

**BLUE AND GOLD AUTOMOTIVE HEALTH TRUST FUND  
ADOPTION AGREEMENT**

This Adoption Agreement is made and entered into by and between the undersigned “Participating Employer” and the Blue and Gold Automotive Health Trust Fund (“Trust Fund”) effective as of the date signed below.

**ELIGIBILITY**

The Participating Employer will contribute to the Trust Fund and provide coverage to the following (check one):

- All employees
- Specified classifications: \_\_\_\_\_

\_\_\_\_\_

The Participating Employer understands that there is a waiting period of first of the month following sixty (60) days of employment. The Participating Employer acknowledges it is responsible for its compliance with the employer mandate provisions of the Patient Protection and Affordable Care Act.

**COVERAGE WAIVER ELECTION**

By checking the box below, the Participating Employer elects not to contribute to the Trust Fund for employees who submit a signed Trust Fund Declination of Coverage Form under which the employee waives coverage and provides proof of alternative coverage:

- The Participating Employer will not contribute for employees who waive coverage and are covered under another group health plan.

If the Participating Employer checks the box above, in the event that the Trust Fund reviews the payroll records of the Participating Employer, all Declination of Coverage Forms must be presented to the Trust Fund auditor for review. It is the responsibility of the Participating Employer to maintain copies of these forms for no less than six (6) years after they are signed.

The Participating Employer may allow employees to decline coverage only if they provide proof they are covered under another group health benefit plan offered to their spouses or if they are covered under another group health benefit plan offered by the Participating Employer. No other reasons for declination of coverage by employees are recognized by the Trust Fund. It is the responsibility of the Participating Employer to obtain written proof of alternate insurance coverage by employees declining coverage. The Participating Employer must also provide the Trust Fund auditor with copies of the proof of alternate insurance during any payroll record review.

It is the responsibility of the Participating Employer to immediately notify the Trust Fund of any change in status of employees who have declined coverage. The Trust Fund has no obligation to communicate with the Participating Employer’s employees about their

alternate coverage or their declination of coverage. This is a responsibility of the Participating Employer.

The Participating Employer will fully defend, indemnify and save harmless the Trust Fund and its Trustees, employees and administrators against any and all loss, damage, liability, claim, demand or suit resulting from injury or harm to any person or property arising out of or in any way connected with a waiver of coverage by any employee of the Participating Employer under this the Adoption Agreement. This is intended to include, but is not limited to, employment-related claims, statutory violations, breach of contract claims, claims for health and welfare and/or medical benefits of any type, resulting from any medical condition, illness, personal injury or injury to property.

The Participating Employer also agrees that any dispute arising under this employee waiver provision of this Adoption Agreement, involving itself or any employee, will be submitted to arbitration. Any Participating Employer adversely affected by any action of the Trust Fund or its Trustees under this employee waiver provision will be entitled, within sixty (60) days after being apprised of the Trustees' decision leading to such adverse action, to request the Trustees in writing to conduct a hearing. The Trustees will conduct a hearing which will entitle the Participating Employer, and any participating employee, dependent or beneficiary to present his position against the adverse action. The Participating Employer, participating employee, beneficiary or dependent may be represented by an attorney or other individual designated. The Trustees will issue a written decision concerning their ruling following the hearing.

If the Participating Employer, the participating employee or a beneficiary or dependent remains dissatisfied with the written decision of the Trustees after the hearing, he shall be entitled to appeal the matter to arbitration in accordance with the appropriate rules of the American Arbitration Association. Any request for arbitration must be submitted in writing to the Trustees within sixty (60) days of the receipt of the written decision. The arbitrator will only consider (1) whether the Trustees were in error upon any issue of law; (2) whether they acted arbitrarily or capriciously in the exercise of their discretion; or (3) whether their findings of fact were supported by substantial evidence. The decision of the arbitrator shall be final and binding upon all parties. The expenses of arbitration shall be borne equally by the parties. The location of any arbitration will be in San Diego, California.

## CONTRIBUTIONS

The Participating Employer will comply with employer contribution and payment rules, and policies and procedures, adopted by the Trustees.

If the Participating Employer requires eligible employees to pay a portion of the premium required for employee coverage, the maximum portion that an employee can be required to pay is an amount equal to 50% of the lowest cost coverage option. The portion of the premium the Participating Employer will contribute (specified as either a percentage or a dollar amount) shall be disclosed to participants in writing during the annual open enrollment process. The Participating Employer is responsible for its compliance with the coverage affordability provisions of the Patient Protection and Affordable Care Act.

## GENERAL PROVISIONS

The Participating Employer may request a copy of the Trust Agreement of the Trust Fund, and agrees to be bound to the provisions contained therein, and any future amendments, which terms are incorporated into this Adoption Agreement by reference as though fully set forth.

In the event legal action is required to enforce any of the provisions of this Adoption Agreement, the venue of any such legal action will be in either a federal or state court of competent jurisdiction in San Diego County, California, which is the location where the benefit plan is to be administered and the obligations under this Adoption Agreement are to be performed. The Trustees have no duty to exhaust any arbitration or grievance procedure prior to initiating legal proceedings to collect delinquent contributions.

The Participating Employer may not terminate this Adoption Agreement until the end of the current insurance policy period following the effective date set forth above. At the end of any month thereafter, the Participating Employer may terminate this Adoption Agreement by giving written notice of termination to the Trust Fund thirty (30) days in advance of the specific termination date. The Trustees may terminate this Adoption Agreement at any time for the reasons set forth in Article VII, Section 2 of the Trust Agreement.

The Participating Employer will fully defend, indemnify and save harmless the Trust Fund and its Trustees, employees, consultants and administrators against any and all loss, damage, liability, claim, demand or suit resulting from injury or harm to any person or property arising out of or in any way connected with the participation of the Participating Employer under this Adoption Agreement. This is intended to include, but is not limited to, employment-related claims, statutory violations, breach of contract claims and claims for damages resulting from personal injury or injury to property.

Employee contributions and remittance forms are due by the 10th day of the month following the month the employee receives pay for hours that are worked. The payment of contributions will begin during the month of \_\_\_\_\_, 20\_\_\_\_, and will continue each month during the terms of this Adoption Agreement.

**BENEFIT OPTION ELECTION**

**(Effective December 1, 2017)**

| <u>Medical Benefits</u>                    | <u>Salary</u>            | <u>Hourly</u>            |
|--|--------------------------|--------------------------|
| UnitedHealthcare PPO 1000/2000 Deductible  | <input type="checkbox"/> | <input type="checkbox"/> |
| UnitedHealthcare PPO 2700/5400 Ded/HSA     | <input type="checkbox"/> | <input type="checkbox"/> |
| UnitedHealthcare PPO 3500/7000 Deductible  | <input type="checkbox"/> | <input type="checkbox"/> |
| UnitedHealthcare PPO 5500/11000 Deductible | <input type="checkbox"/> | <input type="checkbox"/> |
| <br><u>Dental Benefits</u>                 |                          |                          |
| PPO Dental                                 | <input type="checkbox"/> | <input type="checkbox"/> |

Vision Benefits  
Vision Plan

The parties signatory to this Adoption Agreement are as follows:

TRUST FUND

PARTICIPATING EMPLOYER

By: \_\_\_\_\_  
Authorized Representative

By: \_\_\_\_\_  
Authorized Representative

By: \_\_\_\_\_  
Title

By: \_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

#### PARTICIPATING EMPLOYER INFORMATION

TYPE OF EMPLOYER (Circle One: Corporation, Partnership, Sole Proprietorship,  
Joint Venture or LLC)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Employer Identification Number: \_\_\_\_\_

Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_

E-mail: \_\_\_\_\_

Payroll Manager: \_\_\_\_\_

Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_ E-mail: \_\_\_\_\_

Name of Corporate President or Business Owner: \_\_\_\_\_