

# NORTHERN CALIFORNIA PIPE TRADES TRUST FUNDS FOR UA LOCAL 342

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**APRIL 2023**

**TO: ACTIVE AND RETIRED PARTICIPANTS**

**RE: ANNUAL NOTICES & IMPORTANT INFORMATION**

This Notice includes Annual Notices the Northern California Pipe Trades Health and Welfare Plan (“Plan”) is required to provide you with under the Affordable Care Act (“ACA”) and other Federal Laws. This Notice is intended for informational purposes only and to remind you of certain Plan rules. No action is necessary on your part for certain items.

**YOU SHOULD RETAIN THIS DOCUMENT WITH YOUR COPY OF THE PLAN’S SUMMARY PLAN DESCRIPTION/PLAN DOCUMENT (also known as the “Plan Rules”).**

## **A. AFFORDABLE CARE ACT**

### **GRANDFATHERED HEALTH PLAN (FOR ALL RETIREE MEDICAL PLAN OPTIONS)**

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

Questions regarding which protections apply and which protections do not apply to a Grandfathered Health Plan and what might cause a Plan to change from Grandfathered Health Plan status can be directed to the Employee Benefits Security Administration, U.S. Department of Labor (DOL) at 866/444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to Grandfathered Health Plans.

### **AVAILABILITY OF SUMMARY OF BENEFITS AND COVERAGE (“SBC”)**

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

### **MINIMUM ESSENTIAL COVERAGE**

The ACA establishes a minimum value standard of benefits for health plans. The minimum value standard is 60% (actuarial value) and Grandfathered Health plans (such as the Retiree Medical Plan Options) are considered minimum essential coverage. **This Plan provides minimum essential coverage and meets the minimum value standard for the benefits it provides (exceeds 60%).**

Depending on which Plan option you are enrolled in, Kaiser or Blue Shield should have already sent you a statement (known as Form 1095-B) about the 2022 coverage you and/or your Dependents were enrolled in. Kaiser and Blue Shield are required to file these Forms with the IRS. If you did not receive such statement yet, please contact your selected Health Plan (Kaiser or Blue Shield).

## **B. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (“HIPAA”) AVAILABILITY OF THE NOTICE OF PRIVACY PRACTICES**

The Board of Trustees of the Plan have adopted a Notice of Privacy Practices. The Notice of Privacy Practices describes the permitted ways that the Plan uses and discloses your Protected Health Information (“PHI”), your HIPAA privacy rights, and the Plan’s legal responsibility regarding your PHI. A copy is available on the Plan’s website at [www.ncpttf.com](http://www.ncpttf.com) or by contacting the Trust Fund Office (“TFO”) to request a copy of the Notice at any time. The Notice is also automatically provided to you at least once every three years or when there is a material change to the Notice. Depending on the insured coverage you are enrolled in, Kaiser or Blue Shield have their own HIPAA Notice of Privacy Practices and may also send you a copy of their own rules.

## **C. WOMEN’S HEALTH AND CANCER RIGHTS ACT OF 1998**

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

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

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

## **D. NEWBORNS AND MOTHERS HEALTH PROTECTION ACT**

Under Federal Law, Group Health Plans, Health Insurance Issuers, and Health Maintenance Organizations (such as Kaiser and the Blue Shield HMO option) may not generally, restrict benefits for any hospital length of stay in connection with childbirth for the Mother or Newborn child less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or Issuer (Kaiser or Blue Shield) may pay for a shorter stay if the attending provider (e.g., your Physician, Nurse, Midwife, or Physician Assistant), after consultation with the Mother, discharges the Mother or Newborn earlier.

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

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

## **E. PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (“CHIP”)**

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, the State you reside in may have a Premium Assistance Program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these Premium Assistance Programs. Note: If you live in California, you can contact the California Department of Health Care services for further information on eligibility and premium assistance under the Health Insurance Premium Payment (HIPP) Program at: [www.dhcs.ca.gov](http://www.dhcs.ca.gov) and E-mail at [HIPP@dhcs.ca.gov](mailto:HIPP@dhcs.ca.gov).

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

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

If it is determined that you or your Dependents are eligible for Premium Assistance under Medicaid or CHIP, as well as eligible under the Plan rules, you may enroll in your employer Plan if you are not already enrolled. The employer cannot stop you from enrolling. This is called a “Special Enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for Premium Assistance. If you have questions about enrolling in your employer Plan, you can contact the Department of Labor electronically at [www.askebsa.dol.gov](http://www.askebsa.dol.gov) or by calling 866/444-EBSA (3272).

To find out if the State you reside in provides assistance in paying your employer health Plan premiums or for more information on eligibility, visit <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra> for a list of participating States.

To see if any more States have added a Premium Assistance Program since January 31, 2023, or for more information on special enrollment rights, you can also contact either:

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

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
877/267-2323, Menu Option 4, Ext. 61565

## **F. PLAN REMINDERS**

### **ONE (1) YEAR LIMITATION PERIOD FOR FILING A LAWSUIT**

Under the Plan’s Claims and Appeals rules, no lawsuit may be brought against the Plan and/or the Board of Trustees and/or any Individual Trustee and/or any other person or entity involved or associated with the denial decision more than one (1) year after services were provided, or benefits were partially or totally denied, or an adverse benefit determination was issued. This would be one year from the date on the appeal determination letter you receive. In addition, you must first utilize the Plan’s Appeal Procedures before commencing a lawsuit, if any, against the Plan and/or the Board of Trustees and/or any Individual Trustee and/or any Individual Trustee and/or any other person or entity involved or associated with the denial decision. Any outside entity providing services for the Plan (e.g., Kaiser, Blue Shield, Delta Dental of California, Vision Service Plan (“VSP”), Principal Life Insurance Company) has their own Claims and Appeals procedures, and you would need to contact them for more information.

If you are enrolled in Kaiser, Blue Shield, Delta Dental of California and/or VSP, please refer to the applicable Evidence of Coverage Documents for its Appeal and Grievance procedures.

## **RETIREE RETURNING TO COVERED EMPLOYMENT**

If you are retired and considering returning to work, prior to commencing any Work After Retirement, you **must** submit a written request to the Board of Trustees for a determination on whether your contemplated Work After Retirement would be considered “Prohibited Employment” under Plan rules.

Returning to any type of “Prohibited Employment” will suspend your monthly Retirement Benefit. In addition, if you retired under an Early Retirement and return to any type of “Prohibited Employment,” your Retirement Benefit will be suspended until you attain Normal Retirement Age (Age 65).

If you are eligible for Retiree Health and Welfare Benefits, and your Retirement Benefit is suspended more than once due to returning to Prohibited Employment, you will permanently lose your rights to Retiree Health and Welfare Benefits. Refer to Article XIII, Section A.9 of the SPD for more details.

When there is Full Employment, or Full Employment in certain designated positions, and the Board of Trustees establishes a Temporary Retiree Return to Work Program, special rules will apply.

Refer to the Northern California Pipe Trades Pension Plan, Suspension of Retirement Benefits Notice for additional information. This information is available at [www.ncptf.com](http://www.ncptf.com).

## **MEDICARE COORDINATION – YOU ARE REQUIRED TO ENROLL**

Medicare is our country's Federal Health Insurance Program for people who worked at least ten (10) years in Medicare-covered employment who are age 65 or older, for people under age 65 with certain disabilities, and for people of any age who have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). If you are receiving Social Security Disability Income (“SSDI”) benefits, you generally become eligible for Medicare coverage 24 months after your SSDI benefits begin.

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

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

However, if you or your spouse are still working (after reaching Age 65), Medicare works a little differently. Generally, if you have job-based health insurance through your (or your spouse's) current job, you don't have to sign up for Medicare while you (or your spouse) are still working. You can wait to sign up until you (or your spouse) stop working or you lose your health insurance (whichever comes first).

Medicare's prescription drug Plan (Medicare Part D) is available to Medicare beneficiaries and is part of your coverage if you are enrolled in the Retiree Health and Welfare Plan. If you earn a higher income (above \$97,000 annually for individuals or above \$194,000 annually for married couples), Federal Law requires that you pay an additional premium for your Medicare Part D coverage to the Social Security Administration. NOTE: If your income is \$97,000 or less (single) or \$194,000 or less (married) you will not be assessed the Medicare Part D additional premium.

This additional premium is called the Income-Related Monthly Adjustment Amount (also known as “IRMAA”). The premium is based on your modified adjusted gross income as reported on your IRS tax return from two years prior (thus, the fee in 2023 will be based on your adjusted gross income on your 2021 tax return). If you must pay a higher premium, Medicare will send you a letter with your premium amounts and the reason for their determination.

For more information on Medicare Part D or IRMAA, please call Medicare at 800/MEDICARE (800/633-4227) or visit [www.medicare.gov](http://www.medicare.gov). TTY users should call 877/486-2048. If you have any questions, please contact the TFO at 925/356-8921 ext. 246.

### **HIPAA GROUP SPECIAL ENROLLMENT RIGHTS**

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

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

The Plan will also allow a Special Enrollment opportunity if you and/or your eligible Dependents either: (1) lose Medicaid or CHIP coverage because you are no longer eligible; or (2) become eligible for a State’s Premium Assistance Program under Medicaid or CHIP. For these enrollment opportunities you will have 60 days from the date of the Medicaid/CHIP eligibility change to request enrollment in the Plan.

Although there is a Special Enrollment period required by Federal Law, this Plan also allows Participants to make changes throughout the year. For more information, please contact the TFO.

### **DOMESTIC PARTNERSHIP PREMIUM PAYMENTS**

Pursuant to the Plan rules a Participant is responsible for the timely monthly payment in full of imputed income taxes for coverage of an eligible Domestic Partner and the Domestic Partner’s Child(ren). This payment is due one month in advance of the month the eligibility is provided. Failure to pay the required payment in full by the due date may result in immediate termination of your Domestic Partner’s coverage on the last day of the month in which the payment is not received. Please contact the TFO for more information and refer to pages 19 to 20 of the SPD for details on the Plan’s Domestic Partnership rules.

### **LOSS OF COVERAGE FOR A SEPARATED SPOUSE**

Pursuant to the Plan rules a Spouse that no longer lives in the participant’s home resulting in an unofficial separation by joint decision is a basis for termination of the Separated Spouse’s coverage and a COBRA qualifying event under the Plan. You are required to timely notify the TFO within 120 days of the date of the separation (legal or by joint decision). Contact the TFO for more information and refer to pages 18 and 30 and of the SPD for details.

### **ENROLLMENT PROVISIONS**

It is your responsibility to notify the TFO of changes to your address and/or changes in your life circumstances (e.g., divorce, separation, Dependent Child ceases to be an eligible Dependent). You will be required to complete the appropriate Enrollment/Change Form or Change Request Form, both of which are available at [www.ncpttf.com](http://www.ncpttf.com).

You should update your Beneficiary Designation Form when you have a change in your life circumstances. The Beneficiary Designation Form is available at [www.ncpttf.com](http://www.ncpttf.com) or you may contact the TFO.

No benefits will be paid by the Plan for fraudulent premiums, fraudulent Beneficiary Designation Forms, claims or services made by a Participant, Dependent, or any other person, for any other reasons (including, but not limited to enrolling ineligible Dependents, failing to notify the Plan that a previously eligible Dependent no longer qualifies as a Dependent, failure to timely enroll in Medicare or failure to notify the TFO of you or your Dependent’s eligibility to

enroll in Medicare). If payment is made on behalf of any person for fraudulent claims, the Participant, and any person on whose behalf a fraudulent claim was submitted will be responsible for repaying the Plan.

The following classifications are only permitted to enroll in the Plan's Kaiser HMO option (except under limited special circumstances):

- Residential and Residential Light Commercial Employees and their eligible Dependents;
- Tradesmen and Servicemen Employees and their eligible Dependents;
- Shortline Helper and MLA Helper Employees and their eligible Dependents;
- U.A. National Distribution Agreement Employees and their eligible Dependents;
- Safety Attendants Levels 2-4, Foreman, General Foreman, and Senior General and their eligible Dependents.

Below is a list of Contacts for your convenience:

Provider/Contact	Type of Benefit	Website	Phone Number
Kaiser Permanente	Medical & Rx	<a href="http://www.kaiserpermanente.org">www.kaiserpermanente.org</a>	800/464-4000
Blue Shield of California	Medical & Rx	<a href="http://www.blueshieldca.com">www.blueshieldca.com</a>	855/256-9404
Delta Dental of California	Dental	<a href="http://www.deltadentalins.com">www.deltadentalins.com</a>	800/765-6003
Vision Service Plan	Vision	<a href="http://www.vsp.com">www.vsp.com</a>	800/877-7195
NWPS	Health Reimbursement Account	<a href="http://www.kandg.com">www.kandg.com</a>	855/512-1170

If you or your Dependents have any questions, contact the TFO at 925/356-8921 ext. 246.

Respectfully submitted,

Fund Manager  
On Behalf of the Board of Trustees