Prevailing Wage Contractors
HEALTH AND WELFARE TRUST
(PWCHWT)

FRINGE BENEFIT CONTRIBUTION PAYMENT GUIDELINES FOR PARTICIPATING EMPLOYERS

The Trustees of the] PWC Health and Welfare Trust Fund ("Trust Fund") have adopted these guidelines to inform participating employers about reporting and contribution requirements and to answer frequently asked questions. Since many of the questions/answers contained herein are general in nature, specific guidance is also available from the administrative office.

I. INFORMATION ABOUT THE TRUST

A. What type of organization is the Trust Fund?

The Trust Fund is a separate Multi-employer Trust fund, It operates as a voluntary employees' beneficiary association as defined in section 501(c)(9) of the Internal Revenue Code. The Trust Fund will request recognition as tax-exempt by the Internal Revenue Service and the California Franchise Tax Board.

B. Who are the trustees of the Trust Fund?

The trustees are appointed to administer the plan for employer members and their employees. Voluntarily AND than by a vote or appointment of the member Employers The current Trustees have volunteered to whole the position for the first 12 months after starting up.

C. What geographical area does the plan cover?

The geographical area of coverage by the primary Medical/Hospital system is known as the County of San Diego Ca. and parts of Riverside County (see coverage in Sharp brochure)

D. Who administers the Trust Fund and plan?

The trustees administer the Trust Fund and plan with the assistance of several professional consultants. The appointed Professional Plan administrative manager is MVI Administrators Insurance Solutions, Inc. and legal services are provided by Sheppard Mullins law firm. These consultants assist the trustees in complying with applicable laws and regulations. Questions about the Trust Fund should be directed to the administrative office located at 1011 Camino Del Rio South, Suite 300, San Diego, CA 92108. The telephone number is (619) 260-2660.

E. How are benefits provided to employees?

The plan currently provides comprehensive fully insured medical, dental, vision, and life insurance benefits. Eligibility rules and benefit schedules are included in the summary plan description which is supplied to all participating employees. Additional copies are available from the administrative office. The insurers and managed care providers are responsible for processing employee benefit claims.

II. EMPLOYER PARTICIPATION RULES

A. Which companies are eligible to participate?

Only employers who have agreed to regulations of the trust fund and have signed the Adoption agreement of the PWCHWT may participate in the plan and which are party to any other agreements with the Trust Fund. If a company ceases to be an active member, its participation in the Trust Fund will be terminated.

B. May an employer participate when it has no work?

The trustees require participating employers to be active employers to continue participation. Your company will be considered active if it meets any of the following conditions: (1) you hire employees in addition to the owners or officers; (2) you engage in the Construction work and the Prevailing Wage industry; and/or (3) you have
revenue from Prevailing Wage Davis Bacon or like job site opportunities and/or the industry. If a company becomes inactive, it may continue participation for six months. To continue beyond this Six-month period, the company must demonstrate its compliance with one of the conditions set forth above.

C. Do all related companies have to participate?

Participating employers may be members of controlled groups of corporations, partnerships or joint ventures. Each employer that contributes to the Trust Fund must be bound to a written adoption agreement. The general rule is that if a parent corporation participates, all subsidiary corporations must participate. Situations involving controlled groups, joint ventures, and partnerships will be evaluated on a case-by-case basis. Questions in this area should be addressed to the administrative office before participation begins.

D. How does employer participation begin and end?

Each participating employer must sign a written adoption agreement and agree to participate a minimum of twelve months. A participating employer may terminate its participation on 60 days' written notice to the Trust Fund after the minimum twelve-month period has ended. The trustees may terminate participation of an employer because of contribution delinquencies, non-compliance with Trust Fund rules, or for any other reason in the trustees' discretion. A termination notice must be in writing to be effective.

E. How often are contributions paid?

Trust contributions are paid monthly at rates established from time to time by the trustees. Participating employers must identify all reported employees on monthly remittance forms provided by the Trust Fund. Contributions and remittance forms are due by the 5th of the month following the month preceding the month of month coverage. Contributions are delinquent if not postmarked by the 15th of the month.

F. What happens if contributions are paid late?

If contributions are not postmarked by the 15th of the month as referred to above, liquidated damages may be automatically assessed at the rate of 10% of the total contributions due. The trustees have discretion to terminate the participation of any participating employer for contribution delinquencies.

G. Are employer contributions audited?

The Trust Fund performs payroll record reviews to assure that proper reporting practices are maintained. Each employer must assure that only covered employees are reported and that all covered employees are reported. Verification will be required during the payroll record review. The Trust Fund will bill each employer $100 if the employer is not prepared to conduct the payroll record review as scheduled. Participating employers should refer to the payroll record review and dispute resolution in procedures for a more detailed discussion of these rules.

H. What are employers' obligations under privacy rules to protect health information?

The Department of Labor has issued strict rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") protecting the privacy of participants' health care information. While the HIPAA privacy rule is directed to health benefit plans and health care providers ("covered entities") the rule also affects communications between covered entities and employers that sponsor plans. The trust has implemented policies and procedures that comply with the HIPAA privacy rule, which have been adopted by the plan administrator and other service providers. As a result, all communications between employers and the plan benefit providers concerning treatment, claims, payment, and health conditions should be managed by the plan administrator. Employers should contact the plan administrator with any questions or concerns that they or their employees have regarding medical information that relates to the benefit plan.

The HIPAA privacy rule, however, does not impact workers' compensation claims or other types of medical information that employers receive unrelated to the health benefit plan. Such information includes, but is not limited to, medical information employers receive from employees concerning sick leave, drug testing, pre-employment physicals, and fitness for duty examinations. The HIPAA privacy rule also does not affect employers' compliance with other state and federal laws

such as the Americans With Disabilities Act ("ADA"), the Family Medical Leave Act ("FMLA"), the California Family Rights Act ("CFRA"), the Pregnancy Disability Act, or the California Fair Employment and Housing Act ("FEHA"). Medical information about employees unrelated to their employer-sponsored health benefits, however, may be protected by state and federal medical privacy laws other than HIPAA.
Employers should consult with competent labor counsel regarding their obligations to protect employees' right to privacy in complying with these and other non-benefit plan related laws.

III. EMPLOYEE COVERAGE AND ELIGIBILITY

A. Which employees can be covered?

Employers may cover hourly and/or office/salaried employees. Employees covered by collective bargaining agreements are excluded from participation and contributions may not be made in their behalf.

B. Does the plan require hourly or monthly contributions?

Each employer shall make monthly contributions for eligible employees. Only active employees, and employees entitled to contributions under applicable federal or state family and medical leave and continuation of coverage laws, are eligible for coverage. Contributions for Prevailing Wage will be based on hourly dollar amounts from Fringe monies and consistent with assuring that an employee will qualify for the plans.

C. When do employees become eligible for benefits?

Employees will become eligible for coverage on the first day of the month following the eligibility waiting period selected by the employer in its adoption agreement. For example, if an employee starts work on the first of March, the employee will be covered effective May 1st if the employer elected a 60 day-eligibility waiting period. Employees must be actively at work on the effective date of their insurance to be eligible for coverage.

D. How much is contributed for reported employees?

The company pays contribution rates established by the trustees as reflected on the monthly remittance report form. If contribution rates are changed, the employer will be notified in advance.

E. May employees waive coverage?

Yes./No Employers may elect not to contribute to the Trust Fund for employees who are covered by another health plan offered by an employer to a spouse or are covered under a military coverage or Medicare. Employees covered under an hour/dollar bank (Davis Bacon) may not waive coverage. An employer who allows employee waivers of coverage will sign a separate addendum to its adoption agreement with the Trust Fund which holds the Trust Fund harmless from employee claims.

F. May employees waive coverage?

Yes. If the participating employer permits employee waivers, employees may elect to waive coverage according to the Trust Fund's rules and procedures. A waiver of health coverage by an employee will operate as a waiver of all ancillary benefits, including dental, vision and life insurance. Accordingly, an employee may not choose to enroll for dental insurance but waive health coverage. If the employee enrolls for health benefits, ancillary benefits such as dental, vision and life insurance may be individually waived. Employers who elect to allow employees to waive coverage are responsible for maintaining employee waiver or declination of coverage forms.

G. May an employer require employees to pay for dependent coverage?

Employers may require employees to pay for the cost of dependent coverage. However, the company may not require the employee to pay for the cost of his or her own employee coverage. The plan requires the employer to pay the full cost for all employee coverage.

H. Are domestic partners covered?

Employees may provide domestic partner coverage under the plan's domestic partner coverage rules and procedures. Employees electing domestic partner coverage qualify as domestic partners and meet certain criteria, including residing together. If an employee elects domestic partner coverage, he or she will be able to choose from the benefit plans that have agreed to provide coverage of domestic partners. Domestic partner coverage rules and procedures are available from the plan administrative office.

I. What are employers' obligations regarding employees on military leave?

Employers may be required to continue making contributions to the plan for a participating employee's benefits during an absence from work because of military service. Participating employees on military leave are entitled to plan benefits that are available to other employees on non-military leave. Employers should consult with competent labor counsel regarding their specific military leave obligations. If an employee's benefit coverage terminates because of military leave, the employee may elect to continue health coverage similar to COBRA continuation coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Employers should contact the plan administrator immediately if the employer stops making contributions because of an employee's military leave.

Employers returning to active employment following qualifying military leave are entitled to reinstatement in the plan. Employers should contact the plan administrator immediately if an employee returns to active employment following a USERRA leave of absence.

J. May employers make contributions for employees who are not actively working?

Only employees who are actively working are entitled to employer contributions, unless the participating employer determines that an inactive employee is entitled to contributions under applicable state or federal law during a leave of absence. Such laws include, but are not limited to, the Family Medical Leave Act, California Family Rights Act, the Workers' Compensation Act, the California Fair Employment and Housing Act, the Uniformed Services Employment and Reemployment Rights Act of 1994, and the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").

K. Are employees entitled to continue benefit coverage following the termination of their insurance coverage under the Plan?

Employees who experience a COBRA qualifying event may elect COBRA continuation coverage under federal law. COBRA continuation coverage extends for a period of 18, 29, or 36 months depending upon the qualifying event and any eligibility for a disability extension. COBRA continuation coverage is administered by the Plan's Administrative Manager, which provides the required notices to participants and collects premium payments. COBRA continuation coverage premiums are paid by the participant or dependent electing COBRA.

In addition, employees and their dependents who receive less than thirty-six (36) months of COBRA may extend their continuation coverage following the exhaustion of their federal COBRA continuation period by electing Cal-COBRA coverage. Notification of their right to extended coverage under Cal-COBRA for up to a total of thirty-six (36) months of combined coverage is provided by the Administrative Manager. Cal-COBRA, however, is administered by the individual insurance carriers. In addition, employees and their dependents may be entitled to purchase individual conversion coverage directly from the insurance carrier following the termination of their group benefit coverage.

Participating employers making contributions on behalf of inactive employees during leaves of absence must notify the plan administrator in writing when such contributions are made. Participating employers may be required to provide additional information concerning these inactive employees. The trustees may in their discretion reject contributions on behalf of inactive employees that are determined to be inappropriate.

Adopted this ____day of _____, 20____.

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[NAME], Chairman [NAME], Secretary