

**SUMMARY PLAN DESCRIPTION/
PLAN RULES AND REGULATIONS**

OF THE

SOUTHERN CALIFORNIA PIPE TRADES

**HEALTH AND WELFARE FUND
PENSIONERS AND
SURVIVING SPOUSES PLAN**

With Benefits Effective January 1, 2000

And Amendments Effective January 1, 2001

Revised Printing: April 2001

TABLE OF CONTENTS

- INTRODUCTION**5
- SCHEDULE OF BENEFITS**7
- MONTHLY CO-PAYMENT**8
- ENROLLMENT AND ELIGIBILITY**8
 - ENROLLMENT/BENEFICIARY FORMS8
 - ELIGIBILITY9
 - When You Become Eligible9
- PENSIONERS**9
- SURVIVING SPOUSES OF PENSIONERS AND ACTIVE MEMBERS**9
- COBRA**10
- WIDOW SELF-PAY PROGRAM**10
 - SUSPENSION AND TERMINATION OF ELIGIBILITY11
 - When Your Coverage is Suspended11
 - When Your Coverage Terminates11
 - EXTENSION OF ELIGIBILITY12
 - Free Coverage for Total Disability12
 - DEPENDENT ELIGIBILITY12
 - Who Are Eligible Dependents?12
 - When Dependent Coverage Starts12
 - When Dependent Coverage Terminates12
 - Extension of Eligibility - Dependents12
 - COBRA CONTINUATION COVERAGE FOR SURVIVING AND DIVORCED SPOUSES13
 - The Consolidated Omnibus Budget Reconciliation Act (COBRA)13
 - Rights of Dependent Spouse13
 - Period of COBRA Continuation Coverage13
 - Termination of COBRA Coverage13
 - Duty to Notify the Fund14
 - HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)14
- FILING CLAIMS**15
 - PROCESSING CLAIMS FOR BENEFITS15
 - How to File a Medical Claim15
- APPEALS PROCEDURE**16
 - COORDINATION OF BENEFITS17
 - BENEFIT REDUCTION18
 - Coordination of Benefits with Medicare18
 - THIRD PARTY LIABILITY19
- HOW TO MANAGE THE COST OF YOUR MEDICAL CARE**20
 - CALENDAR YEAR DEDUCTIBLE20
 - ALLOWABLE CHARGES/AHF CONTRACT RATE20
 - LIFETIME MAXIMUM BENEFIT21
 - AFFILIATED HEALTH FUNDS21

INTRODUCTION

This booklet describes the benefits offered by the Southern California Pipe Trades Trust Fund, Health and Welfare Fund - Pensioners and Surviving Spouses Plan. Any printed material dated prior to January 1, 2000 applies to claims incurred prior to that date. This booklet applies to all claims for services incurred on and after January 1, 2000. Please refer to prior written material only for claims for services received prior to January 1, 2000.

The Plan does not pay benefits for work-related Illnesses and Injuries. In general, this Plan does not cover Active Employees, whose benefits are set forth in a separate booklet.

The Full Board of Trustees is authorized to interpret the Plan. The Board has discretion to decide all questions about the Plan, including questions about your eligibility for benefits, the amount and type of benefits payable to you and the definition of any plan term. No individual Trustee, Employer or union representative has authority to interpret this Plan on behalf of the Board or to act as an agent of the Board. The Board also has the authority to make any factual determinations concerning your claim.

The Board has authorized the Fund Office to respond in writing to your written questions. If you have an important question about your benefits, please write to the Fund Office for an answer.

As a courtesy to you, the Fund Office may also respond informally to oral questions. However, oral information and answers are not binding upon the Board of Trustees and cannot be relied on in any dispute concerning your benefits.

Plan rules and benefits may change from time to time. If this occurs, you will receive written notice explaining the change. Please be sure to read all Plan communications and keep them with this booklet.

IMPORTANT

IF YOU HAVE ANY QUESTIONS REGARDING YOUR ELIGIBILITY,
BENEFITS OR SPECIFIC SERVICES OR PROCEDURES
PLEASE CONTACT THE FUND OFFICE.

IF YOU HAVE A CHANGE IN FAMILY STATUS, SUCH AS MARRIAGE,
DIVORCE, DEATH OR IF YOU CHANGE YOUR ADDRESS, YOU MUST
NOTIFY THE FUND OFFICE WITHIN 30 DAYS.

SOUTHERN CALIFORNIA PIPE TRADES HEALTH & WELFARE FUND
501 SHATTO PLACE - 5TH FLOOR
LOS ANGELES, CALIFORNIA 90020
(213) 385-6161 OR
(800) 595 -7473 (IN CALIFORNIA ONLY)
WEB SITE: www.scptac.org

SCHEDULE OF BENEFITS

| | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CALENDAR YEAR DEDUCTIBLE | \$250 per person |
| LIFETIME MAXIMUM BENEFIT (Per eligible individual) (Benefits paid are reduced by benefits paid under the Active Health and Welfare Plan.) | \$250,000 prior to 1/1/2001 and if you have been covered under the Plan for fewer than 24 months; \$500,000, effective 1/1/2001 if you have been covered under the Plan for more than 24 months; Up to \$2,500 reinstated annually |
| HOSPITAL (In and Out Patient) AHF Contracting Non-AHF Contracting | 85% of AHF Contract Rate 80% of Allowable Charge |
| PHYSICIAN'S SERVICES AHF Contracting Non-AHF Contracting | 80% of AHF Contract Rate 80% of Allowable Charge |
| CHIROPRACTOR (Benefits are reduced by Chiropractic Benefits paid under the Active Plan for expenses incurred in the same Calendar Year) | Maximum of \$600 per Calendar Year |
| PRESCRIPTION DRUGS (Benefits are reduced by Prescription Benefits paid under the Active Plan for expenses incurred in the same Calendar Year) | \$600 per Calendar Year per person; separate \$50 deductible. DOES NOT APPLY TO THE CALENDAR YEAR DEDUCTIBLE |
| HEARING AID | \$400 per device per 36-month period. |
| MENTAL HEALTH OUTPATIENT AHF Contracting Non-AHF Contracting (Benefits are reduced by Mental Health Benefits paid under the Active Plan for expenses incurred in the same Calendar Year) | 100% of Contract Rate; Maximum 9 visits per Calendar Year. 36% of AHF Contract Rate; Maximum 25 visits per Calendar Year. |
| MENTAL HEALTH INPATIENT AHF Contracting Non-AHF Contracting (Benefits are reduced by Mental Health Benefits paid under the Active Plan for expenses incurred in the same Calendar Year or Lifetime) | 85% of Contract Rate not to exceed a total of 10 days per Calendar Year. 80% of Allowable Charge not to exceed a total of 10 days per Calendar Year. TOTAL OF 60 DAYS PER LIFETIME MAXIMUM. |

MONTHLY CO-PAYMENT

| | |
|---------------------------------------------------------------------|--------------------|
| Member not eligible for Medicare; Member Only or Member & Spouse | \$150.00 per month |
| Member eligible for Medicare; Member Only or Member & Spouse | \$50.00 per month |
| Surviving Spouse (Surviving Spouse only) | \$140.00 per month |

ENROLLMENT AND ELIGIBILITY

ENROLLMENT/BENEFICIARY FORMS

You must complete an Enrollment/Beneficiary Form in order to receive your Health and Welfare Identification Card. It is not necessary to complete a new Enrollment/Beneficiary Form if you have a current Form on file.

Payment of Health and Welfare claims will be delayed until the Fund Office receives the completed Enrollment/Beneficiary Form.

If you wish to change your beneficiary, indicate a change in your marital status, add or remove a Dependent, or change your address, please obtain another blank Enrollment/Beneficiary Form from your Local Union or the Fund Office, fill it out completely and send it to the Fund Office.

In order to add or remove a Dependent you must provide the Fund Office with the appropriate documentation, such as a certified marriage certificate. If applicable, you must submit original copies of divorce decrees and death certificates.

ELIGIBILITY

The eligibility rules described on the following pages apply to all the health benefits available through the Fund to Pensioners and Surviving Spouses of deceased members of the Southern California Pipe Trades.

When You Become Eligible

PENSIONERS

You may elect coverage under the Southern California Pipe Trades Health and Welfare Fund -- Pensioners and Surviving Spouses Plan if:

1. You are receiving a monthly pension from the Southern California Pipe Trades Retirement Fund based on twelve (12) or more years pension credit; and
2. You have been eligible for Health and Welfare benefits under the Active Plan as an Employee or Self-contributor for at least one month during the 24 months prior to the effective date of your pension; and
3. You have been eligible for Health and Welfare benefits under the Active Plan as an Employee or Self-contributor for at least five (5) of the ten (10) years preceding your retirement; and
4. You elect coverage at the time you retire; and
5. You pay the applicable monthly co-payment on a timely basis; and
6. You have submitted a fully completed Beneficiary Form.

Your eligibility begins the later of:

1. The first day of the month in which you receive a monthly pension benefit; or
2. The first day of the month in which you lose eligibility as an Employee or Self-Contributor.

SURVIVING SPOUSES OF PENSIONERS AND ACTIVE MEMBERS

In the event of your death while covered as a Pensioner, coverage for your surviving spouse will continue, at no cost, for 90 days following the month in which you died. This 90-day period is called the “Special Extension period.”

Surviving spouses of Active Members are eligible for the Special Extension period if, at the time of the Active Member’s death, the number of days in the Member’s eligibility bank is less than 90. The length of the Special Extension period is the number of days necessary, in combination with the days remaining in the Member’s eligibility bank, to give the surviving spouse coverage for 90 days following the month in which you died.

At the end of the Special Extension period, surviving spouses may choose to continue coverage either through COBRA or the Widow Self-Pay Program.

COBRA

Your spouse may continue coverage by making self-payments according to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), if eligibility is lost as a result of your death or divorce. See page 13 for a full description of COBRA rights.

WIDOW SELF-PAY PROGRAM

At any time during the first 180 days after your death (either during the Special Extension period or during the next 90 days), your surviving spouse may elect to be covered for an additional period of time under the **Widow Self-Pay Program**. Once this election is made, the surviving spouse has 90 days from the date of election to pay the retroactive premium for second 90-day period (i.e., the period beginning after the Special Extension period ends).

There are three types of surviving spouses who can qualify for the Widow Self-Pay Program and choose to continue coverage under the Southern California Pipe Trades Health and Welfare Fund -- Pensioners and Surviving Spouses Plan:

- 1. Surviving spouses of deceased Pensioners;**
- 2. Surviving spouses who are eligible to receive a pension benefit under the five-year guarantee feature of the Southern California Pipe Trades Retirement Fund** (Note that for this category of surviving spouses, coverage is provided at the Pensioners' self-pay rate for as long as the spouse is eligible to receive the pension benefit);
- 3. Surviving spouses of Active Members who are covered on the Active Member's date of death** (for additional information regarding this category of surviving spouses, see Summary Plan Description for the Health and Welfare Fund Active Members -- Section 1 in your Summary Plan Descriptions).

The Trust Fund will provide the eligible surviving spouse with the Application for the Widow Self-Pay Program.

Deadline. The Trust Fund Office must receive the completed application, together with the self-contribution, no later than 90 days following the Special Extension period in order for coverage to commence the first of the month following loss of eligibility.

Payment. The amount of the self-contribution shall be sufficient to cover the period for which coverage is desired. The Trustees establish the amount from time to time.

Timely Contributions. Subsequent self-contributions are due by the 15th of the month before which coverage is desired so that coverage will be maintained continuously in effect. A surviving spouse who fails to maintain continuous coverage through timely self-contributions shall not be permitted to reinstate coverage.

Coverage Limitation. Coverage may be continued indefinitely unless a surviving spouse remarries. In this case, coverage will terminate on the last day of the month in which the spouse remarried.

SUSPENSION AND TERMINATION OF

When Your Coverage is Suspended

Your benefits are suspended on the date you start performing work in the plumbing, heating and piping industry which is not pursuant to a recognized collective bargaining agreement.

If your benefits have been suspended for this reason, you may reestablish your eligibility under this Plan but only if you work enough hours in covered employment to have earned a quarter pension credit under the Pension Plan for the Southern California Pipe Trades Retirement Fund for each calendar quarter you worked at least one hour in non-covered employment. If you meet this rule, you must elect coverage at the time you are reinstated under the Pension Plan and you must timely recommence payment of the monthly self-payment.

When Your Coverage Terminates

Your coverage will terminate on the earliest of the following dates:

- 1) the first day of the month following 30 days from the date the Trust Fund Office received your written request to terminate coverage. If coverage is terminated for this reason, you will not be permitted to reenroll in the Plan, unless you are continuously enrolled in an HMO Medicare-at-Risk program (including other Medicare managed care plans);
- 2) the first day of the month in which your monthly pension benefit from the Southern California Pipe Trades Retirement Fund stops;
- 3) the date you start performing work in the plumbing, heating and piping industry which is not pursuant to a recognized collective bargaining agreement; or
- 4) the date the Plan Terminates.

Your spouse's coverage will terminate on the earliest of the following dates:

- 1) the date your eligibility terminates;
- 2) the first day of the month following 30 days from the date the Trust Fund Office received your written request to terminate your spouse's coverage. If coverage is terminated for this reason, your spouse will not be permitted to reenroll in the Plan, unless you are continuously enrolled in a Medicare-at-Risk program.
- 3) the date your spouse no longer qualifies as a dependent; or
- 4) the date the Plan terminates.

EXTENSION OF ELIGIBILITY

Free Coverage for Total Disability

If your eligibility terminates while you are Totally Disabled, Medical Expense Benefits will be available for that disabling condition only for three months after the loss of eligibility. **(This extension is for the disabled member only.)**

DEPENDENT ELIGIBILITY

Who Are Eligible Dependents?

Your Eligible Dependent is only your lawful spouse.

Other relatives, including children, stepchildren, grandchildren and guardianships, will not be covered even though you may be financially responsible for them.

If a person has dual coverage under the Plan both as a Pensioner and a Dependent, the total amount of benefits payable under the Plan will not exceed the scheduled amount for each benefit provided.

When Dependent Coverage Starts

Your Dependent's coverage starts on the later of the following dates:

- 1) the date you become eligible;
- 2) the date the person becomes your Dependent.

When Dependent Coverage Terminates

Your Dependent's coverage will terminate on the earliest of the following dates:

- 1) the date your eligibility terminates; or
- 2) the date the Dependent no longer qualifies as a Dependent; or
- 3) the date of death of the Dependent; or
- 4) the date the Plan terminates.

Extension of Eligibility - Dependents

If your Dependent's eligibility terminates while your Dependent is Totally Disabled, Medical Expense Benefits will be available for that disabling condition only for three months after the loss of eligibility. **(This disability extension is for the disabled Dependent only.)** See below for information on COBRA coverage.

COBRA CONTINUATION COVERAGE FOR SURVIVING AND DIVORCED SPOUSES

The Consolidated Omnibus Budget Reconciliation Act (COBRA)

Federal law requires that group health plans offer covered Eligible Dependents the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances (called "qualifying events") where coverage under the Plan would otherwise end. To receive this continuation coverage, **the Eligible Dependent must pay timely monthly premiums** directly to the Trust.

Rights of Dependent Spouse

If you are the spouse of a covered Pensioner, you may have the right to choose continuation coverage for yourself if you lose group health coverage under the Plan for **any** of the following reasons:

- 1) the death of the covered Pensioner;
- 2) divorce from the covered Pensioner;

Period of COBRA Continuation Coverage

In accordance with federal law, your spouse is entitled to pay for a temporary extension of health coverage under certain circumstances.

| QUALIFYING EVENT | QUALIFIED BENEFICIARY | YOUR MAXIMUM CONTINUATION PERIOD UNDER THE PLAN |
|---------------------------------|-----------------------|-------------------------------------------------|
| 1. Death of covered Pensioner | Spouse | 36 months after the date of qualifying event |
| 2. Divorce of covered Pensioner | Spouse | 36 months after date of qualifying event |

Termination of COBRA Coverage

COBRA continuation coverage will end before the 36-month continuation coverage period expires if:

- 1) your Eligible Dependent fails to pay the required contribution on time;
- 2) your Eligible Dependent becomes covered by another group health plan (except a plan that excludes or limits benefits for a pre-existing condition affecting your dependent, and such exclusion or limitation is enforceable under Health Insurance Portability and Accountability Act (HIPAA));
- 3) your Eligible Dependent becomes entitled to Medicare;

COBRA continuation coverage will no longer be available under this Plan if this Plan terminates.

Duty to Notify the Fund

Coverage for a spouse ends on the date of divorce. However, the spouse has the right to pay for COBRA continuation coverage. Without COBRA payments, no benefits will be paid on behalf of a former spouse. COBRA coverage can last for up to 36 months. In the event of your death, your Dependent must provide written notice with a copy of the Death Certificate within 60 days of the date of your death. In the event of a divorce, written notice of the divorce and a copy of the final decree must be given to the Fund Office within 60 days after the final decree is entered.

No benefits will be paid without COBRA payments. The Fund Office must be notified in writing when divorce occurs. Notice must be given within 60 days after the later of (1) the divorce or loss of Dependent status, or (2) the actual loss of coverage. If the required notice is not provided within the time allowed, COBRA self-payment will not be permitted.

No benefits are payable after the loss of Dependent status. You will be required to refund any benefit payments issued for expenses incurred after the termination of coverage.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

When your coverage ends you and/or your covered Dependents will automatically receive a certificate of creditable coverage. Certificates of creditable coverage indicate the period of time you and/or your Dependent(s) were covered under the Plan (including, if applicable, your COBRA coverage period), as well as certain additional information required by law.

This certificate may be necessary if you and/or your Dependent(s) become eligible for coverage under another group health plan, or if you buy for yourself and/or your covered Dependents an individual health insurance policy within 63 days after your coverage under this Plan ends. The certificate is necessary because it may reduce any exclusion period for pre-existing conditions that may apply to you and/or your covered Dependents under your new group health plan or health insurance policy.

This certificate will be provided to you shortly after this Plan knows, or has reason to know, that coverage (including COBRA coverage) for you and/or your covered Dependent(s) has ended. A duplicate certificate will be provided upon request, provided that the Fund Office receives the request within two years after the later of the date your coverage under this Plan ended or the date your COBRA coverage ended.

The certificate will be sent to you (or to any of your covered Dependents) by first class mail shortly after coverage under this Plan ends. If you (or any of your covered Dependents) elect COBRA coverage, another certificate will be sent by first class mail shortly after the COBRA coverage ends for any reason.

Please address all requests for certificates of creditable coverage to the Fund Office.

FILING CLAIMS

PROCESSING CLAIMS FOR BENEFITS

How to File a Medical Claim

All claims for benefits must be filed with the Fund Office in writing. A claim will be considered to have been filed as soon as it is received at the Fund Office, provided it is substantially complete, with all necessary documentation. If additional documentation is required, you will be notified as soon as reasonably possible.

When you or your eligible Dependent incur expenses for Hospital, medical, or surgical care follow these steps for prompt claims processing:

- 1) Obtain a claim form from the Fund Office or the local union office. (A fully completed claim form is required every six months for ongoing claims. A new form is required with each new Illness or accident.)
- 2) Ask the provider of service to attach a fully itemized billing, containing the following:
 - a. Pensioner's name and Social Security Number;
 - b. Patient's name, date of birth and Social Security Number;
 - c. Diagnosis;
 - d. Date or dates of Service;
 - e. Procedure codes (description of service);
 - f. Charge for each service; and
 - g. Assignment of benefits; Payment will automatically be made to AHF contracting providers of service whether or not an assignment of benefits is submitted.
- 3) The Plan may require additional information to process the claim such as:
 - a. Dependent employment status;
 - b. Other Group Medical Insurance or Plan;
 - c. Operative reports;
 - d. Laboratory results;
 - e. X-ray results;
 - f. Accident information.
- 4) Payment of benefits may be delayed if the Plan does not receive the necessary information.
- 5) Submit the itemized billing and fully completed claim for to the Fund Office at:

Southern California Pipe Trades Health and Welfare Fund
Claims Department
501 Shatto Place, 5th Floor, Los Angeles, CA 90020

Claims should be submitted to the Fund Office at the above address within 90 days after the date services were provided. Claims submitted more than 12 months after the date of service will be denied.

APPEALS PROCEDURES

This Plan includes a claims and appeal procedure that must be followed. Be sure to read it carefully before filing a claim or a lawsuit involving the Plan, the Board of Trustees or the Fund. The purpose of the claims procedure is to make it possible for claims and disputes to be resolved fairly and efficiently without costly litigation.

If your application for benefits under this Plan is denied in whole or in part, or your claim for benefits is otherwise denied, you will receive a written explanation including the specific reasons for denial from the Fund Office. If you are not satisfied with the decision of the Fund Office you have the right to have the Board of Trustees review and reconsider your claim. The Board of Trustees has full discretion to interpret all plan documents and to decide all factual questions concerning your claim.

To have your claim reviewed, you must file a written appeal with the Fund Office within 180 days after you receive the initial denial of your claim. Your appeal must state the specific reasons why you believe the denial of the claim was in error. You may submit supporting documents or records and have the right to representation throughout the review procedure. You or your representative may review the Plan documents and submit written comments to the Fund Office. Personal appearances on appeals are at the discretion of the Appeal Committee of the Board of Trustees.

If you need additional time to present evidence in support of your appeal, you may request such additional time by filing a written request with the Board of Trustees. Once the Board of Trustees has reviewed your appeal you will be advised of the decision in writing, and will be given specific reasons for the decision with specific references to pertinent provisions on which the decision is based. This written decision will be sent to you not later than 60 days after receipt of your written appeal, unless special circumstances require an extension of time for processing the appeal, or obtaining more information, or conducting an investigation of the facts. If additional time is required, written notice of the extension will be furnished to you before the extension period begins. If you do not receive a written decision within 120 days after the Trustees receive your written appeal you may treat the appeal as denied.

The decision of the Board of Trustees is final and binding upon all parties. No lawsuit may be filed without first exhausting the above appeals procedure. Nor may any evidence be used in court unless it was first submitted to the Trustees prior to the decision on your appeal. In any such lawsuit, the determinations made by the Board of Trustees are subject to judicial review only for abuse of discretion. No legal action may be commenced or maintained against the Trust, the Plan or the Trustees more than two years after a claim has been denied.

COORDINATION OF BENEFITS

This Plan has been designed to help you meet the cost of medical expenses. The Plan does not pay more than the actual medical expenses you must pay. Benefits under this Plan will be coordinated with the coverage you and your Dependent have under any other group benefit or service plan. For any expense allowable under the Plan, you will receive either:

- 1) the full regular benefits; or
- 2) a reduced amount, which, when added to the benefits available under the other Plan, equals 100% of the Allowable Charges or AHF Contract Rate incurred.

"Other plans" means any plan under which medical services are provided by:

- 1) group insurance or any other arrangement of coverage for individuals in a group whether or not insured; or
- 2) Blue Cross, Blue Shield, Kaiser or any other prepaid medical arrangement; or
- 3) Medicare.

BENEFIT REDUCTION

- 1) If the other Plan is a prepaid HMO plan and if the patient does not use the HMO plan's contracted providers for services and supplies that would normally be covered under the HMO plan, the benefits payable under this Plan are reduced to 20% of the Allowable Charges or AHF Contract Rate.
- 2) If your Dependent could have been covered as an Employee under another plan at no cost to him/her, but declined such coverage, the benefit payable shall be reduced to 20% of the Allowable Charges or AHF Contract Rate.

Which Plan Pays First - Coordination of Benefits

- 1) Husband and wife employed with coverage:
 - a. The plan covering the patient as an Employee is the primary payer.
 - b. The plan covering the patient as a Dependent is the secondary payer.
- 2) One spouse retired, one spouse actively employed:
 - a. The plan providing active coverage is primary payer.
 - b. The plan providing retiree coverage is secondary payer.

- 3) Employee retired using Eligibility Bank, spouse actively employed:
 - a. The plan providing coverage for active Employee is the primary payer.
 - b. The plan using the eligibility bank is secondary payer.
- 4) Dependent is covered by an HMO:
 - a. If the HMO is primary and HMO providers are not utilized, the Plan pays 20% of Allowable Charges or the 20% of the AHF Contract Rate.

Coordination of Benefits with Medicare

Social Security currently advises people to apply for Medicare 90 days before their 65th birthday. Medicare will then become effective the first of the month in which you reach age 65.

IMPORTANT

In order to get full benefits under this Plan, you must enroll for both **Part A and Part B** of Medicare before you or your Dependent becomes eligible for Medicare.

Medicare is the primary payer of your benefits from the date you retire, even if you are using the Active Eligibility Bank. Medicare is considered by this Plan to be the primary payer of benefits for Pensioners and their eligible spouses who are eligible for Medicare whether or not they are enrolled in the Medicare Program. This means that if you do not enroll in Medicare as soon you are eligible, this Plan will not pay for benefits that Medicare would have paid had you been enrolled in Medicare.

Which Plan Pays First - Medicare

- 1) Employee and Spouse both employed with coverage and eligible for Medicare:
 - a. Plan providing active coverage is the primary payer.
 - b. Plan providing Dependent coverage is the secondary payer.
 - c. Medicare is the third payer.
- 2) Employee Active, Spouse retired, both eligible for Medicare:
 - a. Plan providing active coverage is the primary payer.
 - b. Medicare is secondary for retired individual.
 - c. Plan providing retiree coverage is third.
- 3) Employee Retired using Active Eligibility Bank and eligible for Medicare:
 - a. Medicare is the primary payer.
 - b. Plan using eligibility bank is the secondary payer.

THIRD PARTY LIABILITY

This Plan does not cover any Illness, Injury, disease or other condition for which a third party 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.

If any service provided was required because of an Injury caused by the negligence of a third person, and if the covered participant or Eligible Dependent receive reimbursement from or on behalf of a negligent party, or if a person covered under the Plan is injured and receives insurance benefits, the Plan is entitled to recover the full amount of benefits paid under the Plan for such services, up to the extent of such recovery by the Employee or eligible Dependent. Upon settlement of the claim against the negligent party or insurance company, the participant will pay or cause to be paid to the Plan all amounts to which the Plan is entitled, in accordance with this paragraph.

The Plan has a right to first reimbursement of any recovery from a third party, even if you are not otherwise made whole and without regard to how your recovery is characterized. The Employee must complete forms required by the Plan in order for any claims to be paid before your recovery from a third party.

With respect to claims involving subrogation (legal action that the Fund takes in your name against the responsible person or entity to recover the benefits it paid to you), payment of benefits may be delayed pending receipt of all necessary paperwork from the Employee, Dependent or their legal representative, medical providers and the like. If the Plan pays benefits and you do not reimburse it after you receive payments from a third party, the Plan may withhold any benefits that may be payable in the future, or may take legal action against you, in order to recover the amount you were paid plus interest. The Trustees have the absolute discretion to settle subrogation claims on any basis they deem warranted and appropriate under the circumstances.

HOW TO MANAGE THE COST OF YOUR MEDICAL CARE

CALENDAR YEAR DEDUCTIBLE

You are responsible for the first \$250 in covered expenses. This is called your "Calendar Year Deductible." The Calendar Year Deductible applies separately to you and your Eligible Dependent Spouse.

Allowable Charges **incurred and applied** to the Calendar Year Deductible during the last quarter of the year (October, November and December) are carried over and applied to the next year Calendar Year Deductible.

The Calendar Year Deductible does not apply to Prescription Drug Benefit. There is a separate \$50 Calendar Year Deductible for prescription drugs.

Non-covered charges do not count towards the deductibles. Neither charges payable by the Plan nor the percentage of covered charges that you are required to pay may be used to satisfy the deductible.

Emergency Room Deductible

In addition to the Calendar Year Deductible you are responsible for the first \$50 of non-accident Allowable Charges incurred in the emergency room of a hospital. This deductible applies every time you or your Eligible Dependent receive care in the emergency room and incur non-accident related expenses. This is in addition to the Calendar Year Deductible.

ALLOWABLE CHARGES/AHF CONTRACT RATE

After your Calendar Year Deductible is satisfied, the Plan will pay for subsequent treatment based on either the "**AHF Contract Rate**" or "**Allowable Charges**," depending on the type of provider you select, provided that the services are certified by the treating Physician and determined by the Plan to be Medically Necessary for the care and treatment of your Injury or Illness.

If you use providers who are part of the AHF Contract Network, payment for the covered portion of your claim will be based on the "AHF Contract Rate." The AHF Contract Rate is the amount the providers have agreed to accept in payment for specific services. They cannot charge you above the AHF Contract Rate. If you use providers who do not belong to the AHF network, payment for the covered portion of your claim will be based on "Allowable Charges." "Allowable Charges" are determined under a schedule of payments established by the Trustees and revised at their discretion from time to time. You may receive a copy of the schedule of payments without cost by written request.

LIFETIME MAXIMUM BENEFIT

Prior to January 1, 2001 or if you have been covered under the Plan for fewer than 24 months, the Plan will pay no more than \$250,000 in benefits for each eligible individual. Interruptions in coverage do not affect your Lifetime Maximum. If you return to coverage, the Lifetime Maximum is applied as if no interruption of coverage occurred. However, if you qualify as both an Employee and as a Dependent of an Employee, you would have two separate Lifetime Maximums.

Effective January 1, 2001, the Lifetime Maximum Benefit for each eligible individual is \$500,000. The additional \$250,000 is applicable only to expenses incurred on or after January 1, 2001 if you have been covered under this Plan for more than 24 months. Periods in which you are covered through your Eligibility Bank, under COBRA, under the Plan's self-payment provisions or under the Southern California Pipe Trades Health and Welfare Fund -- Pensioners and Surviving Spouses Plan are included in determining whether you have been covered for more than 24 months. If you have been covered for fewer than 24 months, or with respect to expenses incurred before January 1, 2001, your Lifetime Maximum Benefit is \$250,000.

If you have fewer than 24 months of coverage and you lose your coverage and then regain coverage within the 24-month period immediately following your loss of coverage, you will be eligible for a Lifetime Maximum Benefit of \$500,000 once your total period of cumulative coverage under the Plan both before and after your break in coverage is more than 24 months.

In applying the Lifetime Maximum, benefits previously paid under the Active Plan are included.

On January 1 of each year, up to \$2,500 will automatically be reinstated if your remaining Lifetime Maximum is less than the maximum amount. If you qualify both as an Employee and as a Dependent of an Employee, separate Lifetime Maximums apply.

AFFILIATED HEALTH FUNDS

Affiliated Health Funds (AHF) is a non-profit organization created by four large building trades' health plans in Southern California (the Pipe Trades, Carpenters, Ironworkers, and Operating Engineers). AHF has contracted with more than 60 Hospitals and over 2,000 doctors in Southern California. These contracts allow you to obtain quality health care services with less out-of-pocket expense.

AHF is a voluntary program. You may continue to choose any doctor and Hospital you wish. However, there is a financial advantage to you and your Plan if you choose doctors and Hospitals from the AHF network.

Why is it to your advantage to use AHF Hospitals and Physicians?

Hospital:

Your out-of-pocket expense will be lower. You pay 15% of the AHF Contract Rate instead of paying 20% of Allowable Hospital Charges.

Other Charges:

The Plan pays a scheduled amount ("Allowable Charges") for most medical and surgical treatment. Any charges that exceed the "Allowable Charge" are out-of-pocket expenses to you. AHF Physicians have agreed to provide medical care to you and/or your family at reduced contract rates (AHF Contract Rate). In most cases, the Plan pays at least 80% of those reduced AHF Contract Rates.

Here is how the program works:

When you need to see a doctor, simply select one from the AHF directory.

IMPORTANT: To verify that the provider of service is still a member of the AHF program call the Fund Office at (213) 385-6161 or (800) 595-7473 (California only).

A list (directory) of AHF Providers will be mailed to you periodically without charge. In many cases, you will be pleased to find that your current Physician is a member of AHF.

When you visit the Physician you have chosen, be sure to let the Physician's receptionist know that you are covered by the Southern California Pipe Trades Health and Welfare Fund -- Pensioners and Surviving Spouses Plan and by AHF. **If you are referred to a specialist or to a Hospital, or if you need laboratory work, remind your doctor that you want to use AHF Physicians, laboratories and Hospitals. If you seek services at an Emergency Room, make sure the Emergency Room personnel are part of the AHF program. Sometimes an AHF Hospital will contract out the Emergency Room Services to a non-AHF group of providers. In that case, although Hospital charges will be paid at the AHF rate, the Emergency Room charges will be reimbursed based on a non-AHF rate.**

Please consider taking advantage of the AHF program. Both you and your Health and Welfare Fund will enjoy savings that will help keep the cost of medical care down. Obtaining services from an AHF contracting provider does not necessarily mean that the services will be covered. Services that are not covered by the Plan are excluded, regardless of where or by whom the services are provided.

No health care provider is an agent or representative of the Plan or of the Board of Trustees. The Plan does not provide medical services itself, nor control or direct the provision of health care services and/or supplies to Plan participants and beneficiaries by anyone else. The Plan makes no representation or guarantee of any kind that any provider will furnish health care services or supplies that are malpractice-free. This applies to any and all health care providers, including both preferred and non-preferred providers under the terms of the Plan, and all entities (and their agents, Employees and representatives) that contract with the Plan to offer preferred provider networks, or health-related services or supplies to participants and beneficiaries. Nothing in this Plan affects the ability of a provider to disclose alternative treatment options to a participant or beneficiary.

YOUR COVERAGE

MEDICAL BENEFITS

Inpatient Hospital

If you or your Dependent is confined in a Hospital as a registered bed patient, with the approval of a Physician, the Plan will pay:

AHF Hospital: The Plan will pay 85% of the AHF Contract Rate for all Room and Board and Medically Necessary services. The patient is responsible for the remaining 15% co-payment.

Non-AHF Hospital: The Plan will pay 80% of the Allowable Charges for room and board and other Medically Necessary services and supplies. The patient is responsible for the balance. The maximum allowable room and board charge per day is equal to the Hospital's semi-private room rate. Allowable Charges for intensive care, cardiac care unit are limited to 2fi times the Hospital's semi-private room rate.

Inpatient Mental and Nervous Disorders

The following benefits are covered if you or your Dependent is confined in a Hospital as a registered bed patient for a Mental and Nervous Disorder (with the approval of a Physician):

AHF Hospital: The Plan will pay 85% of the AHF Contract Rate for all Room and Board and Medically Necessary services. The patient is responsible for the remaining 15% co-payment. Coverage is provided up to a maximum of:

- 10 days per Calendar Year; and
- 60 days per lifetime.

Non-AHF Hospital: The Plan will pay 90% of the Allowable Charges for room and board and other necessary services and supplies. The patient pays the balance. The maximum allowable room and board charge per day is equal to the Hospital's semi-private room rate. Allowable Charges for intensive care unit is limited to 2fi times the Hospital's semi-private room rate to a maximum of:

- 10 days per Calendar Year; and
- 60 days per lifetime.

The Maximum Inpatient Mental and Nervous Benefits will be reduced by Mental and Nervous Benefits paid under the Active Health and Welfare Plan.

Extended Care Facility

The Plan will pay 80% of Allowable Charges for a maximum of 120 days per calendar year. Home visits by a Nurse reduce the 120 days.

Outpatient Hospital

The Plan covers expenses that you or your Dependent incur for Medically Necessary facility services and supplies received in the Outpatient Department of a Hospital in connection with:

- Surgery;
- Emergency medical treatment that normally cannot be performed in a Physician's office; or
- Treatment received within 24 hours of an accident for bodily injuries sustained in an accident.

AHF Hospital: The Plan will pay 85% of the AHF Contract Rate. The patient is responsible for the remaining 15% co-payment.

Non-AHF Hospital: The Plan will pay 80% of Allowable Charges. The patient is responsible for the remaining balance.

Physician Visits/Professional Services

IN THE HOSPITAL

If you or your Dependent incurs expenses for any of the services listed below, the Plan will pay 80% of the Allowable Charges or the AHF Contract Rate when authorized and performed in a Hospital by a licensed Physician, Podiatrist or Dentist:

- Physician Visits
- Surgery
- Anesthesia

IN THE PHYSICIAN'S OFFICE

AHF Contracting Physicians: The Plan will pay the percentage of the AHF Contract Rate listed below:

| | |
|-------------------|-----|
| Physician Visits | 80% |
| Surgery | 80% |
| Anesthesia | 80% |
| Laboratory Tests | 80% |
| X-rays | 80% |
| Injections | 80% |
| Radiation Therapy | 80% |
| Chemotherapy | 80% |

Non-AHF Contracting Physicians: If you or your Dependent incur expenses for any of the services listed above, the Plan will pay the applicable percentage (listed above) of the Allowable Charges when authorized or performed by a licensed Physician, chiropractor, podiatrist.

Allergy Treatment

If you or your Dependent incur expenses for antigens the Plan will provide up to \$75 per vial of antigens, payable at 80% not to exceed a maximum of \$750 per Calendar Year.

The maximum antigen benefit will be reduced by antigen benefits paid under the Active Health and Welfare Plan for services incurred in the same Calendar Year.

Chiropractic Care

If you or your Dependent incurs expenses for chiropractic care, the Plan will pay 80% of the charges up to a maximum of \$600 per Calendar Year.

The maximum Chiropractic Benefit will be reduced by Chiropractic Benefits paid under the Active Health and Welfare Plan for services incurred in the same Calendar Year.

Outpatient Treatment for Mental and Nervous Disorders

If you or your Dependent is referred by a Physician to a licensed psychologist, clinical social worker, master social worker or marriage counselor who is practicing within the scope of his/her license in the state in which he/she practices, and thereafter receive treatment, the Plan will pay:

AHF Contracting Providers: 100% of the AHF Contract Rate, up to a maximum of nine (9) visits per Calendar Year.

Non-AHF Contracting Providers: 36% of the AHF contract rate up to a maximum of 25 visits per Calendar Year.

The maximum Outpatient Mental and Nervous Benefit will be reduced by Outpatient Mental and Nervous Benefits paid under the Active Health and Welfare Plan for services incurred in the same Calendar Year.

Prescription Drug Benefits

If you or your Dependent incurs expenses for drugs or medicines related to an Illness or Injury, which are lawfully obtainable only upon prescription of a Physician and purchased at a licensed pharmacy, the Plan will pay 100% of the Allowable Charges incurred that exceed the separate Prescription Drug \$50 Calendar Year Deductible.

The maximum Calendar Year prescription benefit is \$600 per Eligible Individual. Drugs or medications include oral contraceptives and up to 30 pills annually for the treatment of erectile dysfunction.

A claim for reimbursement may be submitted each time within a Calendar Year the Allowable Charges for covered drugs or medication, per individual, total \$200 or more. If the charges do not exceed \$200, the claim for reimbursement should be made in the month of January following the end of the Calendar Year in which the charges were incurred.

The maximum Prescription Drug Benefit will be reduced by Prescription Drug Benefits purchased under the Active Health and Welfare Plan for services in the same Calendar Year.

Hearing Aid Benefit

If you or your Dependent incurs charges for the fitting and purchase of a hearing aid, the Plan will pay 80% of the charge up to a maximum of \$400 per device and not to exceed one device per ear in a 36-month period.

If the Plan paid a benefit for the existing device, replacement will not be covered until 36 months have elapsed from the date the expense was incurred for the existing device.

The Hearing Aid Benefit will be reduced by Hearing Aid Benefits paid under the Active Health and Welfare Plan.

Ambulance/Air Ambulance

Charges for professional ambulance or air ambulance services will be reimbursed 80% of the charge up to a maximum payment of \$150 per trip.

Pain Management

If you or your Dependent incurs expenses for pain management, the Plan will pay 80% of the charges up to a maximum of \$10,000 per Lifetime. This includes charges for the physician and facility.

Pain Management Benefits will be reduced by Pain Management benefits paid under the Active Health and Welfare Plan.

Outpatient Physical Therapy

If you or your Dependent incurs charges for outpatient physical therapy, by a licensed physical therapist, the Plan will pay 80% of the Allowable Charges up to a maximum of \$600 per Calendar Year.

Outpatient Physical Therapy Benefits will be reduced by Outpatient Physical Therapy benefits paid under the Active Health and Welfare Plan for services in the same Calendar Year.

Other Services and Supplies

If you or your Dependent is ill or injured, the Plan will pay 80% of the AHF Contract Rate for AHF Contracting providers or 80% of Allowable Charges for non-AHF Contracting providers for the items listed below when authorized by a licensed Physician or Podiatrist:

- 1)** services of a graduate Registered Nurse, not to exceed \$75 per day (Home Health Care Agency);
- 2)** blood and blood plasma, if not replaced;
- 3)** surgical dressings, splints, casts and other devices for the reduction of fractures and dislocations;
- 4)** oxygen and rental of equipment for its administration;
- 5)** rental of wheel chair, hospital bed, and other durable equipment, not to exceed the purchase price of the item;
- 6)** artificial Durable Medical Devices (other than dental, but not including orthopedic appliances and plaster molds in connection with the treatment of Temporomandibular Joint Dysfunction) or prosthetic devices that replace all or part of a body organ or that improve or maintain the function of an impaired body organ;
- 7)** trusses, braces or crutches; or
- 8)** diabetic supplies, including glucose monitors, test strips, and other self-testing supplies, if prescribed by a Physician;
- 9)** other Durable Medical Equipment.

Transplants

The Plan provides coverage only for the following transplants; all other transplants or stem cell transfers **are not** covered by the Plan:

- Kidney transplants;
- Liver transplants for congenital biliary atresia only;
- Transplants of organ parts limited to corneas, skin, bones, and tendons. Bone marrow transplants (including Stem Cell Transfers/Transplants) are covered only if the diagnosis is severe aplastic anemia, provided such anemia is not intentionally induced for treatment of another disease or acute leukemias.

Artificial parts transplants are limited to: Joint replacement for functional reasons; skin; heart valves, vascular grafts and patches; pacemakers; metal plates, and eye lens after cataract surgery.

The maximum payable in connection with any one-organ transplant is \$100,000, including any pre-care or follow-up care. The maximum payable in connection with any one-organ transplant (\$100,000) is included in your Lifetime Maximum Benefit.

Donor expenses. In reference to an organ transplant surgery, Plan benefits shall be provided to an organ donor for Allowable Charges or AHF Contract Rate incurred by the donor (whether or not the donor is eligible under the Plan), which are directly related to the transplant surgery only if the organ recipient is eligible under this Plan and provided that such expenses are not payable from any other source including, but not limited to, medical plans, medical research organizations and charitable organizations. The Allowable Charges or AHF Contract Rate for an organ donor is included in the maximum payable in connection with any one-organ transplant of \$100,000 and is included in your Lifetime Maximum Benefit.

Transplant Benefits may be reduced by Transplant Benefits paid under the Active Health and Welfare Plan for services related to any one-organ transplant.

Women's Health and Cancer Rights

The Plan provides benefits for medically necessary mastectomies.

The Plan also provides benefits for the following procedures:

- 1)** reconstruction of the breast on which the mastectomy was performed;
- 2)** surgery and reconstruction of the other breast to produce symmetrical appearance;
- 3)** prostheses; and
- 4)** treatment of physical complications of all stages of the mastectomy, including lymphedemas.

Benefits are determined based on the nature of the treatment and whether or not you choose an AHF contracting provider, in accordance with normal Plan limits.

Medical Expense Exclusions and Limitations

In addition to the exclusions and limitations listed under the specific benefits, the Plan will not provide benefits for:

- 1)** Services that are not reasonably necessary for the care or treatment of bodily injuries or Illness;
- 2)** Services, treatments, or supplies for the care and treatment of bodily injuries or Illness that are in excess of the charges that would have been made in the absence of the benefits provided by the plan;
- 3)** Any claim for medical treatment or services and/or supplies that is not filed within 12 months from the date the expense is incurred;
- 4)** Routine physical examinations and testing;
- 5)** Preventive Care, such as flu shots, vitamins (prescription and over-the-counter) immunizations/vaccinations, exposure to disease;
- 6)** Prescription drugs dispensed in the Physician's office;
- 7)** Weight Control, such as diet management, surgical procedures, medications, exercise programs, or nutritional training;
- 8)** Services, prescriptions, medications and supplies received outside of the United States and its territories, unless the services, medications or supplies were the result of an accident or life-threatening emergency or the eligible participant submits proof of residency in the country where the services were rendered;
- 9)** Services by a provider related to you or your Dependent by blood or marriage;
- 10)** Dental examinations or treatment;
- 11)** Dental work or treatment, except for conditions resulting from an accident, to a sound natural tooth or teeth and occurring within 90 days of the accident; or
- 12)** Outpatient Speech Therapy;
- 13)** Outpatient Cardiac Rehabilitation Therapy;
- 14)** Outpatient Respiratory/Pulmonary Rehabilitation Therapy;
- 15)** Home Intravenous Therapy (IV Therapy);
- 16)** Temporomandibular Joint Dysfunction (TMJ);
- 17)** Acupuncture except as provided by an M.D.;
- 18)** Over-the-counter medical supplies, such as gauze, bandages, shoe inserts, and herbal medicines;

- 19) Exercise equipment, tanning booths, whirlpools, swimming pools, saunas, spas, massage therapy or gym membership;
- 20) Blood pressure monitors;
- 21) Transplants and Stem Cell transfers (except as noted under Transplant Benefit);
- 22) Expenses for travel or transportation, except as provided under Ambulance Benefits;
- 23) Family planning (except Prescription Drug benefit for coverage of birth control pills);
- 24) Care or treatment for pregnancy or related conditions for anyone;
- 25) Treatment of infertility, including artificial insemination and in-vitro fertilization, or any charges associated with direct inducement of pregnancy or reversal or attempted reversal of an elective sterilization procedure;
- 26) Any goal-oriented behavior modification therapy, such as smoking cessation or weight loss;
- 27) Replacement of Durable Medical Equipment within 36 months, including prosthetics;
- 28) Occupational Therapy (except for the treatment of a hand Injury or disability);
- 29) Eye examinations, Vision care;
- 30) Eye glasses or contact lenses;
- 31) Radial keratotomy and any other type of Refractive Eye Surgery, i.e. Laser or Lasik surgery;
- 32) Care or treatment for the use of drugs or alcohol or drug addiction, and/or alcoholism or resultant mental conditions;
- 33) Charges for personal comfort, beautification, or convenience items or services;
- 34) Cosmetic surgery, except for conditions resulting from accidental Injury, functional disorder or congenital malformation. In addition, you or your Dependent should obtain pre-authorization from the Fund Office prior to the Surgery to determine if benefits will be paid;
- 35) Hospice or Hospice Programs;
- 36) Hospital or Extended Care Facility charges for personal items such as charges for radio, television, telephone and other similar items;
- 37) Housekeeping services;
- 38) Custodial Care;
- 39) Services associated with sex transformations and resulting complications;

- 40)** Any charges paid for or payable by another group benefit or service plan, or insurance;
- 41)** Charges you would not be required to pay for in the absence of this coverage;
- 42)** Charges for phone consultations;
- 43)** Charges for the completion of claim forms or billing and medical reports;
- 44)** Charges for missed or broken appointments;
- 45)** Interest on unpaid balances;
- 46)** Care by Homeopathic Practitioners, Naturopathic Practitioners (NP), Acupuncturist, and Medical Doctors Licensed in the Orient (OMD);
- 47)** Any Illness, Injury or disability covered by any Workers' Compensation laws;
- 48)** Care or treatment furnished at the expense of a federal, state or political subdivision government agency for which you are not required to pay except to the extent benefits are required by law to be paid by the Plan;
- 49)** Care or treatment obtained in a Hospital owned or operated by a government agency for which you are not required to pay except to the extent benefits are required by law to be paid by the Plan;
- 50)** Conditions caused by an act of war, armed invasion or aggression;
- 51)** Care or treatment as a mentally abnormal or mentally disordered sex offender or deviate in any Hospital or facility of any state or political subdivision;
- 52)** Care or treatment in any penal institution;
- 53)** Any bodily Injury or Illness for which a Physician does not provide treatment, except as specifically provided;
- 54)** Any services or procedures that are experimental or investigational in nature or are not within the standards of generally accepted medical practice.

No health care provider is an agent or representative of the Plan or of the Board of Trustees. The Plan does not provide health care services or supplies. The Plan does not control or direct the provision of health care services and/or supplies to Plan participants and beneficiaries by anyone. The Plan makes no representation or guarantee of any kind that any provider will furnish health care services or supplies that are malpractice-free. This applies to any and all health care providers, including both preferred and non-preferred providers under the terms of the Plan, and to all entities (and their agents, Employees and representatives) that contract with the Plan to offer preferred provider networks, or health-related services or supplies to participants and beneficiaries. Nothing in this Plan affects the ability of a provider to disclose alternative treatment options to a participant or beneficiary.

DEFINITION OF TERMS

The following terms define specific wording used in this Plan. These definitions should not be interpreted to extend coverage unless specifically provided for. The Trustees have final discretion to interpret and apply these and any other terms used in the Plan.

Accident

An unforeseen and unavoidable event resulting in an Injury.

Affiliated Health Funds (AHF)

Affiliated Health Funds (AHF) is a non-profit organization created to allow you to obtain quality health care services on a voluntary basis with less out-of-pocket expense. (See Affiliated Health Funds, AHF, under Medical Benefits on page 23.)

AHF Contract Rate

The rate set by contract between the Trust Fund and Affiliated Health Funds.

Allowable Charges

The scheduled amounts for medical and dental services and supplies established by the Board of Trustees. Any amount that exceeds the Allowable Charge is not payable or recognized by the Plan for any purpose. To the extent that the cost of the service exceeds Allowable Charges, the patient is responsible for the balance. (See Allowable Charges under Medical Benefits on page 23.)

Benefit(s) - Lifetime Maximum

Refer to page 21.

Calendar Year

Calendar Year means January 1 through December 31 of each year.

Chiropractor

A person acting within the scope of his/her license, holding the degree of Doctor of Chiropractic (D.C.), and who is legally entitled to practice chiropractic care in all its branches under applicable laws where the services are rendered and who is not a family member.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 that provides for continuation coverage and is explained on page 13.

Collective Bargaining Agreement

The negotiated labor agreement between a Contributing Employer and United Association, District Council 16, requiring contributions to the Southern California Pipe Trades Health

and Welfare Fund, including but not limited to the Master Labor Agreement for the Plumbing and Piping Industry of Southern California between Southern California Contractors and Southern California Pipe Trades District Council No. 16 of the United Association.

Contributing Employer

The Employers signed to a Collective Bargaining Agreement or Participation Agreement that requires contributions to the Southern California Pipe Trades Health and Welfare Fund.

Co-payment

The portion of covered health care costs (i.e. the **AHF Contract Rate** or **Allowable Charges**) for which the covered person has financial responsibility. Typically, the deductible must be met before the co-payment is applied.

Covered Expenses (See Allowable Charges.)

The items of medical and dental expense for which Comprehensive Medical Expense, Outpatient Treatment for Mental and Nervous Disorders, Hearing Aid Benefits may be payable.

Custodial Care

Care that is primarily for the purpose of meeting personal needs which could be provided by persons without professional skills or training. This includes, but is not limited to help in walking, bathing, dressing, eating, taking medicine and getting in and out of bed.

Deductible

A deductible is the amount you must pay before the plan will consider expenses for reimbursement. It can be an annual amount or, in the case of hearing aids, a per device amount. **Not all out of pocket expenses count toward the deductible.** The individual deductible applies separately to each covered person. The family deductible applies collectively to all covered persons in the same family. Separate deductibles apply to the Prescription Drug Benefit and the Emergency Room Care.

Dentist

A person acting within the scope of his/her license, holding the degree of Doctor of Dental Surgery (D.D.S.), or Doctor of Dental Medicine (D.M.D.), and who is legally entitled to practice dentistry in all its branches under the laws of the state or jurisdiction where the services are rendered and who is not a family member.

Dependent

Please refer to page 12.

Durable Medical Equipment

Equipment that meets the following criteria:

- 1) can withstand repeated use;
- 2) is primarily and customarily used for a medical purpose and is not generally useful in

- the absence of Injury or Illness;
- 3) is not primarily used for exercise;
- 4) is not disposable or nondurable; and
- 5) is used by the patient only.

Emergency

A serious and unexpected onset of acute Illness or accidental Injury, for which the patient secures immediate care within 24 hours of the onset of symptoms and which, in the absence of immediate emergency medical treatment, could be expected to result in:

- 1) severe jeopardy to the patient's health;
- 2) serious impairment to bodily functions; or
- 3) serious dysfunction of any bodily organ or part.

Emergency Hospitalization or Confinement

A Hospital admission that takes place within 24 hours of the sudden and unexpected severe symptom of an Illness or within 24 hours of an accidental Injury causing a life-threatening situation.

ERISA

Employee Retirement Income Security Act of 1974, as amended. See page 46 for an explanation of your ERISA rights.

Experimental Treatment

Experimental treatment means:

- 1) any medical procedure, equipment, treatment or course of treatment, or drug or medicine that is under investigation or is limited to research;
- 2) techniques that are restricted to use at those centers that are capable of carrying out disciplined clinical efforts and scientific studies;
- 3) procedures that are not proven in an objective way to have therapeutic value or benefit; and
- 4) any procedure or treatment whose effectiveness is medically questionable.

This Plan does not cover Experimental or Investigational Treatments.

Extended Care Facility

An institution, or a distinct part thereof, that is licensed pursuant to applicable laws and is operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from Injury or Illness and:

- 1) is approved by and is a participating extended care facility of Medicare;
- 2) has organized facilities for medical treatment and provides 24-hour nursing services under the full-time supervision of a Physician or registered nurse;
- 3) maintains daily clinical records on each patient and has available the services of a

Physician under the established agreements;

- 4) provides appropriate methods for dispensing and administering drugs and medicines;
- 5) has transfer arrangements with one or more Hospitals, a utilization review plan in effect and operations policies developed with the advice of, and reviewed by, a professional group including at least one Physician; and
- 6) is not an institution that is primarily a place for rest, a place for custodial care, a place for the aged, a place for drug addicts, a place for alcoholics, a hotel, or similar institution.

Fund

The Southern California Pipe Trades Trust Fund created by the Trust Agreement establishing that Fund.

HIPAA

The Health Insurance Portability and Accountability Act of 1996.

Home Health Care Agency

A licensed home health care agency that meets all of the following requirements:

- 1) it must primarily provide skilled nursing services and other therapeutic services under the supervision of Physicians or registered nurses;
- 2) it must be run according to rules established by a group of medical professionals, including Physicians and nurses;
- 3) it must maintain clinical records on all patients;
- 4) it must be licensed by the jurisdiction where it is located, if licensure is required, and run according to applicable law; and
- 5) it must not be an institution which is primarily a place for rest, a place for custodial care, a place for the aged, a place for drug addicts, a place for alcoholics, a hotel, or similar institution.

Hospice

A facility that provides a Hospice Care Program and operates in accordance with applicable law is a Hospice. It operates as a unit or program that only admits terminally ill patients. It is separate from any other facility but may be affiliated with a Hospital, nursing home or home health care agency.

Hospice Care Program

A coordinated program of inpatient and home care that treats the terminally ill patient and the family as a unit is a Hospice Care Program. The Plan provides care to meet the special needs of the patient and the family during the final stages of terminal illness and during bereavement.

Hospital

A public or private facility, licensed and operating according to applicable law, that provides care and treatment by Physicians and nurses on a 24-hour basis for an Illness or Injury through the medical, surgical and diagnostic facilities on its premises.

A Hospital also includes mental and nervous disorders treatment facilities that is licensed and operated according to applicable law.

A Hospital is not an institution that is primarily a place for rest, a place for custodial care, a place for the aged, a place for drug addicts, a place for alcoholics, a hotel, or similar institution or a facility or any part thereof which is a residential treatment facility.

Illness

Any bodily sickness or disease as diagnosed by a Physician.

Injury

Trauma or damage to a body part by an external force or accident. Injury does not include Illness or infection.

Medically Necessary/Medical Necessity

Appropriate for the condition being treated, in accordance with standards of good medical practice, and not for the convenience of the patient or provider of services. To be considered medically necessary, the service or supply must be one that cannot be omitted without adversely affecting the patient's condition. The mere fact that a doctor orders the treatment does not mean that it is medically necessary.

Medical necessity also applies to the type of facility in which the patient receives care. For example, a Hospitalization will not be considered medically necessary if the care could be provided at home or in a less expensive facility such as a skilled nursing facility or outpatient clinic.

The Plan does not cover treatments that are not Medically Necessary.

Medicare

Medicare means Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act as amended.

Mental and Nervous Disorder

Conditions, Illnesses, diseases and disorders listed in the most recent edition of International Classification of Diseases (ICD) as psychoses, neurotic disorders, and personality disorders; also other non-psychotic disorders listed in the ICD, to be determined by the Plan. A mental/nervous disorder includes any mental/nervous disorder manifested by physical symptoms, any physical disorder manifested mental/nervous symptoms, and any condition involving a combination of physical and mental/nervous causes and/or physical and mental/nervous symptoms.

Nondurable

Goods/supplies that cannot withstand repeated use and/or are considered disposable and limited to a one-person or one-time use, including but not limited to, incontinence pads, diapers, soap, etc.

Nurse

A person acting within the scope of his/her license and holding a degree/licensure of a Registered Nurse (R.N.), Nurse Practitioner (N.P.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.), Certified Nurse Midwife (CNM) and who is not a family member.

Occupational Illness or Injury

An Illness or Injury related to work under the applicable Workers' Compensation law, occupational disease law, or similar legislation, whether or not the individual is covered by Workers' Compensation insurance.

Outpatient

Treatment or services received either outside of a Hospital setting or at a Hospital when room and board charges are not incurred.

Pharmacy

A licensed establishment where covered prescription drugs are filled and dispensed by a pharmacist licensed under applicable law.

Physician

A person acting within the scope of his/her license and holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), who is legally entitled to practice medicine in all its branches under applicable laws, and who is not a family member.

A Homeopathic Practitioner, Naturopath (N.P.) and Oriental Medical Doctor (O.M.D.) are not included.

Plan

The benefits and provisions described in this document.

Podiatrist

A podiatrist or chiropodist licensed to practice podiatry or chiropody within the meaning of the license granted by the state in which the podiatrist or chiropodist is practicing and who is not a family member.

Psychiatrist

A psychologist licensed to practice psychology and prescribe medications within the meaning of the license granted by the state in which the psychiatrist is practicing and who is not a family member.

Psychologist

A psychologist licensed under Section 2948 of the Business and Profession Code of the State of California or any similar Business and Profession Code of any other state and who is not a family member.

Signatory Contractors

Employees of a contractor signatory to the Collective Bargaining Agreement who satisfy all of the conditions of Section II of the Master Agreement for the Plumbing and Piping Industry of Southern California between Southern California Contractors and Southern California Pipe Trades District Council No. 16 of the United Association. The Contractor Employer of such Employees must contribute 110 hours per month for covered or collectively bargained Employees.

Surgery

Any operative or diagnostic procedure performed in the treatment of an Injury or Illness by instrument or cutting procedure through any natural body opening or incision.

Surviving Spouse

Any individual who satisfies the eligibility requirements under the Rules and Regulations Providing Health and Welfare Benefits for Pensioners and Surviving Spouses of the Southern California Pipe Trades Trust Fund.

Terminally Ill

The condition of a patient who does not have a reasonable prospect for a cure and who has a life expectancy of six months or less.

Totally Disabled

Wholly prevented by bodily Injury or Illness from engaging in any occupation or employment and, in the case of a dependent, total inability to perform the daily living activities of a person of comparable age.

Travel

Transportation of the patient by ambulance to obtain medical care when care is not available in the area where the patient lives.

Trustees

The Plan Trustees are Employer and Employee representatives that manage the funds of the trust and administer the provisions of the Plan.

Whenever a personal pronoun in the masculine gender is used, it includes the feminine, unless the context clearly indicates otherwise.

IMPORTANT INFORMATION ABOUT THE PLAN

1. Name of Plan

This Plan is known as the Southern California Pipe Trades Health and Welfare Fund-- Pensioner and Surviving Spouses Plan.

2. Plan Sponsor and Administrator

The Board of Trustees is both the legal Plan Sponsor and the legal Plan Administrator under the Employee Retirement Income Security Act.

3. Board of Trustees

The Board of Trustees consists of Employer and union representatives, selected by the Employers and unions in accordance with the Trust Agreement that relates to this Plan. If you wish to contact the Board of Trustees you may do so at:

Southern California Pipe Trades Health and Welfare Fund
501 Shatto Place, 5th Floor
Los Angeles, California 90020
(213) 385-6161
(800) 595-7473 (in California Only)
Website: www.scptac.org

The Board of Trustees has designated a Trust Fund Administrator to perform the routine functions of the Plan. The Trust Fund Administrator is:

Mr. Milton D. Johnson
Southern California Pipe Trades Administrative Corporation
501 Shatto Place, 5th Floor
Los Angeles, California 90020
(213) 385-6161
(800) 595-7473 (in California Only)
Website: www.scptac.org

4. Names, Titles and Addresses of any Trustee or Trustees

As of April 1, 2001, the Trustees of this Plan are:

UNION TRUSTEES

| | |
|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| Mr. Mike Ayre U.A. Local No. 761 1305 North Niagara Street Burbank, CA 91505 | Mr. John C. Hall U.A. Local No. 78 1111 West 9th Street Los Angeles, CA 90015 |
| Mr. Eddie Barnes U.A. Local No. 250 18355 South Figueroa Street Gardena, CA 90248 | Mr. John Hammond U.A. Local No. 409 3710 Broad Street San Luis Obispo, CA 93401 |
| Mr. Reuben Bautista U.A. Local No. 345 142 West Pomona Avenue Monrovia, CA 91016 | Mr. H. J. Kirkconnell U.A. Local No. 494 1246 Locust Avenue Long Beach, CA 90813 |
| Mr. Nico Ferraro U.A. Local No. 230 6313 Nancy Ridge Drive San Diego, CA 92121 | Mr. Ed Kraemer U. A. Local No. 484 1955 North Ventura Avenue Ventura, CA 93001 |
| Mr. Dan Foreman U.A. Local No. 114 93 Thomas Road Buellton, CA 93427 | Mr. Dean McGougan U. A. Local No. 398 170 West San Jose Avenue, Suite 303 Claremont, CA 91711 |
| Mr. Gene Genovese U. A. Local 582 3904 West First Street Santa Ana, CA 92703 | Mr. Sid C. Stolper District Council No. 16 501 Shatto Place, Suite 400 Los Angeles, CA 90020 |

EMPLOYER TRUSTEES

| | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p style="text-align: center;">Mr. Timothy Brink C. H. Stone Plumbing Co., Inc. 973 South Western Avenue Los Angeles, CA 90006-1092</p> | <p style="text-align: center;">Mr. Robert Hollowed Scott Co. of California 14920 South San Pedro Gardena, CA 90248</p> |
| <p style="text-align: center;">Mr. John Carlson Carlson's Landscaping 9050 Blackbird Avenue Fountain Valley, CA 92708</p> | <p style="text-align: center;">Mr. Charles (Chip) Martin California Plumbing & echanical Contractors Assoc. (CPMCA) 370 Amapola Avenue, Suite 205 Torrance, CA 90501</p> |
| <p style="text-align: center;">Mr. Dennis Castaldo Don Brandel Plumbing, Inc. 15100 Texaco Avenue Paramount, CA 90723-3916</p> | <p style="text-align: center;">Mr. Richard Sawhill Air-Conditioning & Refrigeration Contractors Assn/MCA. 501 Shatto Place, Suite 306 Los Angeles, CA 90020</p> |
| <p style="text-align: center;">Mr. Don Chase Muir-Chase Plumbing Co., Inc. 1940 Gardena Avenue Glendale, CA 91204-1940</p> | <p style="text-align: center;">Mr. Tom Shelby Kiewit Pacific Co. 10704 Shoemaker Avenue Santa Fe Springs, CA 90670</p> |
| <p style="text-align: center;">Mr. Don Giarratano D/K Mechanical Contractors, Inc. 3870 East Eagle Drive Anaheim, CA 92807</p> | <p style="text-align: center;">Mr. Steve Shirley University Mechanical & Engineering Contractors 1168 Fesler Street El Cajon, CA 92020-1812</p> |
| <p style="text-align: center;">Mr. Cliff Heck Kiewit Pacific Co. 24103 South Figueroa Street Carson, CA 90745</p> | <p style="text-align: center;">Mr. Rick Stafford Murray Company 2919 East Victoria Street Rancho Dominguez, CA 90221</p> |

5. Identification Numbers

The number assigned to the Plan by the Internal Revenue Service is 95-1867598. The Plan number is 501.

6. Agent for Service of Legal Process

The name and address of the agent designated for the service of legal process is:

Mr. Milton D. Johnson
Southern California Pipe Trades Administrative Corporation
501 Shatto Place, 5th Floor
Los Angeles, California 90020

7. Source of Contributions

The benefits described in this section are provided through Employer contributions to this Plan. The amount of Employer contributions to this Plan is determined by the provisions of the Collective Bargaining Agreement or by a Participation Agreement. The Collective Bargaining Agreements require contributions to this Plan at fixed rates per hour worked. Self-payments are also required as described in the Eligibility Rules.

The Fund Office will provide you, upon written request, a complete list of Employers and Unions and their addresses that are parties to the Collective Bargaining Agreement. All contributions and income from earnings are used exclusively for providing benefits to eligible Employees and their Dependents, and for paying expenses incurred with respect to the operation of the Plan.

8. Type of Plan

This Plan is a multi-employer health and welfare benefit plan maintained for the purpose of providing medical, hearing aid, prescription drug benefits in the event of Illness or Injury.

No payments provided under this Plan are insured by a contract of insurance and there is no liability on the Board of Trustees or any other individual or entity to provide payments above and beyond the amounts in the Fund collected and available for such purpose.

9. Collective Bargaining Agreement

Contributions to this Plan are made in accordance with Collective Bargaining Agreements between Employers and Southern California Pipe Trades District Council No. 16 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry. The United Association local unions affiliated with District Council 16 are Nos. 78, 114, 230, 250, 345, 398, 409, 484, 494, 582 and 761.

The Fund Office will provide you, upon written request, a copy of the applicable Collective Bargaining Agreement. The Collective Bargaining Agreement is also available for examination at the office of the plan administrator.

10. Plan Termination

It is intended that the Health and Welfare Fund will continue indefinitely, but the Board of Trustees reserves the right to change and/or discontinue the Plan or the Fund at any time. Assets may also be transferred to a successor fund providing health care benefits. In no

event will termination of the Plan or the Fund result in a reversion of any assets to the Contributing Employers or the Union. The Trustees may terminate the Plan or Fund by a document in writing adopted by a majority of the Union Trustees and a majority of the Employer Trustees if in their opinion or the Fund is not adequate to carry out its intended purpose or is not adequate to meet the payments due or which may come due. The Plan or Fund may also be terminated if there are no individuals living who qualify as Employees or Dependents or if there is no longer any Collective Bargaining Agreement requiring contributions to the Fund. If the Fund is terminated, the Trustees will pay the expenses of the Fund, arrange for a final audit, give any notice and prepare and reports required by law, and apply the Trust Fund in accordance with the Plan, including amendment adopted as part of the termination.

11. Trust Fund

The Fund's assets and reserves are held in trust by the Board of Trustees of the Southern California Pipe Trades Health and Welfare Fund.

12. Identity of Source of Benefits

All of the types of benefits provided by the Plan for Pensioners and Surviving Spouses are set forth in this booklet. There is a separate booklet covering benefits for Active Members. The source of benefits is the Southern California Pipe Trades Health and Welfare Fund.

13. Action of Trustees

The Trustees have full discretion and authority over the standard of proof required for any inquiry, claim, or appeal and over the application and interpretation of the Plan. No legal proceeding shall be filed in any court or before an administrative agency against the Plan or the Trustees, unless all review procedures with the Trustees have been exhausted.

No legal action may be commenced or maintained against the Trust, the Plan, or the Trustees more than two years after a claim has been denied.

14. No Assignment of Benefits

You may not assign your benefits under the Plan, except that you may direct that benefits payable to you be paid to an institution or providers of medical care. However, the Fund is not legally obligated to accept such a direction from you, and no payment by the Fund to a provider can be considered to be a recognition by the Fund that it has a legal duty to pay the provider, except to the extent that it chooses to do so.

15. Erroneous Payments

Every effort will be made to ensure accuracy in the payment of your benefits. If an error is discovered, however, and it is determined that the Fund has paid any benefits that you are not entitled to, the Trustees have the right to seek repayment from you, including the right to reduce future benefit payments by the amount of the erroneous payment.

16. Misrepresentation or Fraud

If you receive benefits as a result of false information or a misleading or fraudulent

representation, you will be required to repay all amounts and you will be liable for all costs of collection including attorneys' fees. The Trustees reserve the right to reduce future benefit payments by the amount of the payment made because of fraud or misrepresentation.

17. No Fund Liability

The use of the services of any Hospital, Physician, or other provider of health care, whether designated by the Fund or otherwise, is your voluntary act. Nothing in this Plan booklet is meant to be a recommendation or instruction to use any provider. You should select a provider or course of treatment based on all appropriate factors, only one of which is coverage by the Plan. Providers are independent contractors, not Employees of the Plan. The Trustees make no representation regarding the quality of service or treatment of any provider and are not responsible for any acts of commission or omission of any provider in connection with Fund coverage. The provider is solely responsible for the services and treatments rendered.

The Plan, the Board of Trustees or any of their designees are not engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or over any health care services provided or delivered to anyone by any health care provider. Neither the Plan, the Board of Trustees, nor any of their designees, have any liability whatsoever for any loss or Injury caused to anyone by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

18. Right to Amend

The Board of Trustees has complete discretion to amend or modify this Plan or the Trust, and any of the provisions of the Plan or the Trust in whole or in part at any time. This means that the Trustees can reduce, eliminate or modify benefits as well as improve benefits. The Trustees may also modify the length of or eliminate coverage for Employees, Dependents and/or Retirees, and the Trustees may also modify any eligibility requirements for coverage.

The benefits under the Plan are not guaranteed and are provided only from assets of the Fund collected and available for such purposes.

19. Preferred Providers

The Board of Trustees may from time to time, in its sole discretion, enter into written agreements with preferred provider organizations. The use of such preferred providers is wholly at your option. The existence of any preferred provider agreement shall not, in any manner, imply an endorsement of any specific provider, nor shall it constitute any guarantee of the services rendered.

20. Plan Year

The Plan Year is the Calendar Year from January 1 through December 31.

YOUR RIGHTS UNDER ERISA

As a participant in the Southern California Pipe Trades Health and Welfare Fund -- Pensioner and Surviving Spouses Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

You have the right to:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan. These include any 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 Pension and Welfare Benefit Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan. These include any insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You also have the right to:

- Continue health care coverage for your Dependent spouse if there is a loss of coverage under the plan as a result of a qualifying event. Your Dependent spouse may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing 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. You must request the certificate of creditable coverage before losing coverage or within 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.

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 Employee benefit 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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 the 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. 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 plan administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. 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. 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.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries
Pension and Welfare Benefits Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

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

You may also find answers to your plan questions at the website of the PWBA at <http://www.dol.gov/dol/pwba/>. A list of PWBA Field Offices is located at <http://www.dol.gov/dol/pwba/public/contacts/folist.htm#TOF>.

DISCLAIMER

Please note that interpretations regarding participation in the Plan and eligibility for benefits, status of Employers and Employers and Employees, or any other matter relating to this Plan may only be obtained in writing through the full Board of Trustees or the Fund Office. The Trustees are not obligated by, responsible for, or bound by opinions, information, or representations from any other source.

This booklet contains a summary in English of your plan rights and benefits under the Plan. If you have difficulty understanding any part of this booklet, contact the Fund Office at 501 Shatto Place, 5th Floor, Los Angeles, California, 90020. The office hours are from 8:00 a.m. to 4:00 p.m., Monday through Friday. You may the Fund Office at (213) 385-6161 or (800) 595-7473 (California only), for assistance.

Este cuaderno cortiene un resumen en ingles de sus beneficios al igual que sus derechos de su plan. Si usted tiene alguna dificultad entendiendo este cuaderno, comuniquese a la oficina de beneficios en 501 Shatto Place, quinto piso, Los Angeles, CA 90020. Las horas de oficina son de 8:00 a.m. a 4:00 p.m. Lunes a Viernes, puede comunicarse a la oficina de beneficios al (213) 385-6161 o (800) 595-7473 en California para asistencia.

INDEX

| | Page |
|---------------------------------------|---------------------------------------|
| A | |
| Accident | 33 |
| Affiliated Health Funds (AHF) | 21 |
| AHF Contract Rate | 20 |
| Allergy Treatment | 25 |
| Allowable Charges | 20,24 |
| Ambulance/Air Ambulance | 26 |
| Appeals Procedure | 16 |
| Appendix A | 53 |
| B | |
| Beneficiary/Enrollment Form | 8 |
| Benefit(s) | 7,23 |
| Birth Control | (See Prescription Drug Benefits) - 26 |
| C | |
| Calendar Year | 33 |
| Calendar Year Deductible | 20 |
| Cardiac Rehabilitation | 30 |
| Chemotherapy | (See Professional Services) - 24 |
| Chiropractic Care | 25 |
| Chiropractor | 33 |
| COBRA | 13 |
| Claims | 15 |
| Collective Bargaining Agreement | 33 |
| Contributing Employer | 34 |
| Coordination of Benefits | 17 |
| Co-payment | 34 |
| Coverage Begins - Dependent | 12 |
| Coverage Begins - Member | 9 |
| Coverage Ends - Dependent | 12 |
| Coverage Ends - Member | 11 |
| Covered Expenses | 34 |
| Covered Medical Services | 23 |
| Custodial Care | 34 |
| D | |
| Deductible | 20,34 |
| Definition of Terms | 33 |
| Dentist | 34 |
| Dependent | 12 |

**SOUTHERN CALIFORNIA PIPE TRADES
HEALTH AND WELFARE FUND
PENSIONERS AND SURVIVING SPOUSES PLAN**

Appendix A

to the Summary Plan Description/Plan Rules and Regulations
of the

Pensioner Health and Welfare Plan

**WORKING RETIREES PROGRAM
EFFECTIVE JANUARY 1, 2001**

It is anticipated that the plumbing and pipefitting industry in Southern California will experience significant manpower shortages during the next few years. As a result, the Trustees have adopted a Working Retirees Program. If all of the requirements of this Program are followed, retirees will be permitted to return to work covered by the Funds on a temporary basis without a suspension of their pension benefits and without a loss of retiree health and welfare coverage.

- 1.** The Program applies only to jobs for which a waiver has been granted. If there is a manpower shortage that cannot be met by working participants, District Council 16 may ask the Trustees for a temporary waiver. A special committee of the Trustees will then decide whether to grant a temporary waiver of the rules for suspension of pension benefits and for loss of retiree health and welfare coverage.
- 2.** The waivers will be limited to work at a specific job site or work of a specific skill type. The waivers will be temporary and subject to cancellation at any time. Work outside the scope of the waivers will still be subject to suspension of pension benefits and loss of retiree health and welfare coverage.
- 3.** The Working Retirees Program is only available to retirees who have been receiving a pension for at least two years.
- 4.** A retiree employed under the Working Retirees Program will continue to receive his monthly pension check as long as he is working in accordance with the job site and other limitations of the waiver. He will also receive credit under the Pension Plan for periods of such employment, and his pension amount will be adjusted annually to account for the increased credit. No adjustments will be made to the pension amount for any prior years, and the adjustments will be limited to the additional incremental amount earned for the year during the waiver employment.

5. A retiree employed under the Working Retirees Program will continue to be covered by the health and welfare plan for pensioners as long as he is working in accordance with the job site or other limitations of the waiver. He will not be eligible for coverage by the health and welfare plan for actives because of employment under the Program.

6. A retiree employed by this Program will not lose his entitlement to the annual payment from the Christmas Bonus Fund as long as he is working in accordance with the job site or other limitations of the waiver.

7. If the retiree stays on the job after the waiver is canceled or if he works outside the limitations of the waiver, his pension benefits will be suspended, his retiree health and welfare coverage will terminate, and he will not be entitled to a Christmas bonus payment for the year.

If you have any questions, call or write the Fund Office for assistance.