have other important changes that affect your benefits or those of a dependent.

#### **5. TERMINATION OF COBRA COVERAGE**

COBRA continuation coverage will end before the 18-, 29- or 36- month continuation coverage period expires if:

- a. Failure to Timely Pay Premium. You or your dependent fail to pay the required premium on time;
- b. Coverage Under Other Plan. You or your dependent become covered by another group health Plan after your COBRA election (except a Plan that excludes or limits benefits for a pre-existing condition affecting you or your dependent and such exclusion or limitation is enforceable under the Health Insurance Portability and Accountability Act (HIPAA));
- c. Medicare Entitlement. You or your dependent become entitled to Medicare after having elected COBRA;
- d. No Longer Disabled. You or your dependents qualified for 29-month maximum continuation period based on disability, but are no longer disabled.
- e. Employer No Longer Contributes. Your Employer who contributed on your behalf ceases to be a contributing Employer; or
- f. No Active Plan. The Trust Fund and your Employer cease to maintain any health Plan for active Employees or retirees.

### **H. HEALTH INSURANCE AND PORTABILITY ACT OF 1996 [HIPAA] (Certificate of Coverage)**

The Health Insurance Portability Accountability Act of 1996 provides that group health Plans must limit the time for which coverage is not provided for pre-existing conditions. (This Plan has no such exclusion; however, some other Plans do.) The law also provides that your coverage under this Plan will reduce the preexisting condition limitation period of another Plan for which you become eligible. For example, if the other Plan has a 12-month pre-existing condition limitation and you have been eligible under this Plan for 12 months prior to becoming eligible under the other Plan, the pre-existing condition limitation of the other Plan will not apply to you.

When you experience a qualifying event under this Plan, the Trust Fund Office will provide you, along with your initial COBRA notice, a certification of the number of months for which you and your dependents have been eligible for benefits under this Plan. The certificate of former group health Plan coverage provides evidence of your health coverage under the U.A. 467 Health and Welfare Trust Fund. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll. If you are eligible for coverage due to new employment, you may want to furnish a copy of this certificate to your new Employer in order that you can become eligible for the greatest number of benefits due to employment as quickly as is possible.

You and/or your new Employer should contact the Trust Fund Office if any additional information certifying your coverage under this Plan is required. Once you become eligible under another Plan which has no pre-existing condition limitation which limits the coverage available to you, your right to continue coverage under this Plan pursuant to COBRA terminates.

## **I. STATEMENT OF ERISA RIGHTS**

As a Participant in the U. A. Local Union No. 467 Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that Plan Participants are entitled to:

### **1. RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS**

Examine, without charge, at the Trust Fund Office and at other specified locations, such as worksites and union halls, 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 Benefit Security Administration.

Obtain, upon written request to the Trust Fund Office, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Trust Fund Office may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report known as a Summary Annual Report ("SAR"). The Trust Fund Office is required by law to furnish each Participant with this Summary Annual Report.

### **2. CONTINUE GROUP HEALTH PLAN COVERAGE**

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

Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health Plan, if you have creditable coverage from another Plan. You should be provided a certificate of creditable coverage, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without

evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

### **3. PRUDENT ACTIONS BY PLAN FIDUCIARIES**

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

### **4. ENFORCE YOUR RIGHTS**

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of certain Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court, although your right to sue may be limited if you have not used the Plan's appeal procedures. In such a case, the court may require the Plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a lawsuit. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. Any such claim shall be limited to benefits due to him or her under the terms of the Plan, or to clarify his rights to future benefits under the terms of the Plan, and shall not include any claim or right to damages, either compensatory or punitive. 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.

If your appeal has been denied or there has been a different form of adverse action taken against you, you have two years from the date of such denied appeal or adverse action to file a lawsuit. If you fail to do so, no lawsuit is permitted. This rule applies to and includes any and every claim to benefits from the Fund, and any claim or right asserted under the Plan or against the Fund, regardless of the basis asserted for the claim, and regardless of when the act or omission upon which the claim is based occurred, and regardless of whether the claimant is a “Participant” or “beneficiary” of the Plan with the meaning of those terms as defined in ERISA.

### **5. ASSISTANCE WITH YOUR QUESTIONS**

If you have any questions about your Plan, you should contact the Trust Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, which is the San Francisco Regional Office, 71 Stevenson Street, Suite 915, P.O. Box 190250, San Francisco, CA (415) 975-4600.

Office of Participant Assistance  
U.S. Department of Labor  
Employee Benefits Security Administration  
200 Constitution Avenue NW  
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. For single copies of publications, contact the EBSA Brochure Request Line at 1-800-998-7542 or contact the EBSA field office nearest you.

You may find answers to your questions and a list of EBSA offices at <http://www.dol.gov/ebsa/welcome.html>

### **J. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996**

Pursuant to the Newborns' and Mothers' Health Protection Act of 1996, the Medical Plans in which you may enroll may not restrict benefits for any hospital length of stay for the mother or newborn child to less than 48 hours following normal delivery or less than 96 hours following a cesarean section delivery.

In accord with Federal Law, those Plans do not require that a provider obtain preauthorization under those Plans for either of the foregoing lengths of stay. However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or her newborn earlier than the applicable time period.

### **K. WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998**

Your Plan covers medical and surgical benefits for mastectomies. This coverage includes:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; or
3. Prosthesis and physical complications of all stages of mastectomy, including lymphedemas.

The coverage is subject to the Plan's annual deductibles and coinsurance provisions.

**NAME OF PLAN**

These Plan Benefits are provided under the U.A. Local 467 Health and Welfare Trust Fund.

**TYPE OF PLAN**

This is a Welfare Plan which provides medical and prescription drug benefits through Kaiser Foundation Health Plan, dental benefits through Delta Dental Plan of California and vision benefits through Vision Service Plan.

**PLAN ADMINISTRATOR**

The official Plan Administrator is the Board of Trustees. Its address and other pertinent information are as follows:

Board of Trustees  
U.A. Local 467 Health and Welfare Trust Fund  
1120 South Bascom Avenue  
Post Office Box 5057  
San Jose, CA 95150  
Telephone: (408) 288-4400

The Employer Identification Number (EIN) assigned to the Plan Sponsor by the Internal Revenue Service is 94-6415220.

The Plan Number is 516.

**TYPE OF ADMINISTRATION**

This Plan is administered by the Board of Trustees with the assistance of a contract administrative organization.

**NAME AND ADDRESS OF AGENT FOR SERVICES OF PROCESS**

Richard Grosboll, Attorney at Law  
Neyhart, Anderson, Flynn & Grosboll  
44 Montgomery Street, Suite 2080  
San Francisco, CA 94104-6702

The service of legal process may also be made on a Plan Trustee or the Contract Administrator.

**NAME, ADDRESS AND TELEPHONE NUMBER OF CONTRACT ADMINISTRATOR**

United Administrative Services  
1120 South Bascom Avenue  
Post Office Box 5057  
San Jose, CA 95150  
Telephone: (408) 288-4400

**END OF PLAN YEAR**

This Plan is on a calendar year basis with the Plan year ending December 31.

**The Board of Trustees has reserved the right to alter or discontinue any plan of benefits provided under this program or to require Employee co-payment, when in its sole discretion it deems it advisable to do so.**

## PLAN ADVISORS

### ADMINISTRATOR

United Administrative Services  
Jean Sukovez  
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### CORPORATE CO-TRUSTEE

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## HEALTH AND WELFARE PLAN TRUSTEES

### EMPLOYEE TRUSTEES

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### EMPLOYER TRUSTEES

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