NORTHERN CALIFORNIA PIPE TRADES TRUST FUNDS FOR UA LOCAL 342

935 Detroit Avenue, Suite 242A, Concord, CA 94518-2501 • Phone 925/356-8921 • Fax 925/356-8938
tfo@ncpttf.com • www.ncpttf.com

DISABILITY EXTENSION OF ELIGIBILITY FOR HEALTH AND WELFARE COVERAGE

If you are unable to work for at least 14 consecutive days during a calendar month either because of an occupational disability for which you receive benefits from Workers' Compensation, or a non-occupational disability for which you receive benefits from State Disability Insurance ("SDI"), you may be entitled to an extension of your Health and Welfare coverage under this Plan for up to a maximum of 6 months per period of Disability within a rolling one (1) year period and not to exceed the maximum of 24 months of Disability Extension Benefits per lifetime effective for Claim Effective Dates beginning on or after March 1, 2025.

During periods of Disability Extension your Reserve Hour Bank ("RHB") will be frozen. (This benefit is separate from the Supplemental Disability benefit which is handled through UA Local 342 and not the Trust Fund Office ["TFO"].)

You may be eligible for this benefit if at the time of your Claim Effective Date ("CED") (if the CED is on or after March 1, 2025) and throughout your periods of disability, you meet all the following requirements:

a) You are a member in good standing with UA Local 342; **and**
b) Must be current on paying Union Dues to UA Local 342 and have not been charged or owed a reinstatement fee to UA Local 342 within the three (3) months immediately preceding your State Disability Insurance or Workers' Compensation CED; **and**
c) There is no monetary value owed to the Health and Welfare Plan due to outstanding Overpayment (on behalf of an ineligible Dependent) that has not entered into a Repayment Agreement, or if a Repayment Agreement is in effect, then you must be current on monthly repayments; **and**
d) Must have at least 12 consecutive months of Active Eligibility (ending with the month of the CED) through hours worked, RHB, Disability Extension, or Active Subsidized Self-Payments (excluding COBRA), **OR** must have at least one (1) month of Active Eligibility through hours worked, RHB, Disability Extension, or Active Subsidized Self-Payments (excluding COBRA) in the three (3) month period immediately preceding your CED **AND** have worked at least 1500 hours in Covered Employment during the 36-months immediately preceding your Claim Effective Date; **and**
e) Must have been working under a contract/classification that permits the Disability Extension Benefit.
f) Proof of 14 consecutive days of State Disability or Workers' Compensation payment during a month in which the Participant is deemed disabled (unable to work due to an occupational disability in which Workers' Compensation is being received or due to a non-occupational disability in which State Disability Insurance is being received) must be provided to the TFO in order to receive the Disability Extension, and continued proof will be required each month in order to extend benefits; **and**
g) Not currently receiving a Retirement Benefit from the Northern California Pipe Trades Pension Plan; **and**
h) The application for Disability Extension Benefit must be received within 60 days of your CED and is approved by the Plan and/or its authorized delegates.

Participants covered under certain contracts (Residential, Helper, Non-Bargained, Tradesman, etc. are not eligible for the Disability Extension Benefit. Contact the Eligibility Department for details at 925/356-8921 ext. 710.

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DISABILITY EXTENSION APPLICATION

Complete the following information and return the completed application along with proof of receipt of State Disability Insurance (SDI) Benefits or Workers' Compensation Benefits to our physical address as noted in the header of this application or by email to tfo@ncpttf.com.

Participant's Name: _____ SSN: xxx-xx-_____

Mailing Address: _____

Primary Phone Number: (____) _____ Email Address: _____

Disability CED: _____

Expected return to work date: _____

Please check the applicable box for the type of disability benefit you are receiving:

❑ State Disability Insurance Benefits

❑ Workers' Compensation Benefits

Complete only if you are receiving Workers' Compensation Benefits:

Claim #_____ Carrier Name: _____

Coverage will only be extended according to the proof of disability for which you provide to our office. Benefits will not be extended for any time period in which our office has not received proof of your State Disability Insurance or Workers' Compensation.

The Plan's skip month eligibility rule applies. **Example**: If a Participant submits proof of disability for August 1st through August 20th, coverage may be granted for October eligibility (based on the August work month providing October eligibility).

Please note that submission of a Disability Extension Application does not guarantee eligibility for the Benefit. Upon receipt of your Application, our office will review your file to determine whether additional documentation and/or information is required. In accordance with Plan rules, if additional documentation is required, eligibility and benefits may not be verified until all required documentation and/or information is received by our office.

_____ _____
Participant's Signature Date