## Summary Plan Description/Plan Rules & Regulations of the Southern California Pipe Trades

# HEALTH & WELFARE

# Fund

(Active Plan)

# SECTION 1
# INTRODUCTION

This Summary Plan Description/Plan Rules and Regulations ("SPD") describes the benefits offered by the Southern California Pipe Trades Health and Welfare Fund ("Plan"). Any printed material dated prior to January 1, 2013 applies to claims incurred prior to that date. This booklet applies to all claims for services incurred on and after January 1, 2013. Please refer to prior written material only for claims for services received prior to January 1, 2013.

This Plan does not cover Pensioners and Surviving Spouses, whose benefits are covered under another plan and set forth in a separate SPD. The Plan does not pay benefits for work-related Illnesses and Injuries.

The Board of Trustees is authorized to interpret the Plan. The Board has discretion to decide all questions about the Plan, including questions about eligibility for benefits, the amount and type of benefits payable and the definition of any Plan term. No Participant, Eligible Dependent, 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 claims.

As a courtesy, the Fund Office may respond informally to oral questions by telephone or in person at the Fund Office. However, oral information and answers are not binding upon the Board of Trustees and cannot be relied on in any dispute concerning the benefits. Keep in mind that in all matters communicated to you, verbal or written, the Board of Trustees will have the ultimate authority and discretion to interpret the Plan documents and make an independent determination about a Participant's or Dependent's entitlement to benefits.

This SPD identifies the Medical, Dental, Weekly Accident and Sickness, Death, and Accidental Death or Dismemberment benefits covered by the Plan. The Plan pays claims only for benefits provided under the Plan.

The SPD also provides information about a number of services that are not covered under the Plan. The Medical Expense Exclusions and Limitations are found in Section 17 of the SPD. Although an attempt has been made to be as complete as reasonably possible in providing this list of Exclusions and Limitations, it is not always possible to list every excluded service or procedure. Therefore, in making decisions about Medical and Dental benefits, the Participant should keep in mind that the Plan will pay only for services and procedures expressly identified in the Plan. A service or procedure not expressly covered by the Plan is excluded and will not be paid.

The Fund Office will respond in writing to written questions. If there is an important question about the benefits, please write to the Fund Office for an answer.

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

The Plan partners with Blue Shield of California with the goal of lowering and controlling patient Out-of-Pocket costs while expanding the network of providers available. Blue Shield provides administrative services only and the Southern California Pipe Trades Health & Welfare Fund provides plan benefits. **Please note that Blue Shield does not administer the Fund's dental, prescription or vision benefits.**

**Generally, terms defined in Section 23 are capitalized throughout this document.**

# SECTION 2
# PURPOSE OF THE PLAN

The Plan was established in 1951 through the negotiating efforts of District Council #16 and Employers in the plumbing and piping industry in Southern California. The Plan currently provides Medical, Dental, Weekly Accident and Sickness, Death, and Accidental Death and Dismemberment benefits for Participants and Eligible Dependents.

The Plan is administered by the Board of Trustees, which is composed of an equal number of Union and Employer Trustees. The Trustees intend to continue the Plan indefinitely. However, the Trustees of the Plan have been given the authority to amend or terminate the Plan, as they deem necessary.

**IMPORTANT**

**If there are any questions regarding a Participant's or Dependent's eligibility or benefits, or if there are any questions regarding specific services or procedures, please contact the Fund Office.**

**If there is a change in family status, such as marriage, divorce, or a change in status of an Eligible Dependent or if there is a change of address, the Fund Office should be notified as soon as possible, but in no event later than 90 days after the change.**

# SECTION 3
# SUMMARY OF ACTIVE PLAN BENEFITS

| CALENDAR YEAR DEDUCTIBLES | DENTAL |
|---|---|
| 1. $250 individual medical Deductible with $750 maximum family medical Deductible<br>2. $50 Dental Calendar Year Deductible per person (INCLUDED IN $250 CALENDAR YEAR DEDUCTIBLE)<br>3. $50 Prescription Drug Benefit Calendar Year Deductible per person (DOES NOT APPLY TO THE CALENDAR YEAR DEDUCTIBLE)<br>4. $50 Hearing Aid per device per person (DOES NOT APPLY TO THE CALENDAR YEAR DEDUCTIBLE) | 1. 100% of Allowable Charge (per the Dental Fee Schedule, see Section 18) incurred up to a maximum of $1,800 per person per Calendar Year<br>2. Orthodontics $600 maximum per Calendar Year with a Lifetime Maximum of $1,800 (applies to $1,800 dental Calendar Year max)<br>3. Three cleanings per Calendar Year subject to the $50 Dental Calendar Year Deductible |

### Annual Maximum Benefit Limits

- If you have been covered under the Plan for 12 or fewer months the Plan will pay no more than $100,000 in total benefits in a Calendar Year.
- If you have been covered under the Plan for more than 12 months, but 24 months or fewer, the Plan will pay no more than $250,000 in total benefits in a Calendar Year.
- If you have been covered under the Plan for more than 24 months, but 60 months or fewer, the Plan will pay no more than $500,000 in total benefits in a Calendar Year.
- If you have been covered under the Plan for more than 60 months, but 120 months or fewer, the Plan will pay no more than $1,000,000 in total benefits in a Calendar Year.
- If you have been covered under the Plan for more than 120 months the Plan will pay no more than $2,000,000 in total benefits in a Calendar Year.

**Effective January 1, 2014, Annual Maximum Benefit limits will be eliminated.**

## USEFUL DEFINITIONS

### Allowable Charge(s)

The scheduled amounts for medical and dental services and supplies are established by the Board of Trustees and Blue Shield of California. Any remaining amount that exceeds the Allowable Charge is not payable or recognized by the Plan for any purpose. The Patient is responsible for the co-payment amount, if any, and any charges that exceed the Allowable Charge.

### Blue Shield of California Contract Rate

The dollar amount agreed upon between Blue Shield of California and the various providers of service. The Patient is responsible for the Copayment, if any.

### Calendar Year

The period of January 1 through December 31.

### Copayment

The portion of the Contract Rate or Allowable Charge, expressed as either a percentage or dollar amount that the Patient is responsible to pay.

### Deductible

The amount the Patient is required to pay prior to the Plan paying any benefits. The Deductible is determined based on either the Contract Rate or the Allowable Charge, not necessarily the full billed amount.

### Out-of-Pocket

The amount the Patient must pay for services and treatment that are not paid by the Plan. This includes, but is not limited to, Deductibles, percentage payable for services rendered, charges in excess of the Allowable Charge or Blue Shield of California Contract Rate and any non-covered services.

# SUMMARY OF ACTIVE PLAN BENEFITS

Please see relevant section for details.

| TYPE OF SERVICE | | BLUE SHIELD OF CALIFORNIA (BSC) CONTRACTING PROVIDER<br><br>Plan Pays: | NON-BLUE SHIELD OF CALIFORNIA CONTRACTING PROVIDER<br><br>Any charges that exceed the Allowable Charge are Out-of-Pocket expenses to the Patient.<br><br>Plan Pays: |
|---|---|---|---|
| **AMBULANCE**<br>(Air and Ground) | | 80% of the Allowable Charge for professional ambulance or air ambulance services deemed Medically Necessary by the Plan. | |
| **ANESTHESIA** | | 100% of the BSC Contract Rate. | 100% of the Allowable Charge. |
| **CHEMOTHERAPY** | | 95% of the BSC Contract Rate. | 95% of the Allowable Charge. |
| **CHIROPRACTOR** | | **Maximum 3 visits per week, 35 visits per Calendar Year (can be combination of contracted and non-contracted providers). Children under the age of 7 (seven) years require a referral to the Chiropractor by their attending physician.** | |
| | | 100% of the BSC Contract Rate. | 100% of the Allowable Charge.<br><br>Up to a maximum of $54. |
| **DURABLE MEDICAL EQUIPMENT**<br>**(The Plan NEVER purchases Durable Medical Equipment)** | | **Benefits paid on rental-to-purchase basis based on monthly eligibility of patient.** | |
| | | 95% of the BSC Contract Rate. | 95% of the Allowable Charge. |
| **HOSPITAL** | **Hospital Inpatient** | 95% of the BSC Contract Rate for all room and board and Medically Necessary services and supplies. | 90% of the Allowable Charge for room and board and other Medically Necessary services and supplies up to $1,215 per day. |
| | **Inpatient Psychiatric**<br>(goal oriented and substance abuse related mental illness not covered) | 95% of the BSC Contract Rate for all room and board and Medically Necessary services. | 90% of the Allowable Charge for room and board and other Medically Necessary services and supplies up to $1,215 per day. |
| | **Hospital Outpatient** | 95% of the BSC Contract Rate. | 90% of the Allowable Charge. |
| **LABORATORY** | | 100% of the BSC Contract Rate. | 100% of the Allowable Charge. |

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Please see relevant section for details.

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|---|---|---|---|
| **MEDICAL SUPPLIES** | | 95% of the BSC Contract Rate. | 95% of the Allowable Charge. |
| **NON-PRESCRIPTION and OVER-THE-COUNTER DRUGS** | | **NOT COVERED** | |
| **PAIN MANAGEMENT** | | • $10,000 Annual Maximum Benefit<br>• 100% of Hospital facility fee up to a maximum Allowable Charge of $900 per day; or<br>• 100% of Surgery Center facility fee up to a maximum Allowable Charge of $800 per day; or<br>• 100% of Physician's office/surgery suite facility fee up to a maximum Allowable Charge of $700 per day; and<br>• Up to $250 per injection<br>• Maximum of 3 injections per day | |
| **PHYSICIAN** | **Physician Visit** | 100% of the BSC Contract Rate. | 100% of Allowable Charge. |
| | **Acupuncture**<br>(Must be performed by a Physician) | Office visit only<br><br>100% of the BSC Contract Rate. | Office visit only<br><br>100% of the Allowable Charge. |
| **PRESCRIPTION**<br><br>**Benefits per Calendar year** | | Maximum Calendar Year prescription benefit is $1,800 per eligible individual.<br><br>$50 Prescription Deductible (does not apply to the Calendar Year Deductible).<br><br>Drugs or medications include oral contraceptives and up to 30 pills annually for the treatment of erectile dysfunction for Participant and Spouse only.<br><br>Prescription Drug Benefits paid under the Pensioners & Surviving Spouses Health Fund will reduce Prescription Drug Benefits paid under the Health & Welfare Fund and vice versa. | |

# SUMMARY OF ACTIVE PLAN BENEFITS

Please see relevant section for details.

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|---|---|---|---|
| PSYCHIATRIC | **OUTPATIENT PSYCHIATRIC**<br>(must be referred by a Physician to a Psychiatrist, licensed Psychologist or doctor of psychology, 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) | 100% of the BSC Contract Rate. | 100% of the Allowable Charge. |
| | **INPATIENT PSYCHIATRIC**<br>Must be performed by a Physician.<br>(Refer to Hospital Benefits) | 100% of the BSC Contract Rate. | 100% of the Allowable Charge up to $1,215 per day. |
| PHYSICAL THERAPY | | 100 % of the BSC Contract Rate for physical therapy services rendered in an Outpatient Hospital setting or Outpatient physical therapy facility.<br>Three visits per week and 30 visits per Calendar Year. | 100% up to a maximum Allowable Charge of $70 per visit for physical therapy services rendered in an Outpatient Hospital setting or Outpatient physical therapy facility. Three visits per week and 30 visits per Calendar Year. |
| RADIATION THERAPY | | 95% of the BSC Contract Rate. | 95% of the Allowable Charge. |
| RADIOLOGY<br>**(X-rays, CT scans, MRI/CAT scans, etc.)** | **Performed in an Outpatient radiology facility or Physician's office** | 100% of the BSC Contract Rate. | 100% of the Allowable Charge. |
| | **Performed in a Hospital** | 95% of the BSC Contract Rate. | 100% of the Allowable Charge. |

# SUMMARY OF ACTIVE PLAN BENEFITS

Please see relevant section for details.

| TYPE OF SERVICE | | BLUE SHIELD OF CALIFORNIA (BSC) CONTRACTING PROVIDER<br><br>Plan Pays: | NON-BLUE SHIELD OF CALIFORNIA CONTRACTING PROVIDER<br><br>Any charges that exceed the Allowable Charge are Out-of-Pocket expenses to the Patient.<br><br>Plan Pays: |
|---|---|---|---|
| RENAL DIALYSIS | **Supplies** | 95% of the BSC Contract Rate. | 95% of the Allowable Charge. |
| | **Facility** | 90% of maximum Allowable Charge up to $200 per visit. | |
| SLEEP APNEA | | Annual Benefit of $950. 100% of Surgeon and facility fee up to a maximum of $950. | |
| SURGERY | **Primary Surgeon** | 100% of the BSC Contract Rate. | 100% of the Allowable Charge. |
| | **Assistant Surgeon** | 20% of the BSC Surgeon's Contract Rate. | 20% of the Surgeon's Allowable Charge. |
| | **Second Assistant Surgeon** | 10% of the BSC Surgeon's Contract Rate. | 10% of the Surgeon's Allowable Charge. |
| VISION CARE | | Up to $200 for charges incurred in a 24-month period for examination, fittings, glasses and contact lenses. | |
| WELL CHILD EXAMS & IMMUNIZATIONS TO AGE 17 | | Well Child Coverage after initial discharge from Hospital/birthing center at the time of birth to age 17. | |

# SECTION 4
# ENROLLMENT

## A) Enrollment & Beneficiary Form

Participants must complete an Enrollment & Beneficiary Form in order to receive Plan Identification Cards. The Enrollment & Beneficiary Form must list the Participant and all Eligible Dependents. A Participant must also use the Enrollment & Beneficiary Form to designate a Beneficiary(ies) for purposes of Death Benefits that may be payable.

Processing of benefit claims will be delayed until the Fund Office receives a completed Enrollment & Beneficiary Form signed by the Participant.

An updated Enrollment & Beneficiary Form must be submitted to the Fund Office upon request or if the Participant wishes to:

i) Change a beneficiary for death benefits;
ii) Change marital status;
iii) Add an Eligible Dependent;
iv) Remove an Eligible Dependent.

Participants may obtain an Enrollment & Beneficiary Form from any Local Union Office, the Fund Office or the Fund Office website at www.scptac.org.

## B) Required Documents

In order to add or remove a Dependent, the Fund Office must be provided with appropriate documentation, such as:

i) A certified copy of the marriage certificate;
ii) A certified copy of the birth certificate;
iii) A copy of the document placing the child for adoption or finalizing the adoption;
iv) A certified copy of the death certificate;
v) A copy of the final divorce decree.

**NOTE**

**Certified copies of the documents cited above must be issued by the appropriate government agency. Non-certified copies of documents from non-governmental agencies, such as hospital birth certificates or church-issued marriage certificates, are not acceptable. Marriage licenses are also not acceptable.**

## C) When Required Enrollment Documents Must Be Submitted to the Fund Office

### i) Marriage Documents

A new Enrollment & Beneficiary Form with the appropriate documentation as listed above must be submitted within 90 days of the date of marriage. If the Enrollment & Beneficiary Form and certified marriage certificate are not received within 90 days of the date of marriage, the eligibility date of the Participant's Spouse will be the date of receipt of the proper documentation, not the date of marriage. The Fund Office must be immediately notified if there is a delay in obtaining a copy of the certified marriage certificate.

### ii) Birth or Adoption Documents

A new Enrollment & Beneficiary Form with the appropriate documentation as listed above must be submitted within 90 days of the date of birth or placement of adoption or the eligibility date of the new Eligible Dependents will be delayed. The Fund Office must be immediately notified if there is a delay in obtaining a copy of the certified birth certificate or adoption documents.

### iii) Death Certificates

A certified copy of the death certificate must be submitted no later than 12 months after the date of death.

### iv) Final Divorce Decrees

A copy of any divorce decree must be submitted to the Fund Office as soon as it is available. The Participant and/or ex-Spouse will be required to repay to the Fund any benefits paid on behalf of an ex-Spouse after the date of divorce.

## D) Change of Address

If a Participant wishes to change his/her address, a Change of Address Form may be obtained from any Local Union Office, the Fund Office or the Fund Office website at www.scptac.org. It must be filled out completely and returned to the Fund Office.

# SECTION 5
# ELIGIBILITY

The eligibility rules described on the following pages apply to all the benefits that may be available under the Plan to Employees working under Collective Bargaining Agreements with District Council #16, to Signatory Employers, to Employees working under Participation Agreements and to Eligible Dependents.

## A) Establishing and Re-establishing Eligibility

Employees become eligible to participate in the Plan based on amounts credited to their Eligibility Bank by Employer contributions to the Plan. Employers make contributions to the Plan on behalf of Employees working in employment covered by a Collective Bargaining Agreement. Additionally, Employers may make contributions on behalf of Employees not covered by a Collective Bargaining Agreement pursuant to a written Participation Agreement approved by the Board of Trustees. Finally, if permitted by a Collective Bargaining Agreement, Employers may make contributions on behalf of certain of their owners and corporate officers.

Not all of the contribution rate paid by an Employer will count towards these dollar amounts. An Employer's contribution may be allocated in part (1) to the Participant's HRA account in the Health & Welfare Fund, (2) to the Southern California Pipe Trades Pensioners and Surviving Spouses Fund, (3) as a general contribution to the Health & Welfare Fund, or (4) as a base contribution for eligibility purposes. In 2013 the base contribution for eligibility purposes (in other words, the portion of the employer's contribution that applied for eligibility purposes) is $5.38.

Employees and their Eligible Dependents become eligible for benefits when $1,375 in Employer base contributions is credited to the Participant's Eligibility Bank within 24 consecutive months. Participants who lose eligibility will be reinstated if $1,375 in Employer base contributions is credited to their Eligibility Bank within 24 consecutive months. The $1,375 amount will be adjusted proportionally whenever the health and welfare base contribution rate under the Collective Bargaining Agreement changes and will be effective the first day of the second month following the month in which the change is effective. Any Employee who does not establish eligibility under the Plan and does not have the newly adjusted amount of contributions made on his/her behalf on any subsequent effective dates for any future adjustments, will not establish eligibility until he/she meets the new threshold, notwithstanding that contributions may have been accumulated prior to the effective date under a different minimum amount rule.

Participants and their Eligible Dependents will be covered under the Plan beginning the first day of the second month following the month in which the Participant's Eligibility Bank is first credited with $1,375 (as adjusted above) in Employer Base Contributions. Contributions are applied to the month worked, not the month the contribution is received by the Fund Office. The coverage may be delayed or applied retroactively if the contributions are not received when due.

**EXAMPLE**

**The Participant begins working for a Contributing Employer in January 2013 and works enough hours for a total of $1,375 in base contributions by the end of March. The Participant becomes eligible for benefits in May, provided the contributions are received.**

## B) Maintaining Eligibility

Base contributions paid on the Participant's behalf by a Contributing Employer will be credited to the Participant's Eligibility Bank. The maximum amount that may be credited to a Participant's Eligibility Bank is the amount that will provide six months of eligibility (Participants who had an Eligibility Bank balance before September 1, 2002 could accumulate a Bank of up to twelve 12 months, but if any part of their Eligibility Bank over six months used after that date will not be restored by subsequent contributions).

A charge will be deducted from a Participant's Eligibility Bank for each month of eligibility. This charge, known as the Monthly Deduction Amount, is $525. The Monthly Deduction Amount will be adjusted proportionally whenever the health and welfare base contribution rate under the Collective Bargaining Agreement changes and will be effective the first day of the second month following the month in which the change is effective.

If the Eligibility Bank balance falls below the Monthly Deduction Amount in effect at the time, eligibility will be terminated. Eligibility Bank balances below the Monthly Deduction Amount remain in the Eligibility Bank for a period not to exceed 24 consecutive months. If eligibility as an Employee is not re-established within the 24-month period by contributions from a Signatory Employer, any residual monies will be forfeited.

The Eligibility Bank may also contain contributions credited under the Weekly Accident and Sickness Benefit (see Weekly Accident and Sickness Benefit, Section 12).

## C) Dependent Eligibility

### i) Who are Eligible Dependents?

a) A Participant's lawful Spouse; or

b) A Participant's dependent child:

1) With one exception as explained below, the Plan will cover Dependent children through age 25, with coverage ending at 12:01 a.m. on the day of the child's 26th birthday. Children will be covered regardless of whether or not they are married; regardless of whether or not they are full-time students; regardless of whether or not they are in the custody of or living with either parent; and regardless of whether or not they depend on any support of either parent. As currently provided under the Plan, legally adopted children will also be covered under the Plan as of the date of adoption or date of placement for adoption; however stepchildren, grandchildren, other relatives of the Participant or other persons placed under the guardianship of the Participant will not be covered under the Plan. In addition, Spouses, children or other dependents of a child covered under the Plan will not be entitled to benefits under the Plan. A Participant may be required to submit to the Fund Office documentation to establish a child's eligibility.

2) **Exception: Through December 31, 2013:** A child between the ages of 19 and 26 will not be eligible to participate in this Plan if he/she is eligible to enroll in an employer-sponsored health plan (other than a group health plan of a parent), such as a plan based on the child's employment or the employment of his/her Spouse. The

Participant and the applicable child dependent are required to notify the Fund Office if the child is eligible for such other employer-sponsored coverage. This exception will be eliminated effective January 1, 2014.

### ii) Dual Coverage

If a person has dual coverage under the Plan (a) both as a Participant and as an Eligible Dependent or (b) as an Eligible Dependent of two Participants, then the total amount of benefits payable under the Plan will not exceed the scheduled amount for each benefit provided.

### iii) When Dependent Coverage Starts

Dependent coverage starts on the later of the following dates:

a) The date the Participant becomes eligible;
b) The date the person becomes an Eligible Dependent; or
c) The date of marriage, unless more than 90 days has passed since the date of marriage, in which case the date the Fund Office receives a marriage certificate.

### iv) When Dependent Coverage Terminates

Dependent coverage terminates on the later of the following dates:

a) The date the Participant's eligibility terminates; or
b) The date the Dependent no longer qualifies as an Eligible Dependent due to divorce from the Participant or because a child turns age 26; or
c) The date of death of the Dependent; or
d) The date the Dependent enters full-time active duty in Military Service; or
e) The date the Plan terminates.

Eligibility may be extended under COBRA Continuation Coverage. See Section 7 for more information.

### v) Surviving Dependents of Deceased Employees

In the event of the Participant's death, Eligible Dependents will remain eligible for benefits until the last day of the month in which the Participant's Eligibility Bank falls below the amount of the Monthly Deduction Amount.

#### a) Surviving Spouses

In the case of a Surviving Spouse of an Active Participant, if the Eligibility Bank is less than three (3) months, the Surviving Spouse may use the Eligibility Bank and be eligible for free coverage under the Southern California Pipe Trades Pensioners and Surviving Spouses Health Plan for three months, less the number of months in the Eligibility Bank.

When the Participant's Eligibility Bank is depleted, the eligible Surviving Spouse has the option of continuing coverage under COBRA or under the Pensioners and Surviving Spouses Health Plan. Surviving Spouses who initially elect COBRA Continuation Coverage under this (Active) Plan forfeit their right to coverage under the Pensioners and Surviving Spouses Health Plan and may not subsequently elect or receive coverage under the Pensioners and Surviving Spouses Health Plan.

#### b) Eligible Dependent Children

When the Participant's Eligibility Bank is depleted, Eligible Dependent children may continue coverage only under COBRA. See Section 7 for information on COBRA Continuation Coverage.

### vi) Extended Coverage for Total Disability

If eligibility terminates and the Eligible Dependent is Totally Disabled, medical benefits are available only for that disabling condition and only for three months after the loss of eligibility. This extension is available only to Eligible Dependents who are Totally Disabled. A statement from the attending Physician is required.

This benefit is not included in COBRA coverage and is not offered to Newly Organized Employees.

**EXAMPLE**

**The Dependent is Totally Disabled due to a broken leg and his/her eligibility terminates because the Participant's eligibility terminates. He/she then receives treatment for a cold. No benefit is payable for the cold because it is not related to the disabling condition of a broken leg.**

Claims for extensions of eligibility for Total Disability are handled under the same procedures and limitations as claims for Weekly Accident and Sickness Benefits or Death or Dismemberment Benefits.

See Section 19 for a general discussion of the Plan's appeals procedures.

### vii) Qualified Medical Child Support Order (QMCSO)

In addition, to the above methods of obtaining eligibility, this Plan will provide coverage for a child if required to do so by a Qualified Medical Child Support Order (QMCSO) in accordance with ERISA Section 609 (a)(2)(A).

A QMCSO is a court order or administrative notice that meets certain legal requirements. A Participant

who has obtained or received a QMSCO that requires the Plan to cover the Participant's dependent should immediately provide the Fund Office with a copy. The Plan has procedures to determine whether the order or other document is a QMCSO. A copy of the Plan's QMCSO procedure is available upon request.

## D) Reciprocal Contributions

When working outside the jurisdiction of District Council #16, contributions earned under another Collective Bargaining Agreement and paid by Employers to another health plan may be transferred to this Plan pursuant to the United Association National Reciprocity Agreement. Contributions are reciprocated only to the home Local reflected in the United Association's records. A Participant should check with the office of the trust fund where he/she is working for detailed procedures.

The amount of contributions varies regionally, and this may affect eligibility. For instance, if the contribution rate is higher where the Participant is working than it is in District Council #16, eligibility may be gained, and the Eligibility Bank may grow, faster. Amounts in excess of the contributions due under this Plan are retained by this Plan and provide the Participant with no additional benefit. Conversely, if the contribution rate is lower where the Participant is working than it is in District Council #16, eligibility may be gained more slowly, and coverage may be interrupted.

Generally it takes at least 30 days before the Plan receives reciprocal contributions from other health plans. Contributions are applied to the month worked, not the month the contribution is made or received by the Fund Office. This may result in an interruption in coverage and the issuance of a COBRA notice depending on the amount in the Participant's Eligibility Bank. (See COBRA Continuation Coverage in Section 7).

**Contributions are applied to the month worked, not the month the contribution was sent to, or received by, the Fund Office. Please be aware the coverage may be delayed or applied retroactively if contributions are not received when due.**

## E) Health Coverage for Retirees Returning to Work for a Contributing Employer

Retirees returning to work may be eligible to participate in the Plan depending on the Retiree's status and the type of work the Retiree performs.

### i) Return to Work Under the Temporary Waiver Program

A Pensioner who returns to work under the Temporary Waiver Program loses coverage under the Southern California Pensioners & Surviving Spouses Health Plan but may continue coverage under the Active Plan by paying the same premium amount the Pensioner would be required to pay under the Pensioners Plan.

### ii) Return to Work Resulting in Suspension of Pension Benefit

A Pensioner who returns to Covered Employment resulting in the suspension of the Pensioner's retirement benefit loses coverage under the Pensioners Plan but may continue coverage under the Active Plan by paying the full COBRA rate to the Active Plan until such time as the Pensioner becomes eligible under the Active Plan on the basis of contributions made to the Active Plan by the Pensioner's Employer for hours worked.

### iii) Return to Work at Age 65 for 39 or Fewer Hours

A Pensioner age 65 to age 70½ who returns to Covered Employment will lose coverage under the Pensioners Plan but may continue coverage under the Active Plan by paying the same premium amount the Pensioner would be required to pay under the Pensioners Plan for the entire period of his/her employment.

### iv) Return to Work at Age 70½

A Pensioner age 70½ or older who returns to Covered Employment loses coverage under the Pensioners Plan but may continue coverage under the Active Plan by paying the same premium amount the Pensioner would be required to pay under the Pensioners Plan until such time as the Pensioner becomes eligible under the Active Plan on the basis of contributions made to the Active Plan by the Pensioner's Employer for hours worked.

### v) Return to Work as an Apprentice and Journeyman Training Trust Instructor

A Pensioner who returns to work as an instructor for the Southern California Pipe Trades Apprentice and Journeyman Training Trust will lose coverage under the Pensioners Plan but may continue coverage under the Active Plan by paying the same premium amount the Pensioner would be required to pay under the Pensioners Plan.

### vi) Reinstatement upon Return to Covered Employment

Once a Retiree who had previously been eligible for and timely enrolled in the Pensioners Health Plan prior to returning to work for a Contributing Employer, ceases working in Covered Employment or in Non-Covered Employment, and upon the exhaustion of any Eligibility Bank in this Plan, if applicable he/she will be eligible to resume coverage in the Pensioner's Health Plan. See the Pensioners Health Plan SPD for complete details.

## F) Eligibility Under USERRA

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), if you leave Covered Employment to serve in the Military Service and

you meet the other requirements of that Act, you are entitled to elect continuation coverage for you and your Eligible Dependents. You may elect Core or Full Coverage, as with COBRA (see Section 7).

### i) Duration of Coverage

USERRA continuation coverage is generally the same as COBRA coverage and will be provided for the lesser of (a) 24 months from the date on which your qualified leave for uniformed service begins or (b) the period beginning on the date your leave for uniformed service begins and ending on the date you fail to sign the out-of work list or otherwise report back to work with a Contributing Employer within the time frames provided in USERRA.

### ii) Cost of Coverage

If you are absent from work to perform Military Service for a period of 30 days or less, the continuation coverage is provided at no cost. If qualified leave is for 31 or more days, the Fund may charge you up to 102% of the full cost of coverage, as with COBRA.

### iii) You have three options under USERRA

a) First, if you have a balance in your Eligibility Bank, you may elect to use up the money in your Eligibility Bank to continue your eligibility for health coverage. Upon your return to employment from the uniformed service, the Fund will allow you to be immediately eligible if you notify the Fund that you desire to resume coverage, but the Fund will charge you up to 102% of the full cost of such coverage until the balance in your Eligibility Bank is greater than the Monthly Deduction Amount.

b) Second, whether or not you have money in your Eligibility Bank, you may choose to pay for the USERRA Continuation Coverage yourself. In this case, the money in your Eligibility Bank will be frozen until you return to Covered Employment from the qualified Military Service and may be used at that time to establish your continuing eligibility for coverage at no cost to you.

c) Third, you may choose NOT to pay for USERRA continuation coverage, and freeze your Eligibility Bank until you return to Covered Employment from the qualified Military Service and then use your Eligibility Bank balance at that time to establish your continuing eligibility for coverage at no cost to you.

### iv) Cost of Coverage

You are required by USERRA to give advance notice to your Employer that you are leaving for a period of Military Service, unless giving such notice is impossible or unreasonable or you were precluded from giving notice by military necessity. Upon giving such notice to your Employer, you should also notify the Fund in writing that you are leaving to perform Military Service and that you elect to continue your medical coverage and/or that you elect to freeze your Eligibility Bank. Within 60 days after receipt of that notice, the Fund Office will provide you with specific information regarding the cost of USERRA continuation coverage, if you so elect.

If you do not give advance notice of your leave for Military Service to the Fund Office, your coverage will be terminated as of the date you leave employment for Military Service. If your failure to give advance notice of your Military Service is excused, because it was impossible or unreasonable to do so or because doing so was precluded by military necessity, the Fund Office will reinstate your health coverage retroactive to the date of departure from employment if you contact the Fund Office to request continuation coverage within 30 days of your departure and return the USERRA Continuation Coverage election form to the Fund Office with your initial payment within 30 days of receiving that form from the Fund Office.

## G) Health Coverage for Employees Transitioning from other Employer-Sponsored Health Coverage

The Transitioning Employee Program gives Employers who have provided health coverage to their First-Year Apprentice Employees or Newly Organized Employees a lower-cost method of providing such Employees immediate coverage from the Fund.

### i) Definition of Transitioning Employee

Persons who qualify for these special rules are Employees (and their Eligible Dependents) who are not Participants in the Fund and who currently have Employer-provided group health coverage. They may be:

a) Category I: Current Employees of a newly organized company that signs a District Council #16 Collective Bargaining Agreement;

b) Category II: Newly organized Employees represented by a Local Union affiliated with District Council #16 who are then employed by a Signatory Employer already contributing to the Trust Fund; or

c) Category III: An existing Employee who is an Apprentice and whose Employer provides health coverage to Apprentices who are not entitled to coverage under the Fund and who advances to a job class under which contributions to the Fund are required.

These special eligibility rules are <u>not</u> available to:

a) Current Employees represented by a District Council #16 Local Union (except for Category III Apprentices); or

b) Travelers from outside District Council #16; or

c) Newly indentured first year apprentices; or

d) Other regular applicants for representation by a

District Council #16 Local Union; or

e) New Employees who do not currently have Employer-provided group health coverage; or

f) Anyone who has previously attained eligibility for benefits from the Trust Fund under a special program for Transitioning Employees.

### ii) Methods by which Transitioning Employees May Become Eligible

The Employee must provide proof of his/her health coverage up to the date that contributions to the Fund commence, in the form of a Certificate of Group Health Plan Coverage from the prior insurer. The Employer must certify that the Employee is Employed on the date coverage from the Fund is to begin. The Employer may choose either to register (1) all of its Transitioning Employees or (2) none of its Transitioning Employees. It may not choose to register only some of its Transitioning Employees.

There are two methods by which Transitioning Employees may become eligible to participate in the Plan:

#### a) Employer Lump Sum

An Employer may agree to make a single lump sum payment on behalf of a Transitioning Employee. This payment is in addition to regular hourly contributions. At the time of printing, the lump sum payment was $687 per Employee. When the health and welfare base contribution rate under the Collective Bargaining Agreement changes, the required lump sum payment will automatically change proportionally on the effective date of the contribution rate change. (The base contribution is that part of the total Employer contribution that is used for the purpose of calculating eligibility.) The Transitioning Employee will start with a zero balance in his/her Eligibility Bank.

##### 1) Category I & II Employees

The Employer lump sum payment must be made upon signing a Collective Bargaining Agreement with District Council #16, or upon employment of the newly organized Transitioning Employee. The newly organized Transitioning Employee will then be covered on the first day of the month following the month in which the newly organized Transitioning Employee begins working under a District Council #16 agreement, provided that such Employee has contributions made on his/her behalf for the minimum number of hours set forth below.

##### 2) Category III Apprentices

The lump sum payment must be made before eligibility from the Fund is to begin. The Transitioning Employee will then be covered on the first day of the month in which the Employee advanced to an Apprentice job class that requires contributions to the Fund, provided that such Employee has contributions made on his/her behalf for the minimum number of hours set forth below.

#### b) Negative Bank

If an Employer does not make the single lump sum payment on behalf of the Transitioning Employee, the Transitioning Employee will start with a negative amount in his/her Eligibility Bank equal to the amount of base contributions required to establish initial eligibility (which at the time of printing was $1,375). (The Base Contribution is that part of the total Employer contribution that is used for the purpose of calculating eligibility.)

When the Base Contribution rate under the Collective Bargaining Agreement changes, the negative Eligibility Bank amount will automatically change proportionally on the effective date of the contribution rate change.

##### 1) Category I & II Employees

The newly organized Transitioning Employee will become eligible to participate in the Plan on the first day of the month following the month during which he/she first worked under a District Council #16 Collective Bargaining Agreement in employment covered by the Trust Fund provided that such Employee has contributions made on his/her behalf for the minimum number of hours set forth below.

##### 2) Category III Apprentices

The Transitioning Employee will be covered on the first day of the month in which the Employee advanced to an Apprentice job class that requires contributions to the Fund, provided that such Employee has contributions made on his/her behalf for the minimum number of hours set forth below.

### iii) Hours Requirement for Transitioning Employees

Each month the Transitioning Employee's Eligibility Bank will be credited with any amounts from the Base Contributions in excess of the Monthly Deduction Amount in effect at the time. The Monthly Deduction Amount (the threshold above which the negative Eligibility Bank will be credited with received Base Contributions) was $525 at the time of printing. The Monthly Deduction Amount will change proportionally whenever the health and welfare Base Contribution rate under the Collective Bargaining Agreement changes, on the effective date of the contribution rate change.

During the first two months of participation, a Transitioning Employee will be eligible. Until the Transitioning Employee's Eligibility Bank equals or exceeds the Monthly Deduction Amount, the Transitioning Employee will lose eligibility two months after any work month in which he is employed for fewer than 100 hours. If eligibility is lost, the Employee may regain eligibility by having sufficient contributions made on his/her behalf as required under the Plan's regular eligibility rules.

### iv) Employer's Minimum Contribution Requirement

The Employer will be required to make contributions based on hours worked. If the Employee works fewer than 120 hours, the Fund will bill the Employer, and the Employer will pay, supplemental contributions in the amount of the difference between hours worked and 120 hours, times the total health contribution rate under the primary Collective Bargaining Agreement in effect at the time, less the portion of the total health contribution due to the Health Reimbursement Arrangement (HRA) and the Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund. No portion of these supplemental contributions will be credited to the Employee.

### v) Self-Pay and COBRA for Transitioning Employees

If a Transitioning Employee loses eligibility, he/she has the same rights to make continuation coverage payments under COBRA as any other Participant. However, if such loss occurs within the first twelve months of eligibility or before any negative Eligibility Bank balance is restored, a Newly Organized Transitioning Employee will not be entitled to the Subsidized Self-pay Program, and he/she must pay the full COBRA amount. Otherwise, COBRA coverage is subject to the Trust Fund's regular rules for such coverage.

### vi) Dependents, Including Spouses, of Transitioning Employees

Dependents of Transitioning Employees will become Eligible Dependents under this special program only if coverage for the dependents was provided under the Employee's previous group health plan. Otherwise, dependents will be Eligible Dependents only after the Transitioning Employee would have otherwise attained eligibility under the Plan's regular rules.

### vii) Special Benefit Provisions for Transitioning Employees

Transitioning Employees and their dependents who attain eligibility under this special program will be subject to a per-person Annual Maximum Benefit of $100,000 during their first twelve months of eligibility. In addition, the Newly-Organized Transitioning Employee is not eligible for the Plan's Weekly Accident and Sickness benefit or for Extended Coverage for Total Disability during the first twelve months of eligibility.

Newly Organized Transitioning Employees and their dependents over the age of 18 who become eligible under this special program are subject to an exclusion from coverage for any pre-existing condition. A pre-existing condition is any condition, other than pregnancy, for which medical advice, diagnosis, care, or treatment was received within the 6-month period ending on the date of eligibility. The exclusion for such pre-existing conditions extends for a period not to exceed 12 months after the eligibility date. This exclusion period is reduced by the length of prior periods of Creditable Coverage under the other plan. In order to reduce the period of the exclusion of coverage for a pre-existing condition, the Transitioning Employee must produce a Certificate of Group Health Plan Coverage from the other plan. For example, if the Employee's certificate shows that he/she was covered by the other plan for the 12 months prior to his/her eligibility, there will be no exclusion of pre-existing conditions.

In addition, except as otherwise specifically stated in this Summary Plan Description, all of the Plan's regular rules continue to apply to all Transitioning Employees and their Eligible Dependents.

# SECTION 6
# HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

If required under the terms of a Collective Bargaining Agreement (CBA) or certain other agreements, an Employer may make pre-tax contributions on behalf of an Employee to this Plan for the purpose of funding a Health Reimbursement Arrangement (HRA). Amounts contributed to an HRA Allowance (defined below), if any, may be used to reimburse a Participant tax-free for certain medical expenses which are not covered by this Plan or any other health plan. If a Participant's Spouse and/or children are eligible under the terms of the Plan, their reimbursable medical expenses qualify for tax-free reimbursement from the HRA Allowance. All HRA contributions are Fund assets. Participants are not vested in any contributions made on their behalf, and an HRA Allowance may only be used in accordance with the terms of the Plan.

## A) Active Participant Eligibility

If an Employer makes an HRA contribution to the Fund on behalf of a Participant, the Participant is entitled to these contributions, subject to the terms of the Plan, once he becomes eligible to participate in the Plan. The Participant's HRA benefit is called an "HRA Allowance." An HRA Allowance may be used to reimburse eligible expenses incurred by the Participant, his eligible Spouse and his Eligible Dependents as defined under the Plan.

## B) Loss of Eligibility

If a Participant with a balance remaining in his HRA Allowance ceases to be eligible for benefits under the Plan, due to such circumstances as termination of employment, reduction of hours of employment, or retirement, he may continue to submit claims for reimbursement from his HRA Allowance up to the amount of this balance. Any dependent who would have been covered before the Participant ceased to be eligible for benefits continues to be covered. However, once an otherwise Eligible Dependent child turns age 26, or an eligible Spouse divorces the Participant, he/she is no longer eligible under the terms of the Plan, and his/her medical expenses incurred after the loss of eligibility are no longer reimbursable from the HRA, unless he/she pays for COBRA coverage (discussed further below).

**EXAMPLE**

**The Participant loses eligibility, at a time when his 25-year-old Dependent child was eligible under the terms of the Plan. The Participant may claim reimbursement for the child's eligible expenses, whether incurred before or after the loss of eligibility, but not for expenses incurred after that child turns age 26.**

**EXAMPLE**

**The Participant loses eligibility, at a time when his Spouse was eligible under the terms of the Plan. The Participant may claim reimbursement for his Spouse's eligible expenses, whether incurred before or after the loss of eligibility, but not for expenses incurred after he and his Spouse later divorce.**

## C) Benefit Amount

The amount of the HRA benefit in any Calendar Year is determined by the number of hours the Participant works in Covered Employment, multiplied by the rate set forth in the CBA or other agreement. If the HRA Allowance is not used in any one Calendar Year it may be carried over year-to-year until depleted. It is expected that this benefit will be provided as long as the CBA or other agreement provides for a contribution for such a benefit and, once an HRA Allowance is established, as long as a Participant has a balance remaining in his HRA Allowance (subject to the forfeiture rules listed below). The Trustees, however, retain the right to change the rules pertaining to this benefit or terminate this benefit at the end of any Calendar Year as they deem appropriate.

**No benefit will be paid from a Participant's HRA Allowance in an amount less than $25.00.**

## D) Forfeitures

If an HRA Allowance is less than $25.00 and no contributions have been received on behalf of the Participant for 24 consecutive months, the HRA Allowance will be forfeited to the Fund. If an HRA Allowance is $25 or more, and if no contributions have been received, and no claims have been filed, for 24 months, and if the Participant does not respond to a letter sent to his last known address by the Fund office, then his HRA Allowance will be forfeited to the Fund.

## E) Payment of Large Claims

If a Participant files a claim for the HRA Allowance but there are insufficient funds in the HRA Allowance to pay the entire claim, the Fund will pay only the amount in the HRA Allowance. Once at least $25.00 in additional contributions has been credited to the HRA allowance, the Participant may re-file the claim for additional reimbursement.

## F) Reimbursable Expenses

An HRA Allowance may be used to reimburse eligible health care expenses incurred by the Participant or his Spouse or his/her Eligible Dependents which would otherwise be only partially covered or excluded from coverage by the Plan and any other health plan. Reimbursable expenses are those that constitute "medical care" under Section 213 of the Internal Revenue Code. An HRA Allowance may be used to reimburse the Participant for Plan deductibles, Copayments, and other non-covered expenses for medical, prescription drug, dental, vision, and psychiatric services. An HRA Allowance may also be used to pay for self-pay premiums, COBRA premiums, other medical plan coverage, Medicare supplemental coverage, Medicare Part B or D monthly payments, and long-term care insurance premiums (but not life insurance premiums).

To be eligible for reimbursement, the expenses must be:

- incurred on or after July 1, 2011; and
- submitted within 12 months after the date the claim was incurred. Claims submitted after 12 months will be denied. Large claims that were initially filed by the 12 month deadline but which still had a remaining balance after the HRA Allowance was exhausted may be re-filed indefinitely as new contributions to the HRA Allowance are received.

**NOTE**

**Generally reimbursement from an HRA Allowance for eligible expenses will not be taxable. However, it is the obligation of the Participant, eligible Spouse or other Eligible Dependent to determine his/her own individual tax obligation.**

i) Examples of eligible expenses are as follows:

- Copayments, co-insurance and Deductibles
- Acupuncture
- Chiropractic visits
- Crutches
- Dental Expenses
- Expenses that exceed medical, hospital, dental or vision plan limits

- Eye exams, glasses and contact lenses
- Hearing aids
- Laser eye surgery
- Orthodontia
- Orthopedic shoes
- Pregnancy services for an Eligible Dependent child
- Physical exams
- Physical therapy
- Prescription Drugs and nonprescription drugs prescribed by a Physician
- Psychotherapy
- Transportation expenses related to medical care
- Well baby and well child care
- Wheelchairs

ii) Examples of ineligible expenses are as follows:

- Cosmetic services
- Expenses claimed on an income tax return
- Expenses that are reimbursed by other sources, such as insurance plans
- Fees for exercise or health clubs, unless Medically Necessary
- Hair transplants
- Illegal treatments, operations or drugs
- Postage and handling fees
- Weight loss programs that are not Medically Necessary

## G) Claims Procedures

No benefit will be paid from a Participant's HRA Allowance in an amount less than $25.00. An HRA Reimbursement Claim Form must be submitted. This form, which is available from the Fund Office, will require the Participant's certification that the expenses were not reimbursed, and are not reimbursable, by this or any other plan. Along with the HRA Reimbursement Claim Form, supporting documentation must be provided describing the expenses and proving that the Participant (or eligible Spouse or other Eligible Dependent) paid the expenses. Supporting documentation may include, but is not limited to, the following, as applicable:

- An itemized bill describing the services provided, the person to whom the services were provided, the name of the provider, the date of service, and the charged amount
- An Explanation of Benefits (EOB)
- A receipt showing proof of payment

## H) COBRA Continuation Coverage

If a Participant, eligible Spouse or other Eligible Dependent has a qualifying event and is eligible for COBRA Continuation Coverage, he/she will have the option to pay for COBRA coverage.

### i) COBRA Coverage for Participants and their Eligible Dependents

A Participant is not required to elect COBRA Continuation Coverage, or to pay COBRA premiums, to retain access to his HRA Allowance.

**EXAMPLE**

**The Participant loses eligibility because his employment is terminated and his Eligibility Bank runs out. He does not elect COBRA Continuation Coverage because he can obtain coverage through his wife's Employer. He may nonetheless continue to claim reimbursement from his HRA Allowance for eligible expenses, including the premiums his wife pays for their medical coverage, as well as the eligible expenses of his eligible Spouse or other Eligible Dependent.**

If the Participant does elect COBRA Continuation Coverage, he has the option to elect HRA COBRA by paying an additional HRA COBRA premium which will add additional contributions to his HRA Allowance. These additions to the HRA allowance will, however, be after-tax amounts.

### ii) COBRA Coverage for Eligible Spouses and other Eligible Dependents

Spouses and other Dependents who qualify as COBRA Beneficiaries fall into two categories:

a) <u>If the Dependent's loss of eligibility is due to the Participant's termination of employment, reduction in hours or death</u>

As noted above, an eligible Spouse or other Eligible Dependent shall continue to be eligible to have qualified expenses reimbursed from the Participant's HRA Allowance upon the Dependent's loss of eligibility in the Plan due to the Participant's termination of employment, reduction in hours or death. The Dependent's expenses will continue to be reimbursed in the same manner as they were reimbursed prior to the loss of eligibility. An eligible Spouse or other Eligible Dependent is not required to elect COBRA to have qualified expenses reimbursed from the Participant's HRA Allowance in these cases. However, if he/she elects COBRA Continuation Coverage, he/she has the option to also elect HRA COBRA by paying an additional HRA COBRA premium. By paying the additional premium, additional contributions will be added to the HRA Allowance.

b) <u>If the Dependent's loss of eligibility is due to divorce or because a Dependent no longer meets the definition of "Eligible Dependent" under the Plan</u>

An eligible Spouse or other Eligible Dependent who loses eligibility under the Plan because he/she no longer meets the definition of an "Eligible Dependent" under the Plan—for example because of divorce in the case of a

Spouse or turning age 26 in the case of a child—shall no longer have access to the Participant's HRA Allowance upon the loss of eligibility unless he/she elects both COBRA Continuation Coverage and HRA COBRA. The additional HRA premium will give the eligible Spouse or other Eligible Dependent access to the HRA Allowance and will also add additional contributions to the HRA Allowance, on an after-tax basis.

An eligible Spouse or other Eligible Dependent who pays a COBRA premium may obtain reimbursement only for his/her own eligible expenses incurred after the start of COBRA coverage, and only to the extent that there is a balance in the HRA Allowance. Eligible expenses incurred before the start of COBRA coverage may still be reimbursable to the Participant.

**EXAMPLE**

**An Eligible Dependent child turns age 26 and therefore loses coverage under the Plan. The child chooses not to pay for COBRA Continuation Coverage. She then suffers an Injury, the treatment for which is not entirely covered by the Plan or any other source. The child may not claim reimbursement from the HRA Allowance, because she did not pay for COBRA coverage.**

**EXAMPLE**

**A Participant and his eligible Spouse divorce, so that the ex-Spouse loses coverage under the Plan. She elects to pay for COBRA Continuation Coverage. She then suffers an Injury, the treatment for which is not entirely covered by the Plan or any other source. The ex-Spouse may claim reimbursement from the HRA Allowance, because she paid for COBRA coverage.**

**EXAMPLE**

**A Participant and his eligible Spouse divorce, so that the ex-Spouse loses coverage from the Plan. She elects to pay for COBRA Continuation Coverage. The couple's Eligible Dependent child, who lives with the ex-Spouse, suffers an Injury the treatment for which is not completely covered by the Plan or by any other source. The ex-Spouse may not claim reimbursement from the HRA Allowance, because COBRA only covers her own expenses. However, the Participant may claim reimbursement for the child's eligible expenses related to the injury.**

## I) HRA COBRA Premiums

The amount of the HRA COBRA Premium will be determined by the Fund and its Trustees who may, from time to time, change the amount as they determine appropriate. The paid premium will be added to the existing HRA Allowance as an additional contribution, with the exception of a small portion that will go to defray administrative expenses. As previously noted, HRA COBRA cannot be elected unless regular COBRA Continuation Coverage (Core or Full) is elected.

**Note:** if the Participant or an eligible Spouse or other Eligible Dependent adds to the HRA Allowance through the payment of a COBRA premium, these amounts are subject to all regular HRA rules and restrictions and may be forfeited per those rules. The amounts added through the payment of a COBRA premium become part of the HRA Allowance and may be used by any individual who is eligible to seek reimbursement from the HRA Allowance, not just the party paying the COBRA premium.

### i) Death of the Participant

If a Participant has an HRA Allowance and he dies prior to submitting a claim to the Fund Office for eligible health care expenses, the expenses may nonetheless constitute eligible expenses and payment may be made to the Participant's estate. Payment can generally not be made to the Beneficiary of other Fund benefits, but only to the participant's estate. In such cases, the claim for reimbursement must be completed and submitted to the Fund Office either by the surviving eligible Spouse or by another eligible Dependent, or by a representative of the estate.

The Participant's eligible Spouse and/or other Eligible Dependents will retain access to any balance in the HRA Allowance to pay for their qualified medical expenses so long as they would have been eligible had the Participant survived and continued to Participate in the Plan as an active Participant. Upon the Participant's death and the death of any surviving eligible Spouse and all other Eligible Dependent(s), any remaining balance in the HRA Allowance will be forfeited to the Fund.

### ii) Family and Medical Leave Act (FMLA)

During a Participant's FMLA leave, his HRA Allowance will be maintained. If the Participant properly notifies his Employer of his leave his Employer may be required to continue to make an HRA contribution to the Fund on the Participant's behalf. Any questions about whether or not a Participant is entitled to continued contributions to his HRA Allowance must be resolved with his Employer.

### iii) Military Leave

Participants serving in qualified Military Service for fewer than 31 days may be entitled under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) to have contributions made to their HRA Allowance by their Employer during this period of service. Any questions about

whether or not a Participant is entitled to continued contributions to his HRA Allowance must be resolved with his Employer. No additional contributions are required to be made to an HRA Allowance for Participants serving longer periods of time in qualified Military Service. However, if a Participant notifies the Fund Office that he/she is serving in qualified Military Service, time spent in Military Service will not be counted in determining whether there has been sufficient inactivity in the account to cause forfeiture.

# SECTION 7
# COBRA CONTINUATION COVERAGE

## A) What is COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) Continuation Coverage?

### i) Introduction

Federal law requires that most group health plans (including this Plan) give Employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under the Plan. Depending on the type of qualifying event, "qualified Beneficiaries" can include the Employee covered under the group health plan, a covered Employee's Spouse, and dependent child(ren) of the covered Employee.

Continuation coverage includes the same health coverage that the Plan gives to other Participants or Beneficiaries under the Plan who are not receiving continuation coverage. However, Death, Accidental Death or Dismemberment, and Weekly Accident and Sickness and Extended Coverage for Total Disability benefits are not provided under COBRA Continuation Coverage. Each Qualified Beneficiary who elects continuation coverage will have the same rights under the Plan as other Participants or Beneficiaries covered under the Plan including special enrollment rights.

An eligible Participant and Eligible Dependent have the option of electing one of the following COBRA Plans:

a) CORE COVERAGE - Provides coverage for medical only.
b) FULL COVERAGE - Provides coverage for medical, dental and vision.

Once Full or Core coverage has been elected, the election may not be changed.

### ii) Rights of Covered Participant

The covered Participant may have a right to choose this continuation coverage if group health coverage is lost because of a qualifying event such as a reduction in the Eligibility Bank to a level below the Monthly Deduction Amount (see Section 5) due to layoff, reduced hours, voluntary termination, disability, retirement, or any other reason except gross misconduct.

If the Participant does not elect COBRA Continuation Coverage, Eligible Dependents have a separate right to elect COBRA.

### iii) Rights of Dependent Spouse

The Spouse of a covered Participant may have the right to choose continuation coverage if the Participant loses group health coverage under the Plan because of a qualifying event such as:

a) A reduction in the Eligibility Bank to a level below the Monthly Deduction Amount (see Section 5) due to layoff, reduced hours, voluntary termination, disability, retirement, or any other reason except gross misconduct.
b) The death of the covered Participant;
c) Divorce from the covered Participant; or
d) The failure of the Participant to elect coverage under the Pensioners and Surviving Spouses Health and Welfare Plan at retirement.

### iv) Rights of Dependent Children

The Dependent child of a Participant covered by the Plan may have the right to continuation coverage if coverage is lost because of a qualifying event such as:

a) A reduction in the Eligibility Bank to a level below the Monthly Deduction Amount due to layoff, reduced hours, voluntary termination, disability, retirement, or any other reason except gross misconduct.
b) The death of a parent who is the covered Participant under this Plan; or
c) The child ceases to be an Eligible Dependent as defined under this Plan.

## B) How long will continuation coverage last?

Generally, in the case of a loss of coverage due to the end of employment or a reduction in hours of employment, coverage may be continued for up to 18 months under COBRA. However, under this Plan, coverage may be extended for up to 24 months. If coverage is lost due to (1) an Employee's death, (2) divorce or legal separation, or (3) a dependent child ceasing to be an Eligible Dependent under the terms of the Plan, coverage may be continued for up to 36 months. When the qualifying event is the end of employment or the reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits fewer than 18 months before the qualifying event, COBRA Continuation Coverage for qualified Beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement.

| Period of COBRA Continuation Coverage | | |
|---|---|---|
| **QUALIFYING EVENT** | **QUALIFIED BENEFICIARY** | **THE MAXIMUM CONTINUATION PERIOD UNDER THE PLAN** |
| **1.** Reduction in covered Participant's hours | Participant, Spouse and Dependent children | 24 months after date of qualifying event * |
| **2.** Termination of covered Participant's employment | Participant, Spouse and Dependent children | 24 months after date of qualifying event * |
| **3.** Death of covered Participant | Spouse and Dependent children | 36 months after the date of qualifying event * |
| **4.** Divorce of covered Participant | Spouse | 36 months after date of qualifying event |
| **5.** Dependent child's loss of that status under the Plan | Affected Dependent child | 36 months after date of qualifying event |
| **6.** Covered Participant's entitlement to Medicare after a qualifying event described in 1 or 2 | Spouse and Dependent children | 36 months after the initial qualifying event |
| **7.** Covered Participant's entitlement to Medicare before a qualifying event described in 1 or 2 | Spouse and Dependent children | Later of 24 months from the qualifying event * or 36 months from the date of the Employee's Medicare entitlement |
| ***Maximum continuation periods include 6 months of subsidized self-payment and the maximum COBRA period. Continuation periods in boxes 1, 2, and 3 begin after the applicable Eligibility Bank is exhausted. Even if the individual is not eligible for the 6-months of subsidized self-payment the individual may elect coverage for a minimum of 24 months by purchasing up to an extra 6 months of COBRA Continuation Coverage.** | | |

Continuation coverage under this Plan will be terminated before the end of the maximum period if any one of the following occurs:

i) Any required premium is not paid on time;
ii) A Qualified Beneficiary becomes covered under another group health plan that does not impose any pre-existing condition Exclusion for a pre-existing condition of the Qualified Beneficiary;
iii) A Qualified Beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage; or
iv) The Plan ceases providing coverage to all Participants.

Continuation coverage may also be terminated for any reason the Plan would terminate the coverage of a Participant or Beneficiary not receiving continuation coverage (such as fraud).

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

Under the terms of this Plan the initial 18-month COBRA coverage period is extended by six months to 24 months. A further extension of this period may be available if a Qualified Beneficiary is disabled or a second qualifying event occurs. The Fund Office must be notified of a disability or a second qualifying event in order to extend this period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage. If a Qualified Beneficiary is already receiving COBRA coverage for the maximum 36-month period, coverage may not be extended due to the occurrence of either of these events.

### C) Disability

A five (5) month extension of coverage may be available if any of the Qualified Beneficiaries is disabled. This

would result in a maximum period of continuation coverage of 29 months. The disability has to have started at some time before the 60th day of continuation coverage and must last at least until the end of the 18-month period of continuation coverage. In order to be considered disabled under the terms of the Plan, the Qualified Beneficiary must be determined to be disabled by the Social Security Administration (SSA). If any Qualified Beneficiary was determined to be disabled by the SSA prior to the beginning of continuation coverage, you must notify the Fund Office of that fact within the first 60 days of continuation coverage. If any Qualified Beneficiary becomes disabled within the first 60 days of continuation coverage, you must notify the Fund Office of that fact within 60 days of the SSA's determination and before the end of the first 24 months of continuation coverage. In either event, your notice must be mailed to the Fund Office and must include a copy of the SSA determination letter. All Qualified Beneficiaries who have elected continuation coverage will be entitled to the five (5) month disability extension if one of them qualifies.

If the Qualified Beneficiary is determined by the SSA to no longer be disabled, you must notify the Fund Office of that fact within 30 days of the SSA's determination.

## D) Duty to Notify the Fund

Coverage for a Spouse ends on the date of divorce. The Participant must provide written notice of the divorce and a copy of the final decree to the Fund Office within 60 days after the final decree is entered.

Coverage for a Dependent child ends on the date the child no longer qualifies as an Eligible Dependent. If the Plan has not notified the Participant of loss of a Dependent child's coverage, the Participant must provide notice of loss of dependent status to the Fund Office within 60 days of the loss of that status.

If the Fund is not notified of the divorce or a dependent's loss of Eligible Dependent status and benefits are issued, the Participant will be responsible and required to reimburse the Fund all benefits issued.

## E) How is continuation coverage elected?

To elect continuation coverage, you must complete the election form and return it according to the directions on the form. Each Qualified Beneficiary has a separate right to elect continuation coverage. For example, the Participant's Spouse may elect continuation coverage even if the Participant does not. Continuation coverage may be elected for only one, several, or for all dependent children who are Qualified Beneficiaries. The Participant may elect coverage on behalf of his/her eligible Spouse and Children and the the Participant's Spouse, may elect to continue coverage on behalf of any Eligible Dependent child(ren).

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. In deciding whether or not to elect continuation coverage, here are some things you should keep in mind:

i) If you have more than a 63-day gap in health coverage and over the age of 18, you could lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans. Election of continuation coverage may help prevent you from having such a gap.
ii) If you elect continuation coverage, but do not continue the coverage for the maximum time available to you, you will lose the guaranteed right, if you are over the age of 18, to purchase individual health insurance policies that do not impose such pre-existing condition exclusions.
iii) You may have other alternatives to continuing coverage under this Plan. Under federal law, for instance, you have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment rights at the end of continuation coverage if you elect continuation coverage and continue the coverage for the maximum time available to you.

## F) How much does continuation coverage cost?

Generally, each Qualified Beneficiary is required to pay the entire cost of continuation coverage. However, this Plan subsidizes the cost of continuation coverage for the first six months of coverage for Participants who meet the conditions to qualify for the subsidy described below. If you qualify for the subsidy, coverage for the first six months will be at the lower subsidized premium and will thereafter increase to the applicable COBRA premium amount. The amount a Qualified Beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated Plan Participant or Beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent). The required payment for continuation coverage is described in the notices you will receive when you become eligible.

## G) When and how must payment for continuation coverage be made?

### i) Your First Payment

If you elect continuation coverage, you do not have to send any payment with the election form.

However, you must make your first payment for continuation coverage not later than 60 days after the date of your election. The Fund Office should receive your initial self-payment no later than the 20th day of the month prior to the month for which you desire coverage. Payment must be received in time in order to avoid delays in claim payments and

eligibility problems. However, this initial payment will be accepted if received within 60 days from the day that you mail the election form. The initial payment must cover the number of months from the date coverage would otherwise have terminated, including the month in which the initial payment is made. If you do not make your first payment for continuation coverage in full within 60 days after the date of your election, you will lose all continuation coverage rights under the Plan.

You are responsible for making sure the amount of your first payment is enough to cover this entire period. You may contact the Southern California Pipe Trades Administrative Corporation, Attention: Eligibility Department, 501 Shatto Place, 5th Floor, Los Angeles, CA 90020, or at (213) 385-6161 or (800) 595-7473, to confirm the correct amount of your first payment.

### ii) Periodic Payments for Continuation Coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments are due by the 20th day of the month preceding each month of coverage. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan may send periodic notices of payments due for those coverage periods, but you are responsible for making the payments timely whether or not you receive the notices.

**EXAMPLE**

**The payment for July 2013 coverage is due no later than June 20, 2013.**

### iii) Grace Period for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days from the beginning of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to the:

Southern California Pipe Trades
Administrative Corporation
Attention: Eligibility Department
501 Shatto Place, 5th Floor
Los Angeles, CA 90020.

### iv) Form of Payment

All payments must be made by check, cashier's check, electric debit, ACH or money order. Cash is not acceptable for COBRA payments. The Participant can obtain the Authorization Agreement for Direct Payments (ACH Debits) from the Fund Office or the SCPTAC website at www.scptac.org. Send the complete agreement to the Fund Office.

## H) Can you elect other health coverage besides continuation coverage?

As described above, you may be eligible to pay for your coverage at a lower subsidized rate for the first six months if you meet certain conditions.

The Plan also offers another alternative to COBRA under which the Surviving Spouse of a deceased Participant may elect to self-pay for coverage under the Southern California Pipe Trades Pensioners & Surviving Spouses Health Plan.

The conditions you must satisfy in order to qualify for each of these options are described below. The applications and elections forms for these options will be sent to you if we are aware that you are eligible for either of these options.

### i) The Self-Payment Subsidy

A Participant is eligible to receive a subsidy from the Fund for the first six months of continuation coverage if he/she meets all of the following conditions. The Participant:

a) Must be available for Covered Employment (i.e. unemployed); and
b) Must maintain membership in good standing with a Local Union affiliated with District Council #16; and
c) Must reside within the geographical jurisdiction of District Council #16 unless the Participant is:
   1) Placed on special assignment by the United Association or is employed by a Building and Construction Trades Labor Council in California; or
   2) Is seeking work outside the jurisdiction of District Council #16 and a travel card is taken for this purpose; and
d) Must make timely and continuous contributions in the amount established for such coverage; and
e) May not be receiving disability benefits; and
f) May not be in the process of retiring; and
g) May not be a Signatory Employer or an Employee covered under a Participation Agreement.

The Participant may self-pay at the subsidized rate for up to six months. After six months, coverage may continue for an additional 18 months at the standard COBRA rates. Another notice and election form will be sent at the end of the six-month subsidy period.

If the Participant does not receive COBRA coverage for the full 18 months after the initial six months of

subsidized coverage, he/she may lose the right to avoid having pre-existing condition exclusions applied to him by other group health plans, and under individual health insurance policies.

### ii) Surviving Spouse Coverage

If the Spouse was married to a Participant under this Plan at the time of his/her death, the Spouse may elect to participate in the Southern California Pipe Trades Pensioners & Surviving Spouse Health Plan. This coverage is for the Surviving Spouse only and does not include coverage for dependent child(ren).

Benefits under the Pensioners & Surviving Spouses Health Plan are different from those provided under this (Active) Plan. For instance, there are no dental or vision benefits and the medical, hospitalization and Prescription Drug benefits are more limited than those available under the Active Plan. The premium for Pensioners and Surviving Spouses Health Plan coverage is significantly lower than the Active Plan COBRA rates. Pensioners and Surviving Spouses Health Plan coverage must be elected within 60 days from the loss of eligibility. This coverage will end on the earliest of the following dates:

a) The date on which the Trust Fund ceases to provide health care coverage; or
b) The date on which the Surviving Spouse fails to make a timely premium payment; or
c) The date the Surviving Spouse remarries.

The Spouse may choose coverage EITHER under the Active COBRA Plan OR under the Pensioners & Surviving Spouses Health Plan, but NOT BOTH. In other words, the Spouse may not choose Active COBRA coverage and then later get coverage under the Pensioners & Surviving Spouses Health Plan, or vice versa.

If the Spouse elects to participate in the Pensioners & Surviving Spouses Health Plan, her Dependent children will be entitled to continue coverage under the Active COBRA Plan.

### iii) For more information

For any questions concerning the information in this notice or rights to coverage, please contact the Fund Office.

For more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

# SECTION 8
# SUSPENSION & TERMINATION OF ELIGIBILITY

## A) When Coverage is Suspended

Coverage will be suspended if a Participant works for an Employer that is signatory to a Collective Bargaining Agreement with District Council #16, but has stopped contributing to this Fund and is providing alternate coverage under the terms of its Collective Bargaining Agreement.

The suspension will result in:

i) No additional Employer contributions being credited to the Participant's Eligibility Bank; and
ii) The required applicable deduction from the Participant's Eligibility Bank for every month of such noncontributing employment during which the coverage is suspended; and
iii) The discontinuation of payment for any benefit claims incurred on the date Employer contributions to the Plan cease and the Employer provides alternate coverage.

The coverage will be suspended for as long as a Participant works for this kind of noncontributing Employer.

## B) When Coverage is Terminated

Coverage will terminate on the earliest of the following dates:

i) The last day of the month in which the Participant's Eligibility Bank falls below the Monthly Deduction Amount in effect at the time (see Section 5); or
ii) The last day of the month in which the maximum months allowed for self-payment and/or COBRA Continuation Coverage have been reached; or
iii) The date a self-payment or COBRA payment is not timely made or not made in the amount required; or
iv) The date of the Participant's death; or
v) The date the Participant starts performing work in the plumbing, heating and piping industry that is not pursuant to a United Association Collective Bargaining Agreement (all contributions credited to the Eligibility Bank will be forfeited if eligibility is lost for this reason, and there is no qualifying event under COBRA); or
vi) The date the Participant enters full-time active duty in the Armed Forces, and, if such service is qualifying military service, the Participant does not elect coverage under the Plan (See Section 5); or
vii) The date the Plan terminates.

**Special Rules for Owners and Bargaining Unit Alumni**
Pursuant to the terms of the Collective Bargaining Agreement:

i) Owners are corporate shareholders or corporate officers of a Signatory Employer.

ii) Alumni are people who previously participated in the Fund based on hours worked in Covered Employment, who may still participate in the Fund but who no longer do bargaining unit work.

In addition to the circumstances listed above in (i) through (vii), an Owner performing bargaining unit work loses his/her coverage and forfeits his/her Eligibility Bank if he/she stops performing bargaining unit work, or the Employer's contributions to the Fund become more than 45 days delinquent, unless the Employer goes out of business, or the Owner becomes unemployed and makes himself available for Covered Employment by signing the Local Union's out-of-work list.

In addition to the circumstances listed above, an Owner engaged in the administration of bargaining unit work or an Alumnus loses his/her coverage and forfeits his/her Eligibility Bank if the Employer elects not to continue participation in the Plan or the Employer's contributions to the Fund become more than 45 days delinquent, unless the Employer goes out of business, or the Owner or Alumnus becomes unemployed and makes himself available for Covered Employment by signing the Local Union's out-of-work list.

## C) Subsidized Self-Pay

Under the subsidized self-pay provisions of this Plan, eligible Participants whose coverage under the Plan would otherwise terminate may continue such coverage (excluding Weekly Accident and Sickness Benefits) for up to six consecutive months by self-paying the monthly premium. (After this period, Participants may be eligible to continue coverage under COBRA.) Under the Plan's subsidized self-pay provision, eligible Participants pay only a portion of the actual cost of the coverage, the Plan subsidizes the remainder of the cost.

To keep up with the continually rising cost of health care, the Trustees have determined that it is appropriate to set the monthly subsidized self-payment rate as a percentage of the Full COBRA premium. Eligible Participants who would otherwise lose coverage may remain eligible under the Plan's subsidized self-pay provision by making a monthly premium payment to the Plan equal to 50% of the Full COBRA premium as established and adjusted from time to time by the Trustees. As the COBRA rate is adjusted in the future the self-payment rate will be adjusted to equal 50% of the monthly Full COBRA premium. This means that eligible Participants will continue to pay only a portion of the actual cost for coverage under the Plan's subsidized self-pay provision. See Section 7.

**EXAMPLE**

**Based on the 2011 Full COBRA premium of $821.00, the self-pay rate would be approximately one-half of the COBRA premium which is $410.00 per month.**

If active coverage terminates, coverage may continue under the subsidized self-pay for a maximum period of six consecutive months by making self-payments.

The Participant is not eligible to make subsidized self-payment if he:

i) Has submitted a pension application to the Fund because he/she is retiring; or
ii) Is Totally Disabled and unable to work; or
iii) Is employed.

In order to qualify for this self-payment provision, a Participant must satisfy ALL of the following requirements:

i) Must be available for Covered Employment (i.e. unemployed); and
ii) Must maintain membership in good standing with a Local Union affiliated with District Council #16; and
iii) Must reside within the geographical jurisdiction of District Council #16 unless the Participant is:
   a) Placed on special assignment by the United Association or is employed by a Building and Construction Trades Labor Council in California; or
   b) Is seeking work outside the jurisdiction of District Council #16 and a travel card is taken for this purpose; and
iv) Must make timely and continuous contributions in the amount established for such coverage; and
v) May not be receiving disability benefits; and
vi) May not be in the process of retiring; and
vii) May not be an owner or corporate officer of a Signatory Employer or an Employee covered under a Participation Agreement.

The amount of the subsidized self-pay rate is established periodically by the Trustees.

## D) Extended Coverage for Total Disability

If eligibility terminates while the Participant is 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 Participant only. Statement from attending Physician is required.)

Claims for extensions of eligibility for Total Disability are handled under the same procedures and Limitations as claims for Weekly Accident and Sickness Benefits or Dismemberment Benefits.

Written decisions of the appeals committee on review of denials of claims for extensions of eligibility for Total Disability, Weekly Accident and Sickness Benefits, and Dismemberment Benefits will be ordinarily mailed no more than 45 days after receipt of an appeal. If special circumstances require an extension of time for processing an appeal involving this kind of claim, a decision will be mailed no later than 90 days after receipt of the appeal. The claimant will be notified in writing prior to the

expiration of the 45-day period of the circumstances requiring the extension and the date by which the appeals committee is expected to reach a decision.

# SECTION 9
# PLAN PROVISIONS

## A) Annual Maximum Benefit

The Annual Maximum Benefit (AMB) from the Fund for each Participant and Eligible Dependent is as follows:

- If you have been covered under a Southern California Pipe Trades Health Plan for 12 or fewer months the Plan will pay no more than $100,000 in total benefits in a Calendar Year.
- If you have been covered under a Southern California Pipe Trades Health Plan for more than 12 months, but 24 months or fewer, the Plan will pay no more than $250,000 in total benefits in a Calendar Year.
- If you have been covered under a Southern California Pipe Trades Health Plan for more than 24 months, but 60 months or fewer, the Plan will pay no more than $500,000 in total benefits in a Calendar Year.
- If you have been covered under a Southern California Pipe Trades Health Plan for more than 60 months, but 120 months or fewer, the Plan will pay no more than $1,000,000 in total benefits in a Calendar Year.
- If you have been covered under a Southern California Pipe Trades Health Plan for more than 120 months the Plan will pay no more than $2,000,000 in total benefits in a Calendar Year.

Interruptions in coverage of fewer than 25 months do not affect your AMB. However, if you lose eligibility for more than 24 consecutive months then, when your coverage is reestablished, instead of being considered a new participant (with a $100,000 AMB) your AMB will revert to the next lower AMB in effect before the interruption. For example, if your AMB is $500,000 before a 25-month coverage interruption then, when your coverage is established, your AMB will revert to $250,000, and 12 additional months of coverage will be required to restore your AMB to $500,000.

**EFFECTIVE JANUARY 1, 2014, ANNUAL MAXIMUM BENEFIT LIMITS WILL BE ELIMINATED.**

### Note that:

Any eligibility under this (Active) Plan or the Pensioner and Surviving Spouses Health Plan is combined to determine which Annual Maximum Benefit (AMB) limit applies. It does not matter whether such eligibility is obtained as a result of:

i) Employment; or
ii) Subsidized Self-Payment; or
iii) COBRA; or
iv) USERRA; or
v) Accident and Sickness benefits; or
vi) Pensioner & Surviving Spouses Health Plan self-payment.

If a Participant's eligibility anniversary date occurs in the middle of the Calendar Year entitling him to a higher AMB, the new AMB will be effective for services rendered as of the anniversary date through the end of the Calendar Year, less amount already applied for the previous AMB.

On January 1 of each year, a patient's AMB will reset to zero.

The following types of benefits do not reduce the Annual Maximum Benefit:

i) Dental benefits;
ii) $40 weekly Accident and Sickness Benefit; or
iii) Lump-sum Death Benefits.

## B) Calendar Year Deductible

The Participant and/or Eligible Dependent(s) are responsible for the first $250 in Allowable Charges that are incurred in a Calendar Year. This is called the "Calendar Year Deductible." The Calendar Year Deductible applies separately to the Participant and each Eligible Dependent up to a maximum of $750 per Calendar Year per family.

The Calendar Year Deductible does NOT apply to the:

i) Prescription Drug Benefit - There is a separate $50 Calendar Year Deductible for Prescription Drugs.
ii) Hearing Aid Benefit - There is a separate $50 per device Deductible.
iii) Vision Benefit - There is no Deductible for vision services.

Non-covered charges do not count towards the Deductibles. Charges payable by the Plan, non-covered charges, or the portion of covered charges that the Patient is required to pay above and beyond the Contract Rate or Allowable Charge may not be used to satisfy the Deductible.

# SECTION 10
# BLUE SHIELD OF CALIFORNIA (BSC)

Blue Shield of California (BSC) is a non-profit organization created to provide Patients, participating in its network through a subscribing health plan like the Southern California Pipe Trades Health & Welfare Plan, with an expansive network of doctors, Hospitals and other health care providers and facilities who have agreed to provide services at fixed and generally lower prices. The goal is to provide for the delivery of quality health care services at reasonable costs.

Blue Shield of California is a voluntary program. Participants

and Eligible Dependents may continue to choose any healthcare provider they wish. However, there is a financial advantage to Participants and the Plan if healthcare providers from the Blue Shield of California network are chosen.

## A) How the Blue Shield of California Network Works

When it is necessary to seek medical care, select a provider from the Blue Shield of California directory to receive the maximum benefit under this Plan and at the lowest cost to you. A list of Blue Shield of California Providers can be found at www.blueshieldca.com.

**IMPORTANT**: To verify that the provider of service is participating in the Blue Shield of California program, call the Fund Office at (213) 385-6161 or (800) 595-7473.

**Many emergency room Physicians and anesthesiologists working in a Blue Shield of California Hospital are not part of the Blue Shield of California network. Most emergency room Physicians and anesthesiologists choose not be part of the Blue Shield of California PPO network and other PPO networks. Benefits will be paid according to the Allowable Charges for the non-Blue Shield of California contracting service providers.**

Obtaining services from a Blue Shield of California contracting provider does not guarantee 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.

**When seeking medical care notify the provider's office or staff that benefits are provided through Blue Shield of California for the Southern California Pipe Trades Health and Welfare Fund. If referred to a specialist or to a Hospital, or if laboratory work is needed, remind the doctor that Blue Shield of California providers, laboratories and Hospitals are to be used. The Participant's Out-of-Pocket expense is less than if a non-Blue Shield of California provider is used. It is also a savings for the Trust Fund.**

## B) Allowable Charges/Blue Shield of California Contract Rate

After the Calendar Year Deductible is satisfied, the Plan will pay for any further Medically Necessary care based on either the "Blue Shield of California Contract Rate" or "Allowable Charge," depending on the type of provider selected, as long as the services are certified by the treating Physician or other recognized provider and determined by the Plan to be "Medically Necessary" for the care and treatment of an Injury or Illness.

If providers are part of the Blue Shield of California Contract Network, payment for the covered portion of the claim will be based on the "Blue Shield of California Contract Rate." The Blue Shield of California Contract Rate is the amount the providers have agreed to accept in payment for specific services. The provider cannot charge above the Blue Shield of California Contract Rate. In most cases, but not all, the Plan pays 100% of the Blue Shield of California Contract Rates.

## C) Allowable Charges for Non-Blue Shield of California contracting providers

If the Patient utilized a Non-Blue Shield of California contracting service provider, the Fund's payment of benefits will be based on the Schedule of Allowable Charges. The Plan pays Allowable Charges for most medical and surgical treatment.

Allowable Charges are determined under a schedule of payments established by Blue Shield of California and adopted by the Trustees. These charges may be revised from time to time without notice. Any charges that exceed the Allowable Charge are Out-of-Pocket expenses to the Patient. If you want to know what the Allowable Charge will be before you schedule your treatment, you may contact the Fund Office or Blue Shield and request this information.

**No health care provider is an agent or representative of the Plan or of the Board of Trustees. The Fund does not provide medical services itself, nor does it control or direct the provision of health care services and/or supplies to Plan Participants and Eligible Dependents 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 error-free or that the provider you select is competent to treat your condition. 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 Fund to offer preferred provider networks, or health-related services or supplies to Participants and Eligible Dependents. Nothing in this Plan affects the ability of a provider to disclose alternative treatment options to a Participant or Eligible Dependent.**

## D) Out of Area Programs

Benefits will be provided for Covered Services received outside of California within the United States, Puerto Rico, and U.S. Virgin Islands. The Southern California Pipe Trades Health and Welfare Fund calculates the Participant's Copayment either as a percentage of the Allowable Amount or a dollar Copayment, as defined in this Summary Plan Description When Covered Services are received in another state, the Participant's Copayment will be based on the local Blue Cross and/or Blue Shield plan's arrangement with its providers. See the BlueCard Program section in this Summary Plan Description.

Blue Shield of California has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever you obtain

healthcare services outside of California, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program.

When you access Covered Services outside of California, you may obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Plan"). In some instances, you may obtain care from non-participating healthcare providers. The Southern California Pipe Trades Health and Welfare Fund's payment practices in both instances are described in this Summary Plan Description.

If you cannot locate a participating provider through the BlueCard Program, you will have to pay for the charges for your medical care and submit a claim form to the local Blue Cross and/or Blue Shield plan or to the Southern California Pipe Trades Health and Welfare Fund for payment. The Southern California Pipe Trades Health and Welfare Fund will notify you of its determination within 30 days after receipt of the claim. The Fund will reimburse you at the Non-Preferred Provider Benefit level. Remember, your Copayment is higher when you use a Non-Preferred Provider. You will be responsible for paying the difference between the amount paid by the Fund and the amount billed.

Charges for services which are not covered, and charges by Non-Preferred Providers in excess of the amount covered by the Plan, are the Participant's responsibility and are not included in Copayment calculations.

To receive the maximum benefits of your Plan, please follow the procedure below.

When you require Covered Services while traveling outside of California:

1) Call *BlueCard Access*® at 1-800-810-BLUE (2583) to locate providers that participate with the local Blue Cross and/or Blue Shield plan, or go to www.bcbs.com and select the "Find a Doctor or Hospital" tab; and,
2) Visit the Participating Physician or Hospital and present your membership card.

The Participating Physician or Hospital will verify your eligibility and coverage information by calling *BlueCard Eligibility* at 1-800-676-BLUE. Once verified and after services are provided, a claim is submitted electronically and the Participating Physician or Hospital is paid directly. You may be asked to pay for your applicable Copayment and Plan Deductible at the time you receive the service.

You will receive an Explanation of Benefits which will show your payment responsibility. You are responsible for the Copayment and Plan Deductible amounts shown in the Explanation of Benefits.

Prior authorization is required for all Inpatient Hospital Services and notification is required for Inpatient Emergency Services. Prior authorization is required for selected Inpatient and Outpatient Services, supplies and Durable Medical Equipment. To receive prior authorization from Blue Shield of California, the out-of-area provider should call the Medical Management Pre-Admission number noted on the back of your identification card.

If you need Emergency Services, you should seek immediate care from the nearest medical facility. The benefits of this Plan will be provided for Covered Services received anywhere in the world for emergency care of an Illness or Injury.

### i) Care for Covered Urgent Care and Emergency Services Outside the United States

Benefits will also be provided for covered urgent and emergent services received outside of the United States, Puerto Rico, and U.S. Virgin Islands. If you need urgent care while out of the country, call the BlueCard Worldwide Service Center at either the toll-free BlueCard Access number (1-800-810-2583) or collect (1-804-673-1177), 24 hours a day, seven days a week. In an emergency, go directly to the nearest Hospital. If your coverage requires precertification or prior authorization, you should also call Blue Shield of California at the Medical Management Pre-Admission number noted on the back of your identification card. For inpatient hospital care, contact the BlueCard Worldwide Service Center to arrange cashless access. If cashless access is arranged, you are responsible for the usual Out-of-Pocket expenses (non-covered charges, Deductibles, and Copayments). If cashless access is not arranged, you will have to pay the entire bill for your medical care and submit a claim to the BlueCard Worldwide Service Center.

When you receive services from a Physician, you will have to pay the doctor and then submit a claim.

Before traveling abroad, call the Fund Office for the most current listing of providers worldwide or go online to www.bcbs.com and select "Find a Doctor or Hospital" and "BlueCard Worldwide."

### ii) BlueCard Program

Under the BlueCard® Program, when you obtain Covered Services within the geographic area served by a Host Plan, the Plan will remain responsible for any payment due, excluding the Participant's liability (e.g., Copayment and Plan Deductible amounts shown in the Benefits Summary Plan Description). However the Host Plan is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

The BlueCard Program enables you to obtain Covered Services outside of California, as defined,

from a healthcare provider participating with a Host Plan, where available. The participating healthcare provider will automatically file a claim for the Covered Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the member Copayment and Deductible amounts, if any, as stated in this Summary Plan Description.

Whenever you access Covered Services outside of California and the claim is processed through the BlueCard Program, the amount you pay for Covered Services, if not a flat dollar copayment, is calculated based on the lower of:

1) The billed covered charges for your Covered Services; or
2) The negotiated price that the Host Plan makes available to Blue Shield of California.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Plan pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price the Southern California Pipe Trades Health and Welfare Fund uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Plan to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

Claims for Covered Services are paid based on the Allowable Amount as defined in this Summary Plan Description.

# SECTION 11
# MEDICAL BENEFITS

## A) Inpatient Hospital

### i) Blue Shield of California Hospital

The Plan will pay 95% of the Blue Shield of California Contract Rate for all room and board and Medically Necessary services. The Patient is responsible for the remaining 5% and for 100% of any non-covered services which may include, but are not limited to, such items as guest expenses, telephone charges, drug testing, tests or treatment not related to the diagnosis, and pregnancy testing for dependent children who are Patients. (See Exclusions, Section 17)

### ii) Non-Blue Shield of California Hospital

The Plan will pay 90% of the Allowable Charges for room and board and other Medically Necessary services and supplies up to a maximum of $1,215.00 per day. The Patient is responsible for the balance and for 100% of non-covered services which may include, but are not limited to, such items as guest expenses, telephone charges, pregnancy testing for dependent children, tests or treatment not related to the diagnosis, and drug testing.

Charges for "trauma teams"/"trauma levels" which are charged by a Hospital for standby services are not a covered benefit unless a fully itemized bill indicates which services were actually performed. Having a "trauma team" available does not qualify as a treatment of an Injury or Illness.

Hospital visits for psychiatric care are allowable only when provided by a Physician. Visits by a Licensed Clinical Social Worker, Psychologist, or Master Social Worker are not a covered benefit. Group therapy in the Hospital is not a covered benefit.

**NOTE:**

(1) A fully itemized bill is required from the facility;
(2) A bill listing an "all inclusive" daily rate will not be paid by the Fund;
(3) Outpatient "day care", "½ day care", residential treatment care, etc. are not covered benefits.

The Fund does not cover charges billed as an "all inclusive" daily rate.

## B) Outpatient Treatment for Mental and Nervous Disorders

When a Participant or Eligible Dependent is referred by a Physician to a 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, the Plan will pay either, but not both of the following schedules:

i) Blue Shield of California Contracting Providers -

100% of the Blue Shield of California Contract Rate.

ii) Non-Blue Shield of California Contracting Providers - 100% of the Allowable Charge.

Children under 5 years of age require a referral by their attending Physician for psychiatric care and/or testing.

## C) Outpatient Hospital

The Plan covers expenses that the Participant or Eligible Dependent incurs for Medically Necessary facility services and supplies received in the Outpatient department of a Hospital in connection with:

i) Surgery;
ii) Emergency medical treatment that normally cannot be performed in a Physician's office;
iii) Treatment received within 24 hours of an Accident for bodily injuries sustained in an Accident;
iv) X-ray and/or Laboratory testing ordered by a Physician, subject to all Plan limits payable according to Condensed Schedule of Benefits; or
v) Physical Therapy ordered by a Physician and subject to all Plan limits.

This does not include charges for the use of the facility for a routine Physician visit.

Charges for "trauma teams"/"trauma levels" which are charged by a Hospital for standby services are not a covered benefit unless a fully itemized bill is provided indicating which services were actually performed. Having a "trauma team" available does not qualify as the treatment of an Injury or Illness.

Blue Shield of California Hospital: The Plan will pay 95% of the Blue Shield of California Contract Rate. The Patient is responsible for the remaining 5% of the Blue Shield of California Contract Rate.

Non-Blue Shield of California Hospital: The Plan will pay 90% of Allowable Charges. The Patient is responsible for the remaining balance.

## D) Physician Visits/Professional Services

### i) In the Hospital

If a Participant or Eligible Dependent incurs expenses for any of the services listed below, the Plan will pay 100% of the Blue Shield of California Contract Rate or the Allowable Charge, whichever is applicable, when authorized and performed in a Hospital by a licensed Physician, Podiatrist or Dentist:

a) Physician visits;
b) Surgery;
c) Anesthesia.

The Plan does not cover "standby" charges. These are charges by a Physician who is not providing any care or treatment. Physician standby charges which are not covered include, but are not limited to standby charges for:

a) A pediatrician during caesarean section for the delivery of a baby; or
b) Charges for trauma teams in the emergency room; or
c) A "standby" surgeon or anesthesiologist during a surgical procedure.

### ii) In the Physician's Office

#### a) Blue Shield of California Contracting Physicians

The Plan will pay the percentage of the Blue Shield of California Contract Rate listed below.

| | |
|---|---|
| Physician Visits | 100% |
| Surgery | 100% |
| Anesthesia | 100% |
| Laboratory Tests | 100% |
| X-rays | 100% |
| Injections | 100% |
| Radiation Therapy | 95% |
| Radiation Treatment Therapy | 100% |
| Chemotherapy | 95% |

#### b) Non-Blue Shield of California Contracting Physicians

The Plan will pay the percentage of the non-Blue Shield of California Allowable Charge.

| | |
|---|---|
| Physician Visits | 100% |
| Surgery | 100% |
| Anesthesia | 100% |
| Laboratory Tests | 100% |
| X-rays | 100% |
| Injections | 100% |
| Radiation Therapy | 95% |
| Radiation Treatment Therapy | 100% |
| Chemotherapy | 95% |
| Administration & Infusion | 100% |

The Plan does not cover "standby" charges. These are charges by a Physician who is not providing any care or treatment. Physician standby charges which are not covered include, but are not limited to, standby charges for:

1) A pediatrician during caesarean section for the delivery of a baby; or
2) Charges for trauma teams in the emergency room; or
3) A "standby" surgeon or anesthesiologist during a surgical procedure.

### iii) Physical Examinations

If a Participant or Eligible Dependent incurs any of the expenses listed below while undergoing a

physical examination authorized and performed by a Physician, the Plan will pay the 100% of the Blue Shield of California Contract Rate or Allowable Charge, whichever is applicable. The Plan covers only one routine physical examination per Calendar Year for each Participant or Eligible Spouse. A physical examination includes, but is not limited to:

a) Physician's examination;
b) Urine Analysis (UA);
c) Complete Blood Count (CBC);
d) General Health Blood Panel;
e) Electrocardiogram (EKG);
f) Chest X-ray;
g) Occult Blood;
h) Proctosigmoidoscopy (office only);
i) Prostate Specific Antigen (PSA) - male;
j) Pap Smear; Mammography - Screening - female.

## E) Prescription Drug Coverage

The Prescription Drug benefit will be paid at 100% of the incurred charges that exceed the separate Prescription Drug $50 Calendar Year Deductible. The Plan covers only Prescription Drugs which are lawfully obtained by prescription of a Physician and purchased from a licensed Pharmacy located in the United States. The Plan does not cover Prescription Drugs purchased out of the country unless the eligible Participant submits proof of residency in the country where the services were rendered or in case of an accident or life-threatening emergency.

Prescription Drugs include oral contraceptives for the Participant or an Eligible Dependent or Spouse and up to 30 pills annually for the treatment of erectile dysfunction for the Participant or dependent Spouse. However, the Plan does not provide coverage for birth control of any type or medications or devices for erectile dysfunction for dependent children.

Prescription Drugs dispensed in a Physician's office are not a covered benefit under the Plan.

The $50 Prescription Drug Deductible does not apply to the Calendar Year Deductible.

The $250 Calendar Year Deductible does not apply to the Prescription Drug benefit.

The Plan's maximum Calendar Year Prescription Drug benefit is $1,800 for each Participant and Eligible Dependent.

The Plan will not cover Prescription Drug claims unless a receipt from the licensed Pharmacy is submitted and the receipt includes all of the following information:

i) Name of Patient;
ii) Name of medication;
iii) Date dispensed;
iv) Name, address & phone number of Pharmacy;
v) Name of prescribing Physician;
vi) RX Number;
vii) NDC Number; and
viii) Cost of Prescription Drug.

A printout from a licensed Pharmacy may be substituted for a receipt but it must include all the above and must be signed by a licensed Pharmacist.
Claims for Prescription Drugs purchased on-line that satisfy all of the requirements above will be paid if a copy of the original prescription from the prescribing Physician is provided along with proof of payment or if a printout is signed by a licensed Pharmacist.

**Services, prescriptions, medications, and supplies received outside of the United States and its territories are excluded, unless (1) the services, medications or supplies were the result of an accident or life-threatening Emergency or (2) the Participant or Eligible Dependent submits proof of residency in the country where the services were rendered.**

## F) Chiropractic Care

For chiropractic care provided by a Blue Shield of California provider, the Plan will pay 100% of the Blue Shield of California Contract Rate per visit, 3 visits per week, not to exceed 35 visits per year.

For chiropractic care by a non-Blue Shield of California provider of service, the Plan will pay 100% of the Allowable Charges up to a maximum of $54 per visit, 3 visits per week, not to exceed 35 visits per Calendar Year. The maximum visits of 35 per year can be a combination of Blue Shield of California and non-Blue Shield of California providers. Children under the age of 7 (seven) years require a referral to the Chiropractor by their attending Physician.

## G) Vision Benefits

The Plan will provide up to $200 for charges incurred in a 24-month period for:

i) Examination and fitting; and
ii) Glasses and contact lenses.

**EXAMPLE**
**The Plan paid vision benefits of $200 for expenses incurred on December 17, 2011. No additional benefits will be paid until December 18, 2013.**

Once the Plan pays a benefit for vision care, benefits will not be payable again until 24 months have elapsed from the date benefits were paid.

Benefits are payable only for prescription lenses. There is no benefit for non-prescription glasses or contact lenses.

There is no Deductible for vision benefits.

The Calendar Year Deductible does not apply to the vision benefit.

## H) Allergy Treatment

The Plan will provide up to $75 per vial of antigens, including charges for the injection, payable at 95%, not to exceed a maximum of $900 per Calendar Year. The Plan will pay for up to a 3-month supply of antigen, but will do so no more than four times in any 12-month period. There is no benefit for the administration of the antigen.

The Plan does not provide benefits for food allergy testing.

## I) Hearing Aid Benefit

The Plan will pay 100% of the charge after a separate $50 Deductible per device up to a maximum of $500 per device and not to exceed one device per ear in a 36-month period. Replacements will not be covered until 36 months have elapsed from the date the expense was incurred for the existing device.

**EXAMPLE**

**If a right ear device is dispensed on March 21, 2011, no additional benefits will be allowed until March 22, 2014. If a left ear device dispensed on October 14, 2012, no additional benefits will be allowed until October 15, 2015.**

The $50 per device Deductible does not apply to the Calendar Year Deductible.

The $250 Calendar Year Deductible does not apply to the hearing aid benefit.

## J) Ambulance/Air Ambulance

Charges for professional ground ambulance or air ambulance services deemed Medically Necessary by the Plan will be reimbursed at 80% of the Blue Shield Contract rate or Allowable Charge.

i) The Plan will pay for:
   a) Ground ambulance service to or from a Hospital or Extended Care Facility in connection with a confinement;
   b) Ground ambulance service to the airport and from the airport to the destination medical facility; and
   c) Intrastate or interstate air ambulance service to a medical facility.

ii) The Plan will <u>not</u> pay for:
   a) The use of a ground ambulance or air ambulance due to lack of other transportation or for convenience, such as a Patient's desire to use his/her own Physician, or a Patient's desire to be near home and family; or
   b) The use of a ground ambulance or air ambulance to transfer from a non-contracting Blue Shield of California Hospital to a Blue Shield of California-contracting Hospital; or
   c) Stand-by time charged by any ambulance; or
   d) Chartered aircraft in lieu of air ambulance unless a bona fide air ambulance is not available; or
   e) More than one air ambulance charge per Illness or Injury; or
   f) Transportation from one Hospital to another for tests, x-rays, scans, etc.

## K) Pain Management

The Plan will pay 100% of the Blue Shield of California Contract Rate or the Allowable Charge, whichever is applicable, up to a maximum of $10,000 per Calendar Year for pain management expenses. This includes charges for the Physician and facility. The allowance applies to both Blue Shield of California and non-Blue Shield of California contracting providers. The Patient will be responsible for any charges in excess of the Blue Shield of California Contract Rate or non-Blue Shield of California charges. Please refer to Section 11D(ii) for details.

## L) Outpatient Physical Therapy

This benefit includes occupational therapy for the treatment of a hand injury or disability.

For physical therapy services provided by a Blue Shield of California provider, the Plan will pay 100% of the Blue Shield of California Contract Rate per visit, 3 visits per week, not to exceed 30 visits per Calendar Year.

For physical therapy services provided by a non-Blue Shield of California provider, the Plan will pay 100% of the Allowable Charge up to a maximum of $70 per visit, 3 visits per week, not to exceed 30 visits per Calendar Year.

These benefits for in and out-of-network outpatient physical therapy providers are the same regardless of where the services are rendered.

## M) Outpatient Speech Therapy Benefits

If a Participant or Eligible Dependent, as a result of an Illness or Injury, suffers speech impairment or loss and is referred by a Physician to a qualified speech pathologist, the Plan will pay up to $22.50 per visit and $1,800 per Calendar Year. Speech therapy does not cover developmental or learning problems or disorders.

## N) Outpatient Cardiac Rehabilitation

The Plan will pay $25 per visit, not to exceed $1,200 per Calendar Year for up to three (3) visits per week.

## O) Temporomandibular Joint Dysfunction (TMJ)

The Plan will pay 100% of the charges for all services and supplies (other than Surgery) up to a maximum of $1,200 per Calendar Year, including charges for physiotherapy up to a maximum of $35 per visit.

## P) Hospice

If a Participant or Eligible Dependent has been diagnosed as Terminally Ill and elects, with the approval of a Physician, to be treated by a Hospice Care Program at a Hospice Facility or at home, the Plan will pay 95% of the Blue Shield of California Contract Rate or Allowable

Charges.

Allowable Charges include the charges for a Nurse, registered nurse, nurse practitioner, licensed vocational nurse, skilled practical nurse, social worker, or home health aide.

## Q) Extended Care Facility/Convalescent or Skilled Nursing Facility

If a Participant or Eligible Dependent is confined in an Extended Care Facility for the treatment of an Illness or Injury, the Plan will pay a maximum of $27 per day. Custodial care is not covered under this benefit.

## R) Other Services and Supplies

The Plan will pay 95% of the Blue Shield of California Contract Rate for Blue Shield of California-Contracting providers or 95% of Allowable Charges for non-Blue Shield of California Contracting providers for the items listed below when authorized by a licensed Physician or Podiatrist:

i) Services of a graduate registered nurse through Home Health Care Agency;
ii) Blood and blood plasma, if not replaced;
iii) Surgical dressings, splints, casts, and other devices for the reduction of fractures and dislocations;
iv) Oxygen and rental of equipment for its administration;
v) Rental of wheel chair, hospital bed, and other durable equipment, not to exceed the purchase price of the item. (The Plan will provide benefits for basic equipment, not for upgraded items such as electric wheel chairs, sports wheel chairs, electric scooters, or electric hospital beds);
vi) 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;
vii) Trusses, braces, or crutches; or
viii) Diabetic supplies, including glucose monitors, test strips, and other self-testing supplies, if prescribed by a Physician;
ix) Other Durable Medical Equipment such as:
    a) Insulin Pumps
        1) Benefit limited to Medicare Allowable Charge;
        2) Replacement allowed once every 72 months;
        3) Repairs allowed once every 36 months;
        4) Supplies allowed monthly with a maximum allowable of $160.
    b) C-pap device
        1) Benefit limited to Medicare Allowable Charge;
        2) Replacement allowed no more often than once every six (6) years;
        3) Repairs allowed once every 36 (thirty six months);
        4) Supplies allowed once every 12 months with a maximum of $150.

See Section 17 for Exclusions and Limitations for Durable Medical Equipment.

## S) Dependent Child Special Disability Benefit

If an Eligible Dependent child incurs expenses for disabilities resulting from disease or Accidental injury and the expense is not covered under any other benefit provided by the Plan, the Plan will pay 90% of the Blue Shield of California Contract Rate or the non-Blue Shield of California Allowable Charges up to a maximum of $2,500 per Calendar Year.

i) Corrective Surgery services rendered by a Physician, Physician's assistant or anesthetist acting within the scope of his/her license;
ii) Therapy rendered in an institution, office, home, clinic or academic school;
iii) Prosthetic devices and their repair; and
iv) Corrective shoes, braces or casts and their repair.

Certification by attending Physician must be received each Calendar Year by the Fund Office, as must a letter from the parent requesting the benefit.

The Eligible Dependent Child Special Benefit has the following Limitations:

i) Treatment by corrective Surgery, therapeutic treatment, or need for prosthetic devices or orthopedic supplies must be certified as Medically Necessary by the Physician and approved by the Plan;
ii) Any portion of the charges that exceeds the Blue Shield of California Contract Rate or the non-Blue Shield of California Allowable Charges is not a covered benefit;
iii) Services or supplies furnished by a provider related to the Participant or Dependent by blood or marriage are not covered by the Plan;
iv) Benefits paid will be considered part of the Annual Maximum Benefit;
v) Benefits will not be payable if there would have been no charge for the treatment, service or device in the absence of this coverage; and
vi) This benefit does not provide coverage for Deductibles or Copayments or charges in excess of the Allowable Charge; and
vii) This benefit does not provide coverage for services, care, supplies, etc. that are covered under any other benefit of this Plan.

## T) Transplants

The Plan covers all Medically Necessary transplants for natural organs and organ parts except for Experimental Treatments.

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 benefit payable in connection with any one-organ transplant is $100,000, including any pre-care or follow-up care. This maximum benefit is included in your Annual Maximum Benefit. This benefit includes all pre and post transplant care, including but not limited to, chemotherapy, radiation therapy, laboratory services, x-ray or scans and prescription medication.

Plan benefits are payable to an organ donor at the Blue Shield of California Contract Rate or the non-Blue Shield of California Allowable Charge, whichever is applicable, up to the maximum benefit limit, 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 Blue Shield of California Contract Rate for an organ donor is included in the maximum payable in connection with any-organ transplant of $100,000 and is included in the Pensioner's or Surviving Spouse's Lifetime Maximum Benefit.

### U) Colonoscopy/Sigmoidoscopy

The Plan covers a Screening Colonoscopy or Sigmoidoscopy once every five (5) years for Participants and Eligible Dependents over age 50. The Plan will allow the Blue Shield of California Contract Rate if the services are rendered by Blue Shield of California contracted providers or the Plan's Allowable Charge if non-Blue Shield of California contracting providers are utilized.

### V) Intrauterine Device

The Plan covers benefits for Intrauterine Devices (IUDs) for eligible Participants and Dependents in this (Active) Plan. The Plan will allow the Blue Shield of California Contract Rate if the device is obtained from a Blue Shield of California contracted provider or the Plan's Allowable Charge if a non-Blue Shield of California contracting provider is utilized. The Fund's Exclusions and Limitations apply.

# SECTION 12
# WEEKLY ACCIDENT AND SICKNESS BENEFIT

For each week the Participant is Totally Disabled, and under a Physician's care because of Injury or Illness, a weekly benefit will be paid as shown below. (Benefits will be paid for conditions that occur as a result of Accidents on and off the job.)

The day of disability on which benefits begin is:

| | |
|---|---|
| For an Accident | First day |
| For an Illness | Eighth calendar day |

The amount of the benefit is increased by the amount necessary to cover the Employer's share of the FICA tax and such amount shall then be deducted by the Plan and paid on behalf of the Participant.

A 1099 form will be issued at the end of the year.
Weekly payments for periods of disability that extend from one to seven days will be made at the rate of one-fifth of the weekly benefit (8 dollars per day) for each regular work day of disability.

The benefit is payable for a maximum of 13 weeks per disability. The benefits cannot exceed 13 weeks per Calendar Year for all disabilities.

Successive periods of disability separated by less than two weeks of full-time active employment are considered as one period of disability.

In order to secure proper disability credit in the Fund's records the Participant must periodically submit a disability certification form that has been completed by the Participant's Physician. These forms can be obtained from the Fund Office, at the Local Union and at www.scptac.org.

Participants must be covered under the Active Plan at the time the disability period begins to be eligible for this benefit. No benefit is payable if the Participant is:

i) Self-paying for coverage;
ii) Covered under COBRA;
iii) Retired and using the Active Eligibility Bank;
iv) Covered as a Signatory Employer;
v) Covered under a Participation Agreement; or
vi) Disabled, due to a non-covered Illness or Injury, except in the case of a Workers' Compensation Illness or Injury.

### Crediting of Hours While Totally Disabled

**If a Participant becomes Totally Disabled and is eligible for Weekly Accident and Sickness Benefits his/her Eligibility Bank will be credited at the rate of $26.25 per day up to a maximum of $131.25 per week, but not more than $525 per month or $1,706.25 per year. These amounts will be adjusted proportionally whenever the Health & Welfare contribution rate under the Collective Bargaining Agreement changes and will be effective the first of the second month following the month in which the change is effective.**

**The Participant will be required to refund any amounts paid should the Participant retire retroactively to a date or prior to the date when Accident and Sickness Benefits were received. This will also result in the reduction in health & welfare contributions made through the Accident and Sickness Benefit and the forfeiture of Pension credits earned through the Accident and Sickness Benefit. (See also COBRA Continuation Coverage in Section 7).**

# SECTION 13
# DEATH BENEFITS AND ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS

## A) Death Benefits

If a Participant or Eligible Dependent dies for any reason (including work-related Illness or Injury) while covered under the Plan or within 31 days after termination of eligibility, the Plan will pay a Death Benefit to the designated Beneficiary, or if none, as provided below. Notwithstanding the above, this benefit is not available to individuals who are covered under the Plan under Subsidized Self-Pay or COBRA.

Written notice of death, including a certified copy of the death certificate issued by the appropriate government agency must be submitted to the Fund Office within one year from the date of death, along with a request for death benefits. No death benefits will be paid under this provision unless a request for benefits and all supporting documentation is received by the Fund Office within 12 months of the date of death.

Death benefits for a Dependent are paid to the Participant. Death benefits for a Participant are subject to the following rules:

A Participant may make or change a beneficiary designation at any time by completing and executing, prior to the date of the Participant's or Eligible Dependent's death, a properly completed Enrollment and Beneficiary Form. The beneficiary designation or change in beneficiary designation will take effect when the signed form is received by the Fund. If a Beneficiary has not been designated or if your Beneficiary predeceases you, the Plan will pay benefits to one or more of the following surviving relatives in the following order:

i) Surviving lawful Spouse;
ii) If none, to be divided equally among the surviving child(ren), including legally adopted child(ren);
iii) If none, to the surviving parent(s);
iv) If none, to be divided equally among the surviving sibling(s); or
v) If none, to your estate.

If the Participant names his/her Spouse as Beneficiary and then divorces, the designation is automatically revoked.

If the Participant wishes to keep his/her former Spouse as the Beneficiary after the dissolution of the marriage, a new Enrollment and Beneficiary Form must be filed with the Fund after the date of dissolution.

Forms can be requested by calling the Fund Office or downloaded from www.scptac.org.

Any death benefits payable to a minor may be paid to the legally appointed guardian of the minor, or if there is no such guardian, to the adult(s) who is (are) determined by the Board of Trustees in their sole discretion to have assumed the custody and principal support of such minor.

A Beneficiary may reject the benefits. In that case, the benefits are paid to the remaining designated Beneficiaries, if none, to the appropriate Beneficiary per the above rules, as if the Participant or Eligible Dependent died without a named Beneficiary.

| Death Benefits for the Death of | Amount |
|---|---|
| Participant | $5,000 |
| Eligible Spouse | $2,000 |

| Eligible Dependent Children | Amount |
|---|---|
| Age 14 days but less than 6 months | $200 |
| Age 6 months but less than age 2 | $400 |
| Age 2 years but less than age 3 | $800 |
| Age 3 but less than age 19 | $1,000 |

**No death benefits are payable under COBRA or the Plan's Subsidized Self-Pay coverage.**

## B) Accidental Death or Dismemberment

If the Participant suffers, directly and independently of all other causes, bodily Injury effected solely through external, violent, and accidental means, and as a result dies or is dismembered, within 90 days of the Accident, the Plan will pay the amount of benefits set forth below. Payment will be made only for the loss for which the largest amount is payable. No loss sustained prior to the Accident shall be considered in determining the amount payable for such Accident.

Accidental Death of Participant $5,000

Accidental Death or Dismemberment (Participant only) for loss of:

| | | |
|---|---|---|
| i) | Any one hand, one foot or the sight of one eye | $2,500 |
| ii) | Any two of hands, feet and eyes (in addition to regular Death Benefits) | $5,000 |

Loss of sight means total and irrecoverable loss of sight. Loss of hand means severance of the hand at or above the wrist. Loss of foot means severance of the foot at or above the ankle.

Accidental Death or Dismemberment benefits are not payable to individuals maintaining coverage under the Plan through COBRA or the Plan's Subsidized Self-Pay program.

## C) Accidental Death or Dismemberment Exclusions and Limitations

Accidental Death or Dismemberment Benefits are not payable for any death or dismemberment that results from:

i) Intentionally self-inflicted injury or suicide;

ii) Bacterial infections (except pyogenic infections occurring simultaneously with and in consequence of bodily Injury for which Accidental Death or Dismemberment benefits are payable);
iii) Bodily or mental infirmity, disease of any kind, or as a result of medical or surgical treatment;
iv) Travel in any aircraft as a pilot or crewman or in any aircraft privately owned, operated or leased; or
v) War, whether declared or undeclared, or insurrection.

Accidental Death or Dismemberment benefits are not payable for the death or dismemberment of an Eligible Dependent.

# SECTION 14
# PROCESSING CLAIMS FOR BENEFITS

## A) How to File a Medical, Dental, Prescription or Vision Claim for Payment

In order to receive benefits from the Fund, a written claim form and an itemized billing must be filed by the Patient or provider with the Fund. The Fund's claims procedures must be followed:

Participants and Eligible Dependents may make claims directly to the Fund or by directly authorizing a provider to act on their behalf, subject to the Plan's Limitations on assignment of benefits. Requests for a determination of whether a person is eligible for benefits will not be considered a claim under these procedures. Casual inquiries about benefits or the circumstances under which benefits might be paid and requests for pre-authorizations are also not claims under these procedures.

**How to File a Medical Claim**

**Please have your provider send medical claims to:**

**Blue Shield of California**
**P.O. Box 272540**
**Chico, CA 95927 - 2540**

**How to File a Prescription, Dental, or Vision Claim for Payment**

**Please send prescription, dental, or vision claims to:**

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

Claims must not be submitted by phone, fax or e-mail. Providers may file electronic claims via Electronic Data Interface ("EDI"). Please contact Blue Shield of California for information on how to file electronically. (Please note that EDI does not refer to regular e-mail.) The Provider must submit enough information for the Fund to determine whether or not benefits are payable. For example, the EDI must identify the Patient, describe the specific medical conditions or symptoms, and describe the specific treatment or service for which payment is requested.

All forms required by the Fund must be completed in full before claims can be processed. Failure to provide all the information necessary to processing a claim will result in the delay or denial of benefits.

Claims (itemized billing) submitted for medical, dental, prescription or vision benefits are post-service claims. These claims involve the payment or reimbursement for services that have already been provided. A provider may call Blue Shield of California to ask if a particular procedure is covered by the Plan. This will not be treated as a claim for benefits. In the case of dental benefits, although the Fund encourages calls for clarification of the plan limits to avoid misunderstandings, pre-authorization is not required.

Claims will be considered submitted for payment determination upon receipt via EDI, by mail, or personal delivery. Claims are not accepted, and are not deemed received by the Fund, when made by telephone, fax and e-mail.

Should additional documentation be required, the Patient and provider will be notified in writing as soon as reasonably possible, but no later than 30 calendar days after the Fund receives the claim. If the Fund requests additional information, this information under most circumstances must be provided within 45 days.

Payment for benefits will be delayed or denied if the Plan does not receive the necessary information.

When the Participant or Eligible Dependent incurs medical or dental care, follow these steps for prompt claims processing:

i) Obtain the Plan's claim form from the Fund Office, the Local Union office or online at www.scptac.org. A fully completed Plan claim form is required once every Calendar Year for ongoing claims and for each Accident.

ii) The provider's fully itemized bill must include the following:
   a) Participant's name and the last four digits of the Participant's Social Security Number or Blue Shield ID number;
   b) Patient's name, date of birth and the last four digits of the patient's Social Security Number or Blue Shield ID number;

c) Diagnosis or diagnosis code number (ICDA);
d) Date(s) of service.
e) Procedure codes (CPT or RVS); and
f) Cost of each service.

iii) A prescription claim receipt from a Pharmacy must include the following:
a) Name of Patient;
b) Name of medication;
c) Date dispensed;
d) Name, address & phone number of Pharmacy;
e) Name of prescribing Physician;
f) RX Number;
g) NDC Number; and
h) Cost of medication.

iv) A printout from the Pharmacy must have all the above and must be signed by the pharmacist.

v) Claims for Prescription Drugs purchased on-line which satisfy all of the requirements above will be paid if a copy of the original prescription from the prescribing Physician is provided along with proof of payment or if a printout is signed by a licensed pharmacist.

vi) The Fund may require additional information to process the claim such as:
a) Patient employment status;
b) Information about any other coverage available to the Patient, including any group medical insurance or plan, including health maintenance organization (HMO), preferred provider organization (PPO), independent physician organization (IPO), or point of service (POS), including reduced charges as a professional courtesy or care provided by an Employer at a reduced or zero charge; (i.e. employed by a Hospital or Physician and care received at that facility is at no charge or a reduced rate.)
c) Operative reports;
d) Laboratory results;
e) X-ray results; or
f) Detailed Accident information, including detailed circumstances surrounding tripping, slipping, falling, dog bites, foreign objects (in the eye, ear, etc.), hit by a projectile or by another person, automobile Accidents, bicycle Accidents, food poisoning, any unforeseen or unavoidable occurrence.

Claims for work-related Injuries are not covered. They may include, but are not limited to, burns, exposure to chemicals, strains & sprains of various body parts, back injuries, cuts & abrasions, and hernias.

**Payment will automatically be made to Blue Shield of California contracting providers of service whether or not an assignment of benefits is submitted.**

The Plan must accept "Signature on File" from the provider of service as authorization to pay the provider any benefits due unless proof of payment is provided to the Fund by the Patient. Receipts are not acceptable for claims or payment purposes.

Assignment of benefits are directions from the Patient to pay the provider of service.

The Fund will notify the Participant or Patient of its determination on claims within a reasonable period of time, but no later than 30 calendar days after its receipt of the claim. This period may be extended by one 15-calendar day period, if special circumstances beyond the control of the Fund require that additional time is needed to process the claim. If the Fund requires an extension the Fund will notify the claimant prior to the expiration of the initial 15-day period of the circumstances requiring an extension and the date by which the Fund expects to reach a decision. If the Fund requires an extension because it does not have the required information necessary to decide the claim, the notice will also describe the information needed to make a decision. The specified information must be received within 45 calendar days after receiving the notice. The Fund's time for making the decision will be suspended until the earlier of the date the information is provided, or 45 calendar days after the request for information.

## B) Timely Filing

Claims should be submitted to the Fund within 90 days after the date services were provided. Claims submitted more than 12 months after the date of service will be automatically denied. Any additional information for a previously submitted claim that is received after 12 months from the date of service will not be reviewed. Replies to the Fund's request for information on claims should be submitted within 90 days of the request. Replies submitted more than 12 months from the date of request will not be accepted.

## C) How to File a Claim for Weekly Accident and Sickness Benefits

All claims for Weekly Accident and Sickness Benefits must be filed with the Fund in writing on the forms available from the Fund or the Local Union office. The claim will be considered submitted as soon as a written claim form is received by the Fund. Claims are not accepted via phone, fax or e-mail. Weekly Accident and Sickness Benefit claims cannot be submitted through EDI. (See Section 12)

The Fund will notify the Participant of its decision on a claim for Weekly Accident and Sickness Benefits within a reasonable time, but not later than 45 calendar days from the date of the receipt of the claim. The initial 45-day period may be extended for up to two additional 30 calendar day periods for circumstances beyond the control of the Fund, if the Fund notifies the claimant of an extension prior to the expirations of the initial 45 day and first 30 day extension period, respectively. Any notice of extension will indicate the circumstances requiring an extension, the date by which a decision is expected to be reached, the standards upon which entitlement to a benefit

is based, the unresolved issues that require an extension, and additional information needed to resolve those issues. There are 45 calendar days after receiving an extension notice to provide additional information or complete a claim.

Claims for Weekly Accident and Sickness Benefits that are filed more than 12 months after the date of the Accident or onset of the sickness, or dismemberment will be denied.

### D) How to File a Claim for Death Benefits and Accidental Death or Dismemberment Benefits

All claims for Death Benefits and Accidental Death or Dismemberment Benefits must be filed with the Fund in writing on the forms available from the Fund or Local Union office. The claim will be considered filed as soon as written claim form is received by the Fund. Claims are not accepted via phone, fax or e-mail. Accidental Death or Dismemberment Benefits cannot be submitted through EDI.

The Fund will send notice of its decision on claims for Death Benefits and Accidental Death or Dismemberment Benefits within 90 calendar days from the date of the receipt of the claim. This period may be extended for up to 90 additional calendar days for special circumstances, if the claimant is notified of the extension and the circumstances prior to the expiration of the first 90-day period.

Claims for Death Benefits and Accidental Death or Dismemberment Benefits that are filed more than 12-months after the date of death will be denied.

### E) Notice of Denial of Claim

If a claim for benefits is denied, in whole or in part, the Fund will provide a written notice that (1) states the specific reason(s) for the denial, (2) refers to the specific Plan provisions on which the denial is based, (3) describes any additional material or information that might help the claim, (4) explains why that information is necessary, and (5) describes the Fund's review procedures and applicable time limits, including a right to bring a civil action under Section 502(a) of ERISA.

If an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination the specific rule, guideline, protocol or similar criterion will be provided, or the claimant will receive a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided upon request.

If the adverse determination is based on a Medical Necessity determination or Experimental Treatment or similar Exclusion or Limitation, you will be provided with an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be given free of charge upon request.

# SECTION 15
# COORDINATION OF BENEFITS

### A) General Rules

This Plan has been designed to assist with the cost of medical expenses incurred by Participants and Eligible Dependents. The Plan does not pay more than the Participant or Eligible Dependent pays for any services. Benefits under this Plan will be coordinated with the other coverage the Participant or Eligible Dependents has under any other group benefit or service plan.

For any expense allowable under the Plan, the Participant or Eligible Dependent will receive:

i) The full regular benefit; or
ii) A reduced amount, which, when added to the benefits available under the other Plan, equals 100% of the Blue Shield of California Contract Rate, the non-Blue-Shield of California provider Allowable Charge or the Patient's liability whichever is least; or
iii) If coverage is provided through an Employer that provides care, the lesser of the Plan's regular benefit or the reduced charge (e.g.: employed by a Hospital or Physician and care received at that facility is at no charge or a reduced rate.)

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

i) Group insurance or any other arrangement of coverage for Participants or Eligible Dependents in a group whether or not insured; or
ii) Blue Cross, Blue Shield, Kaiser or any other prepaid medical arrangement; or
iii) Medicare.

### B) Benefit Reduction

If the other plan is a prepaid HMO or PPO plan and if the Patient does not use the Plan's contracted providers for services and supplies that would normally be covered under the plan, the benefits payable under this Plan are reduced to 20% of the or the Blue Shield of California Contract Rate or the non-Blue Shield of California provider Allowable Charges, whichever is applicable.

If an Eligible Spouse could have been covered as an Employee under another plan but declined such coverage, the benefit payable shall be reduced to 20% of the Blue Shield of California Contract Rate or the non-Blue Shield of California provider Allowable Charges, whichever is applicable.

### C) Which Plan Pays First - Coordination of Benefits

Below are several examples of how the Plan's Coordination of Benefit provisions operate.

If husband and wife are both employed and have medical coverage:

i) The plan covering the Patient as an Employee is the primary payer.
ii) The plan covering the Patient as a dependent is the secondary payer.

If Patient is a child whose parents both have medical coverage and are living together:

i) The plan covering the parent whose birthday falls earlier in the year is the primary payer for the child.
ii) The plan covering the parent whose birthday falls later in the year is the secondary payer for the child.

**EXAMPLE**
**Father's date of birth: October 3, 1964**
**Mother's date of birth: April 20, 1965**
**The plan covering the mother of the child is the primary payer. The plan covering the father of the child is the secondary payer.**

If the Patient is a child whose parents both have medical coverage but are not living together:

i) The plan covering the parent with custody is the primary payer for the child.
ii) The plan covering the parent without custody is secondary payer for the child.

If one Spouse is retired and has medical coverage and one Spouse is actively employed and has medical coverage:

i) The plan providing active coverage is primary payer.
ii) The plan providing retiree coverage is secondary payer.

If a Participant is retired and is using his/her Eligibility Bank to maintain coverage under the Active Plan and the Spouse is actively employed with medical coverage:

i) The plan providing coverage for active Employee is the primary payer.
ii) The plan covering the Participant who is using the Eligibility Bank is secondary payer.

If an Eligible Dependent is covered by an HMO or any other managed care or prepaid plan, and if the HMO, managed care, or prepaid plan is primary, and HMO, managed care, or prepaid Plan providers are not utilized, the Plan pays 20% of Allowable Charges or 20% of the Blue Shield of California Contract Rate.

## D) Coordination of Benefits with Medicare

The Social Security Administration currently advises eligible individuals to apply for Medicare 90 days before their 65th birthday. Medicare will then become effective the first of the month in which the individual attains age 65.

## E) Which Plan Pays First - Medicare

Below are some examples of how the Plan's Coordination of Benefits provisions applies with Medicare.

Participant and Spouse both employed with coverage and eligible for Medicare:

i) Plan providing active coverage is the primary payer.
ii) Plan providing dependent coverage is the secondary payer.
iii) Medicare is the third payer.

If the Participant is actively employed with medical coverage and the Spouse is retired with coverage, and both are eligible for Medicare:

i) Plan providing active coverage is the primary payer.
ii) Medicare is secondary for the Eligible Individual;
iii) Plan providing retiree coverage is third.

If the Participant is retired using his/her Eligibility Bank to maintain coverage under the Active Plan and is eligible for Medicare:

i) Medicare is the primary payer.
ii) Plan using Eligibility Bank is the secondary payer.

## F) Medicare Part D

The Medicare Prescription Drug Improvement and Modernization Act of 2003 ("MMA") added a new prescription benefit for Medicare-eligible Participants and Eligible Dependents called Medicare Part D. The Trustees have determined, with the assistance of an actuary, that the Fund's Prescription Drug program for Medicare-eligible active Participants is "actuarially equivalent" to Medicare Part D. This means that, on average, the Fund's benefits are equal to or better than the standard Medicare Part D drug plan and you may forego enrolling in a Medicare Part D Prescription Drug plan, without penalty, as long the Plan's Prescription Drug plan remains actuarially equivalent to Medicare Part D and you remain covered under the Plan.

As required by MMA, each Medicare-eligible Participant or Eligible Dependent will periodically receive a notice, called a Notice of Creditable Coverage, advising whether the Fund's prescription plan continues to be actuarially equivalent to Medicare Part D. Such Participants and Eligible Dependents are also entitled to receive such Notices upon request to the Fund Administrator.

Participants and dependents in this Plan who are Medicare-eligible are not required to sign up for Medicare Part D. Whether or not they enroll in Part D, they will still be eligible for prescription drug benefits from the Fund. The Fund will coordinate benefits with Medicare Part D. The Fund will be the primary payer for Participants or Eligible Dependents who are Medicare eligible, unless the Participant is retired and running out his/her Eligibility Bank (in which case Medicare is primary from the date of retirement.)

**In order to get full benefits under the Plan, the Pensioner must enroll in both Part A and Part B of Medicare before the Participant and his/her Dependent become eligible for Medicare.**

**Medicare is the primary payer of the Pensioners benefits from the date he/she retires, even if he/she is 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 the Pensioner does not enroll in Medicare as soon as he/she is eligible, this Plan will not pay for benefits that Medicare would have paid had he/she been enrolled in Medicare.**

# SECTION 16
# 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 is provided or medical claims paid in connection to any Illness or Injury caused by a third party, and the covered Participant and/or Eligible Dependent recovers from a third party, insurance policy or uninsured motorist coverage, the Participant or Eligible Dependent must reimburse the Plan from the recovered funds for medical claims paid in connection with the Illness or Injury. The Participant or Eligible Dependent must reimburse the Plan from the recovered funds even if the settlement or judgment is less than anticipated and regardless of whether the recovered funds are designated as payment for medical expenses. Upon settlement of the claim or judgment against the third party, insurance company or uninsured motorist coverage, the covered Participant and/or Eligible Dependent will pay the Plan the recovered funds up to the full amount of medical claims paid on his/her behalf in connection with the Illness or Injury caused by the third party.

The Plan has a right to first reimbursement of any recovery from a third party, any insurance policy or any uninsured motorist coverage, even if the covered Participant and/or Eligible Dependents are not otherwise made whole and without regard to how the recovery is categorized. The Plan's right to reimbursement will not be affected, reduced or eliminated by the make whole doctrine, comparative fault or regulatory diligence or the common fund doctrine. Nor shall the Plan's right to reimbursement be reduced by costs or attorney's fees.

By making payments on behalf of the Participant and/or Eligible Dependents, the Plan is granted a lien on such recovery. The Plan shall be entitled to enforce this requirement by way of any remedy permitted by equity. By accepting payments from the Plan the Participant and/or Eligible Dependents consent to the Plan's lien, agree to cooperate with the Plan to effect the Plan's right to reimbursement and agree to hold any recovery for the benefit of the Plan until the Plan is fully reimbursed.

The covered Participant and/or Eligible Dependents must complete and sign an Agreement to Reimburse in such a form as the Plan may require BEFORE any benefits are paid. If the covered Participant and/or Eligible Dependents refuse to sign an Agreement to Reimburse, or any other such agreement the Plan may require, the covered Participant and/or Eligible Dependents shall not be eligible for benefits under the Plan for medical claims related to this Illness or Injury. No Participant and/or Eligible Dependents may assign any rights or cause of action that he/she may have against a third party to recover medical expenses without the express written consent of the Plan. The Participant or Eligible Dependent may be requested to agree to subrogate any claim they may have against a third party in favor of the Plan as a condition of receiving benefits under the Plan, and the Participant or Eligible Dependent, as a condition of receiving benefits, will be required to full cooperate with the Plan to the extent the Plan pursues any subrogated claim.

If the Plan pays benefits on behalf of the covered Participant and/or Eligible Dependent and the covered Participant and/or Eligible Dependent recovers any proceeds from or on behalf of a third party, any insurance policy or from uninsured motorists coverage, and does not reimburse the Plan, the covered Participant and/or Eligible Dependent will be ineligible for future Plan benefit payments until the Plan has withheld an amount equal to the amount which has not been reimbursed.

# SECTION 17
# MEDICAL EXPENSE EXCLUSIONS & LIMITATIONS

Although an attempt has been made to be as complete as reasonably possible, it is not always possible to list every excluded service and procedure. Therefore, when consulting the list of medical Exclusions and Limitations below, you should keep in mind that the Plan will pay only for services and procedures expressly identified in the Plan. A service or procedure not expressly covered by the Plan is excluded and will not be paid.

In addition to the Exclusions and Limitations listed elsewhere in this Summary Plan Description the Plan will not provide benefits for:

1) A claim for service or procedure not expressly covered by the Plan;
2) Services that are not reasonably necessary for the care or treatment of bodily Injuries or Illness as determined by the Fund, except for dental benefits or routine physical examinations expressly covered by the Plan;
3) Any claim for treatment, services and/or supplies that is

not filed within 12 months from the date the expense is incurred (claim for which the Fund has requested, but not received, additional information will not be considered to be "filed" until such information is received by the Fund);

4) Vitamins, including prenatal vitamins (prescription and over the counter);
5) Well Baby Care during Hospital confinement at the time of birth or equivalent period for home birth, such as routine testing, or pediatrician examination in the Hospital;
6) Newborn "cord blood" testing or storage;
7) "Standby" charges (Those charges in which a Physician is present but is not providing care, treatment, or a diagnosis are not a covered benefit. This includes, but is not limited to, anesthesiologist, pediatricians, and trauma teams);
8) Additional charges for "after hours" and weekend services by a Physician;
9) Charges for obtaining, testing and storing the Patient's blood prior to a medical procedure of any kind;
10) Prescription drugs dispensed in a Physician's office;
11) 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 unless the Eligible Participant submits proof of residency in the country where the services were rendered;
12) Nutritional Counseling, regardless of the diagnoses, including but not limited to diabetes, hypertension, obesity and pregnancy;
13) Over-the-counter medications and medical supplies, such as gauze, bandages, shoe inserts, and herbal medicines;
14) Care or treatment or Accident and Sickness benefits for drug addiction, and/or alcoholism or resultant mental conditions;
15) Treatment of infertility, including artificial insemination and in-vitro fertilization, or any charges associated with direct inducement of pregnancy, any testing during and related to the treatment of infertility or related conditions and/or complications of the treatment (but any resulting pregnancy of the Participant or Eligible Dependent Spouse would be covered);
16) Reversal or attempted reversal of an elective sterilization procedure;
17) Tissue testing for infertility;
18) Genetic screening/testing or chromosome analysis for any reason and/or diagnosis, including a family history of a disease or condition;
19) Family planning (except Prescription Drug benefit for birth control pills for Participant or Eligible Dependent Spouse only);
20) Care or treatment for pregnancy or related conditions and/or complications for anyone other than the Participant or Eligible Dependent Spouse;
21) Any charges or medical claims for which a third party may be liable or legally responsible;
22) Any services or procedures that are Experimental Treatments or investigational in nature or are not within the standards of generally accepted medical practice. Medical services or supplies, including Prescription Drugs, considered educational, investigational, or experimental. A drug, device or medical treatment or procedure is considered experimental or investigational if:
    a) It is a drug or device that cannot be lawfully marketed without approval of the U. S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
    b) Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
    c) Reliable evidence shows that the consensus of opinion among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis. For this purpose, reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.
23) Radial keratotomy and any other type of refractive eye surgery, (e.g. laser or Lasik Surgery), regardless of the diagnosis;
24) Expenses for travel or transportation, except as provided under ambulance benefits;
25) Any Illness, Injury or disability covered by any Workers' Compensation laws except as provided under the Weekly Accident and Sickness Benefits;
26) Replacement of Durable Medical Equipment within 36 months not to exceed $150 annually for repair or replacement, including prosthetics;
27) Cosmetic Surgery, except for conditions resulting from Accidental Injury, functional disorder or congenital malformation (It is suggested but not required that the eligible individual's Physician submit the proposed procedure to the Fund prior to the procedure to determine if benefits are available under the Plan);
28) Hospital or Extended Care Facility charges for personal items such as charges for radio, television, telephone, guest expenses and other similar items;
29) Housekeeping services;
30) Custodial Care, companion care, day care, (e.g. cooking, feeding, dressing, bathing, changing dressings);
31) Care by homeopathic practitioners, naturopathic practitioners (NP), acupuncturist, and medical doctors licensed in the Orient (OMD);
32) Charges for phone consultations (e.g. reading of EKG's or fetal monitoring over the phone);
33) Charges for missed or broken appointments;
34) Charges for completion of forms;
35) Interest on unpaid balance(s);
36) Any charges paid for or payable by another group benefit, service plan, or insurance;
37) Blood pressure monitors, thermometers, vaporizers;
38) Charges for personal comfort, beautification, or

convenience items or services;
39) Services by a provider related to the Participant or Dependent by blood or marriage;
40) Occupational Therapy (except for the treatment of a hand injury or disability);
41) Any service associated with sex transformations and/or resulting complications;
42) Conditions caused by an act of war, armed invasion, aggression, insurrections;
43) 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;
44) Care or treatment in any penal institution;
45) Dental examinations or treatment, except as specifically provided. (See Dental Exclusions in Section 18);
46) EMS (Emergency Medical Service) with no transport, except as stated under the Ambulance Benefit;
47) Physical therapy by any person other than a Registered Physical Therapist or a Registered Physical Therapist assistant under the supervision of a Registered Physical Therapist;
48) Care or treatment obtained in a federal or state facility, or a facility operated by a government agency for which the Participant is not required to pay except to the extent benefits are required by law to be paid by the Plan;
49) Charges for 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;
50) Weight control, such as surgical procedures, diet management, medications, exercise programs, or nutritional training; regardless of any medical condition, related or otherwise;
51) Any goal-oriented behavior modification therapy, such as smoking cessation, alcohol/drug addiction, or weight loss;
52) Exercise equipment, tanning booths, whirlpools, swimming pools, saunas, spas, massage therapy or gym membership, aquatic exercises;
53) Food allergy testing regardless of diagnosis;
54) Certain types of Durable Medical Equipment such as cervical traction units, cervical collars, TENS units, hot/cold therapeutic devices, bone growth stimulators, canes, bionicare knee device, over the counter humidifiers and nasal pillows;
55) Mental health day care centers, ½ day confinements for mental and nervous conditions, residential facilities;
56) Charges by financial institutions for the deposit or cashing of a previously "stop paid" or "outdated" check;
57) Pain infusion pumps for postoperative pain management; and
58) Any surgical procedure to reduce weight regardless of any underlying medical conditions that are exacerbated by the weight (Example: Hypertension, diabetes, arthritis, etc.)

**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 Eligible Dependents 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 Eligible Dependents. Nothing in this Plan affects the ability of a provider to disclose alternative treatment options to a Participant or Eligible Dependent.**

# SECTION 18
# DENTAL BENEFITS

## A) Benefits and Terms

The Plan will pay 100% of the Allowable Charge, as explained in the Schedule of Dental Benefits in Section 22 for dental expenses incurred up to a maximum payment of $1,800 per person per Calendar Year.

It is recommended that a request for predetermination of dental benefits be submitted to the Fund Office for dental care in excess of $300. This will provide both the Patient and the Dentist with the approximate amount payable prior to the services being performed. Although this is recommended, there is no penalty for failing to request a predetermination.

A predetermination is not a guarantee of payment and all payments are subject to all Plan Rules and Limitations on the date of service.

## B) Diagnostic

### i) Diagnostic Procedures

The following procedures to assist the Dentist in evaluating the existing conditions to determine the required dental treatment are covered.

a) An oral examination (once every 6 months);
b) Full mouth series of X-rays (once every 12 months) unless required more often for specific diagnostic reasons. The maximum allowable for X-rays, in one day, will not exceed the allowable amount for a full mouth series. Benefits for digital photos and/or oral images will be allowed in lieu of x-rays and subject to the same Limitations.

### ii) Preventive

The following procedures include cleaning, topical application of fluoride solutions and space maintainers are covered preventative services.

a) Prophylaxis (cleaning) [three (3) times per Calendar year];
b) Fluoride application (once every 12 months for Eligible Dependents children to age 14); and
c) Sealants (once, per lifetime, for Eligible Dependents children to age 14). The benefit is payable per quadrant.

### iii) Oral Surgery

Extractions and other oral Surgery including pre- and postoperative care are covered as expenses of oral Surgery.

### iv) General Anesthesia

General anesthesia is a covered expense when administered for a covered oral surgical procedure performed by a Dentist or oral surgeon.

### v) Restorative Dentistry

Restoration of decayed, diseased or damaged natural teeth to a satisfactory state of health, function and aesthetics are covered services of restorative dentistry.

This includes:
a) Amalgams;
b) Synthetic porcelain;
c) Plastic and/or bonded composite resin; and
d) Benefits for the use of gold restorations, crowns, and jackets are provided when teeth cannot be restored with the above materials.

### vi) Periodontics

Procedures for the treatment of diseases of the tissues supporting the teeth are covered by the Plan.

This includes:
a) Root canal (Osseous Surgery);
b) Root planning or scaling; and
c) Bone replacement.

### vii)Prosthodontics

Artificial replacement of missing natural teeth is a covered service. This includes bridges and partial and complete dentures.

Prosthetic appliances will be replaced only if the existing appliance is unsatisfactory and cannot be made satisfactory. If the Plan paid a benefit for the existing appliance, replacement will not be covered until 36 months have elapsed from the date the expense was incurred for the existing appliance.

### viii)Orthodontics

The Plan covers procedures associated with straightening and realigning teeth as follows:

a) Benefits are limited to $600 maximum per Calendar Year;
b) $1,800 Lifetime Maximum Benefit;
c) The $600 Calendar Year Benefit is included in the Dental Calendar Maximum of $1,800;
d) Space maintainers are covered one time per tooth.

Billings for orthodontia must include the date of service and charge for each service. Monthly billings with no date of service are not acceptable.

### ix) Extended Benefits

In the event of termination of eligibility, dental benefits will be payable provided the work is within 90 days for the completion of any dental work that is in progress at the time of loss of eligibility.

## C) Dental Limitations

In addition to the Limitations listed elsewhere in this Summary Plan Description the following Limitations apply for Dental Benefits:

1) Instruction in oral hygiene and "plaque control" (prevention programs) are included in the preventive benefit (there is no separate allowance);
2) Subgingival curettage (extensive cleaning) and prophylaxis (cleaning) are not payable on the same day;
3) Bitewing X-rays series including periapical anterior films is a covered benefit only once in a 12-month period;
4) Correction of occlusion is considered a part of completed removable and fixed prosthodontics and multiple restorations involving occlusal surfaces;
5) Relines are allowable six months after initial placement of dentures and once each year thereafter;
6) Permanent crowns are allowed for Patients age 14 & over;
7) Stainless crowns are allowed to age 14 only;
8) Routine post-operative visits are considered part of, and included in, the fee for the total surgical procedure;
9) The following are covered only once in any 36 months period:
   a) Jackets, crowns;
   b) Inlays, onlays;
   c) Fixed bridges; and
   d) Partial and complete dentures;
10) Benefits for crowns, inlays, and onlays are allowable only where extensive coronal destruction is radiographically evident or can be demonstrated, and the tooth is beyond restoration with amalgam or composite resin (anterior teeth);
11) Amalgam or composite resin build-ups, including pins, are considered part of the preparation for the completed restoration and are not allowed separately;
12) Root planning is allowable only when need can be demonstrated radiographically;
13) Composite resin restoration in not covered for lingual or occlusal surface (However, payment will be made as if amalgam restoration were done);

14) Fixed prosthesis are not a covered benefit where a large number of teeth are missing in the same arch;
15) Generalized and/or untreated radiographically evident periodontal disease is reason for delay or denial of fixed prosthesis;
16) Osseous Surgery is allowed only when root planning was performed at least one year prior to the proposed Surgery;
17) Optional Treatment;
    a) The allowance for a gold inlay is paid only when a gold inlay is required to restore a tooth to proper contour. In all other cases when a gold inlay is used, the maximum allowance for amalgam, silicate or plastic filling will be paid;
    b) If there are optional methods of treatment, the allowance for the least expensive procedure will be paid;
18) Hospital services for dental procedures must be Medically Necessary and authorized by the attending Physician whereupon the maximum allowable for approved hospital care is $2,500 payable at 90% or 95% (payable under the medical benefit provisions of the Plan);
19) Night guard once every 36 months; and
20) Intravenous sedation allowed up to age 14.

### D) Dental Exclusions

In addition to the Exclusions listed elsewhere in this Summary Plan Description the Plan will not provide benefits for:

1) Specialized techniques (e.g., precision attachments for partials, personalization and characterizations);
2) Debridement;
3) Stress breakers;
4) Precision attachments for partials and appliances associated therewith;
5) Personalization and characterization;
6) Experimental Treatments;
7) Surgical correction by grafts for denture retention purposes;
8) Appliances or restorations to increase vertical dimension;
9) Gnathologic recording (for removable or fixed prosthesis);
10) Procedures associated with overlays (over dentures) and implants (e.g., denture placed over an existing tooth);
11) Splinting of teeth for periodontal support;
12) Porcelain veneers;
13) The replacement of alloy or composite restorations within 12 months;
14) Implants;
15) Oral evaluations (e.g., hygiene instructions, brushing techniques or flossing instructions);
16) Dietary planning for the control of dental caries (cavities);
17) Dental services performed solely for cosmetic reasons;
18) Bonding and/or bleaching;
19) Distal cantilever bridges;
20) Intravenous sedation allowed up to age 14;
21) Replacement retainers, regardless of the reason; and
22) Gingivectomy in conjunction with crown preparation.

# SECTION 19
# APPEALS PROCEDURE

### A) Right to Appeals Committee Review of Denied Claims

If a claim for benefits is denied, in whole or in part, a request may be made to the Appeals Committee of the Board of Trustees to review the benefit denial. All appeals must be in writing and must be received by the Fund within 180 calendar days after the claim denial notice is received from the Fund. Failure to file a timely written appeal shall constitute a complete waiver of the right to appeal, and the decision of the Fund will final and binding.

In presenting the appeal, the claimant has the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits. The claimant is also entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Personal appearances on appeals are at the discretion of the Appeals Committee of the Trustees.

The written appeal should state the specific reasons why the claimant believes the denial of the claim was in error. All documents or records that support the claim should be submitted with the appeal. This does not mean that the claimant is required to cite all of the Plan provisions that apply or to make "legal" arguments; however, the appeal should state clearly why the claimant believes they are entitled to the benefits being claimed. The Appeals Committee can best consider the claimant's position if it clearly understands the claims, reasons or objections. The review by the appeals committee will take into account all comments, documents, records, and other information that you submit, without regard to whether such information was submitted to or considered by the Fund in its determination. The Appeals Committee will also not afford deference to the initial determination by the Fund.

In deciding an appeal of a Fund determination that was based, in whole or in part, on a medical judgment (including determinations about whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate), the Appeals Committee will, when appropriate, consult with a health care professional who has appropriate training and expertise in the particular field of medicine, and who was not consulted by the Fund in connection with its determination. The claimant will also be provided with the identity of any medical or vocational experts whose advice was obtained at any level of the claims and appeals process without regard to whether that advice was relied on.

The following special rules apply to claims for extensions of eligibility for Total Disability, Weekly Accident and Sickness Benefits, and Death or Dismemberment Benefits. Written decisions of the appeals committee on review of denials of these claims benefits will be ordinarily mailed no more than 45 days after receipt of an appeal. If special circumstances require an extension of time for processing an appeal involving this kind of claim, a decision will be mailed no later than 90 days after receipt of the appeal. The claimant will be notified in writing prior to the expiration of the 45-day period of the circumstances requiring the extension and the date by which the appeals committee is expected to reach a decision.

## B) Timing of Appeals Committee Decisions

The Appeals Committee will meet at least once each quarter to review pending appeals. The decision of the Appeals Committee will be made by the meeting immediately following the date the appeal is received by the Fund. If the appeal is received during the 30 days preceding the meeting, the decision will not be made until the second meeting following receipt of the appeal. The time for processing an appeal may be extended in special circumstances by written notice to the claimant prior to the beginning of the extension. Such an extension may only last until the third meeting following receipt of the appeal.

Written notice of the decision of the Appeals Committee will be sent within five days from the date of the meeting at which the appeal was reviewed.

## C) Notice of Appeals Committee Decision

If the appeal is denied, in whole or in part, the written decision of the Appeals Committee will set forth: the specific reason(s) for the denial; the specific Plan provisions on which the denial is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to his/her claim; and a statement of his/her right to bring a civil action under Section 502(a) of ERISA.

If an internal rule, guideline, protocol or similar criterion was relied on in making the adverse determination, the claimant will be provided with the specific rule, guideline, protocol or similar criterion, or will receive a statement that such a rule, guideline, protocol or similar criterion was relied on in making the adverse determination, and a copy of such rule, guideline, protocol or other criterion will be provided to the claimant upon request.

If the decision is based on a Medical Necessity determination or Experimental Treatment or similar Exclusions or Limitation, the claimant will be provided with an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the medical circumstances or a statement that such explanation will be provided free of charge upon request.

## D) Appeals Committee Decisions are Final and Binding

The decision of the Appeals Committee on review is final and binding on all parties, including anyone claiming a benefit on your behalf. As a committee of the Trustees, the Appeals Committee has full discretion and authority to determine all matters relating to the benefits provided under this Plan including, but not limited to, all questions of coverage, eligibility, and methods of providing or arranging for benefits. As a committee of the Trustees, the Appeals Committee also has 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. The Board of Trustees has delegated its authority to make final decisions on appeals to the Appeals Committee. To the extent the Board of Trustees does not delegate this authority for an appeal(s), the Board of Trustees will be substituted for the Appeals Committee in this appeal procedure and will have the full discretion in deciding an appeal as set forth in this paragraph.

If the Appeals Committee denies the appeal, and the claimant decides to seek judicial review, the Appeals Committees' decision will be subject to limited judicial review to determine only whether the decision was arbitrary and capricious. No lawsuit may be brought without first exhausting the above claims and appeals procedure. Nor may any evidence be used in court unless it was first submitted to the Appeals Committee prior to the decision on appeal. No legal action may be commenced or maintained against the Trust, the Plan, or the Trustees more than two years after the claim has been denied.

## E) Right to Authorized Representative

In making a claim or appeal, the claimant may be represented by any authorized representative. If the representative is not an attorney or court appointed guardian, the claimant must designate the representative by a signed written statement. A parent of a minor child is assumed to be the authorized representative of the child for purposes of filing a claim for benefits or appealing a denial of a claim.

## F) Other Appeals

The recipient of any other written correspondence from the Fund that could be interpreted as adversely affecting the recipient's interest may appeal to the Appeals Committee for a determination or review of that correspondence. Such a request for review must be in writing and must be made within 180 days of receipt of the correspondence from the Fund. Such appeals will be processed in the same manner as appeals for claims for benefits.

# SECTION 20
# FEDERAL LAWS

## A) Health Insurance Portability and Accountability Act of 1996 (HIPAA)

### i) Creditable Coverage

When coverage ends the Participant and/or Eligible Dependents will receive a Certificate of Group Health Plan Coverage from the Fund. The Certificate of Group Health Plan Coverage indicates the period of time the Participant and/or Eligible Dependent(s) were covered under the Plan (including, if applicable, any COBRA coverage period), as well as certain additional information required by law.

The Certificate is an important document for Participants and/or Eligible Dependents who become eligible for coverage under another group health plan, or if the Participant buys a health insurance policy for himself/herself or his/her family within 63 days after coverage under this Plan ends. For example, the Certificate may reduce any Exclusion period for pre-existing conditions that may apply to the Participant and/or any Eligible Dependent(s) under the new group health plan or health insurance policy.

The Certificate will be provided shortly after this Plan knows, or has reason to know, that coverage (including COBRA coverage) for the Participant and/or Eligible Dependent(s) has ended. A duplicate Certificate will be provided upon request, provided that the Fund receives the request within two years after the later of the date coverage under this Plan ended or the date COBRA coverage ended. Please address all requests for Certificate of Group Health Plan Coverage to the Fund. The Certificate will be sent to the Participant or to any Eligible Dependent(s) by first class mail shortly after coverage under this Plan ends. If the Participant (or any Eligible Dependent(s)) elects COBRA coverage, another Certificate will be sent by first class mail shortly after the COBRA coverage ends for any reason.

### ii) Protected Health Information

In 2003, the U.S. Department of Health & Human Services (DHHS) issued the Standards for the Privacy of Individually Identifiable Health Information ("Privacy Rules"). Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, these rules give you greater control over who may have access to the information in your medical records. Health plans, such as this Plan, cannot share Protected Health Information ("PHI") under many circumstances without written authorization.

### iii) Use or Disclosure of PHI

The Fund may use or disclose your PHI for treatment, payment or health care operations without your written authorization:

a) Payment generally means the activities of a Fund to collect premiums, to fulfill its coverage responsibilities, and to provide benefits under the Plan, and to obtain or provide reimbursement for the provision of health care. Payment may include, but is not limited to, the following: determining coverage and benefits under the Plan, paying for or obtaining reimbursement for health care, adjudicating subrogation of health care claims or coordination of benefits, billing and collection, making claims for stop-loss insurance, determining Medical Necessity and performing utilization review. For example, the Fund will disclose the minimum necessary PHI to medical service providers for the purposes of payment.

b) Health Care Operations are certain administrative, financial, legal, and quality improvement activities of the Fund that are necessary to run its business and to support the core functions of treatment and payment. For example, the Fund may disclose the minimum necessary PHI to the Fund's attorney, auditor, actuary, and consultant(s) when these professionals perform services for the Fund that requires them to use PHI. Persons who perform services for the Fund are called "business associates." Federal law requires the Fund to have written contracts with its business associates before it shares PHI with them, and the disclosure of your PHI must be consistent with the Fund's contract with them. Other examples of business associates are the Fund's stop-loss insurance carrier, claims repricing services, utilization review companies, prescription benefit managers, PPOs and HMOs.

c) Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a Patient; or the referral of a Patient for health care from one health care provider to another. The Fund is not typically involved in treatment activities.

The Fund is permitted or required to use or disclose your PHI without your written authorization for the following purposes and in the following circumstances, as limited by law:

a) The Fund will use or disclose your PHI to the extent it is required by law to do so.
b) The Fund may disclose your PHI to a public health authority for certain public health activities, such as: (1) reporting of a disease or injury, or births and deaths, (2) conducting public health surveillance, investigations, or interventions; (3) reporting known or suspected child abuse or neglect; (4) ensuring the quality,

safety or effectiveness of an FDA-regulated product or activity; (5) notifying a person who is at risk of contracting or spreading a disease; and (6) notifying an Employer about a member of its workforce, for the purpose of workplace medical surveillance or the evaluation of work-related Illness and Injuries, but only to the extent the Employer needs that information to comply with the Occupational Safety and Health Administration (OSHA), the Mine Safety and Health Administration (MSHA), or State law requirements having a similar purpose.

c) The Fund may disclose your PHI to the appropriate government authority if the Fund reasonably believes that you are a victim of abuse, neglect or domestic violence.

d) The Fund may disclose your PHI to a health oversight agency for oversight activities authorized by law, including: (1) audits; (2) civil, administrative, or criminal investigations; (3) inspections; (4) licensure or disciplinary actions; (5) civil, administrative, or criminal proceedings or actions; and (6) other activities.

e) The Fund may disclose your PHI in the course of any judicial or administrative proceeding in response to an order by a court or administrative tribunal, or in response to a subpoena, discovery request, or other lawful process.

f) The Fund may disclose your PHI for a law enforcement purpose to law enforcement officials. Such purposes include disclosures required by law, or in compliance with a court order or subpoena, grand jury subpoena, or administrative request.

g) The Fund may disclose your PHI in response to a law enforcement official's request, for the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

h) The Fund may disclose your PHI if you are the victim of a crime and you agree to the disclosure or, if the Fund is unable to obtain your consent because of incapacity or emergency, and law enforcement demonstrates a need for the disclosure and/or the Fund determines in its professional judgment that such disclosure is in your best interest.

i) The Fund may disclose your PHI to law enforcement officials to inform them of your death, if the Fund believes your death may have resulted from criminal conduct.

j) The Fund may disclose PHI to law enforcement officials that it believes is evidence that a crime occurred on the premises of the Fund.

k) The Fund may disclose your PHI to a coroner or medical examiner for identification purposes. The Fund may disclose your PHI to a funeral director to carry out his/her duties upon your death or before and in reasonable anticipation of your death.

l) The Fund may disclose your PHI to organ procurement organizations for cadaveric organ, eye, or tissue donation purposes.

m) The Fund may use or disclose your PHI for research purposes, if the Fund obtains one of the following: (1) documented institutional review board or privacy board approval; (2) representations from the researcher that the use or disclosure is being used solely for preparatory research purposes; (3) representations from the researcher that the use or disclosure is solely for research on the PHI of decedents; or (4) an agreement to exclude specific information identifying the individual.

n) The Fund may use or disclose your PHI to avoid a serious threat to the health or safety to you or others.

o) The Fund may disclose your PHI if you are in the Military Service and your PHI is needed by military command authorities. The Fund may also disclose your PHI for the conduct of national security and intelligence activities.

p) The Fund may disclose your PHI to a correctional institution where you are being held.

q) The Fund may disclose your PHI in emergencies or after you provide verbal consent under certain circumstances.

r) The Fund may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

The Fund may use or disclose your PHI to you, to your Personal Representative, to a third party (such as your Spouse) pursuant to an Authorization Form, and to the Board of Trustees of the Fund but only for the purposes and to the extent specified in the Plan:

a) The Fund will provide you with access to your PHI. The Fund will generally require you to complete and execute a "Request for Protected Health Information Form" and will provide you with access to PHI consistent with the Request Form, or as otherwise required by law.

b) The Fund may provide your Personal Representative or Attorney with access to your PHI in the same manner as it would provide you with access, but only upon receipt of documentation demonstrating that your Personal Representative or Attorney has authority under applicable law to act on your behalf.

c) Unless otherwise permitted by law, the Fund will not use or disclose your PHI to someone other than you unless you sign and execute an "Authorization Form." You can revoke an Authorization Form at any time by submitting a "Cancellation of Authorization Form" to the Fund. The Cancellation of Authorization Form revokes the Authorization Form on the date it is received by the Fund.

d) The Fund will disclose your PHI to the Fund's Board of Trustees only in accordance with the provisions of the Fund's Privacy Policy and the provisions of the Plan.

### iv) Individual Rights

You have certain important rights with respect to your PHI. You should contact the Fund's Privacy Officer to exercise these rights.

a) You have a right to request that the Fund restrict use or disclosure of your PHI to carry out payment or health care operations. The Fund is not required to agree to a requested restriction.
b) You have a right to receive confidential communications about your PHI from the Fund by alternative means or at alternative locations, if you submit a written request to the Fund in which you clearly state that the disclosure of all or part of that information could endanger you.
c) You have a right of access to inspect and copy your PHI that is maintained by the Fund in a "designated record set." A "designated record set" consists of records or other information containing your PHI that is maintained, collected, used, or disseminated by or for the Fund in connection with: (1) enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for the Fund, or (2) decisions that the Fund makes about you.
d) You have a right to amend your PHI that was created by the Fund and that is maintained by the Fund in a designated record set, if you submit a written request to the Fund in which you provide reasons for the amendment.
e) You have a right to receive an accounting of disclosures of your PHI, with certain exceptions, if you submit a written request to the Fund. The Fund need not account for disclosures that were made more than six years before the date on which you submit your request, nor any disclosures that were made for treatment, payment or health care operations.

### v) Duties of the Fund

The Fund has the following obligations:

a) The Fund is required by law to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices with respect to PHI. To obtain a copy of the Fund's entire Privacy Policy, you should contact the Fund's Privacy Officer.
b) The Fund is required to abide by the terms of the Notice that is currently in effect.
c) The Fund will provide a paper copy of the Notice that is currently in effect to you upon request.

### vi) Changes to Notice

The Fund reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI it maintains, regardless of whether the PHI was created or received by the Fund prior to issuing the revised notice.

Whenever there is a material change to the Fund's uses and disclosures of PHI, individual rights, the duties of the Fund, or other privacy practices stated in this Notice, the Fund will promptly revise and distribute the new notice to Participants and Beneficiaries.

### vii) Contacts and Complaints

If you believe your privacy rights have been violated, you may file a written complaint with the Fund's Privacy Officer at the following address:

Attn: Privacy Officer
Southern California Pipe Trades
Health & Welfare Fund
501 Shatto Place, 5th Floor
Los Angeles, CA 90020
(800) 595-7473
(213) 385-6161

You may also file a complaint with the U.S. Secretary of Health and Human Services in Washington, DC. The Fund will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any person for filing a complaint.

### viii) For More Information About Privacy

If you want more information about the Fund's policies and procedures regarding privacy of your medical and other personal information, contact the Fund's Privacy Officer at the address above.

## B) Family and Medical Leave Act (FMLA)

The Employer, not the Fund, must continue to pay for health coverage during any approved leave under the federal Family and Medical Leave Act (FMLA). In general, the Employee may qualify for up to 12 weeks of unpaid FMLA leave per year if:

i) The Employer has at least 50 Employees working within a 75 mile radius; and
ii) The Employee worked for the Employer for at least 12 months and for a total of at least 1,250 hours during the most recent 12 months; and
iii) The leave is required for one of the following reasons:
    a) Birth or placement of a child for adoption or foster care,
    b) To care for the Participant's child, Spouse or parent with a serious health condition, or
    c) The Participant's own serious health condition.

Details concerning FMLA leave are available from the Employer. Requests for FMLA leave must be directed to the Employer; the Fund cannot determine whether or not the Participant qualifies. If a dispute arises between the Participant and the Employer concerning eligibility for FMLA leave, health coverage may continue by making COBRA self-payments. If the dispute is resolved in the Participant's favor, the Plan will obtain the FMLA - required contributions from the Employer and will refund the corresponding COBRA payments to the Participant. If the Employer continues coverage during an FMLA

leave and the Participant fails to return to work, the Participant may be required to repay the Employer for all contributions paid to the Plan for coverage during the leave.

### C) Women's Health

#### i) Pregnancy

The Plan will pay benefits for the Participant's pregnancy (or Spouse's pregnancy) on the same basis as an Illness or Injury. The Plan does not pay benefits for pregnancy, pregnancy related conditions, or complications for Eligible Dependent daughters.

Under the Newborns' and Mothers' Health Protection Act of 1996, a federal law, the length of stay in a Hospital for mothers and newborns may not be restricted to less than:

a) 48 hours following vaginal deliveries; or
b) 96 hours following cesarean section deliveries.

The mother's Physician or the newborn's Physician may, after consulting with the mother, discharge the mother or her newborn earlier than 48 hours or 96 hours after childbirth, whichever is applicable. Neither you nor your Physician is required to obtain preauthorization for a Hospital stay in connection with childbirth that is not greater than 48 hours (or 96 hours for cesarean section) after childbirth.

#### ii) Women's Health and Cancer Rights

The Plan complies with the Women's Health and Cancer Rights Act of 1998. The Plan will provide coverage to you or your Eligible Dependent for Medically Necessary mastectomies for cancer treatment.

The Plan also provides benefits for the following procedures:

a) Reconstruction of the breast on which the mastectomy was performed;
b) Surgery and reconstruction of the other breast to produce symmetrical appearance;
c) Prostheses; and
d) Treatment of physical complications of all stages of the mastectomy, including lymph edemas.

Benefits are determined based on the nature of the treatment, whether or not you choose a Blue Shield of California contracting provider, and in accordance with Plan limits.

# SECTION 21
# IMPORTANT INFORMATION ABOUT THE PLAN

### A) Name of Plan

The name of this Plan is the Southern California Pipe Trades Health and Welfare Fund. It is sometimes referred to as the "Active Plan" because it covers active Employees.

### B) Plan Sponsor, Named Fiduciary and Administrator

The Plan is a collectively bargained, jointly trusteed labor-management trust fund. The Plan and Fund are administered by a Board of Trustees. The Board of Trustees is the legal Plan Sponsor, the legal Plan Administrator and the Named Fiduciary under the Employee Retirement Income Security Act.

### C) 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:

Board of Trustees of the
Southern California Pipe Trades Health and Welfare Fund
501 Shatto Place, 5th Floor
Los Angeles, California 90020
(800) 595-7473
(213) 385-6161

### D) Administrator

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

Mr. Joel E. Brick
Southern California Pipe Trades Health and Welfare Fund
501 Shatto Place, 5th Floor
Los Angeles, California 90020
(800) 595-7473
(213) 385-6161
www.scptac.org

### E) Identification Numbers

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

### F) Agent for Service of Legal Process

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

Mr. Joel E. Brick
Southern California Pipe Trades Health and Welfare Fund
501 Shatto Place, 5th Floor
Los Angeles, California 90020

### G) 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 applicable Collective Bargaining Agreement or Participation Agreement. The Collective Bargaining Agreements require contributions to this Plan at fixed rates per hour worked.

Self-payment may be required as described in the eligibility rules section of this Summary Plan Description.

The Fund 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.

## H) Type of Plan

This Plan is a multi-Employer health and welfare benefit plan maintained for the purpose of providing medical, accidental death or dismemberment, weekly accident and sickness, death, hearing aid, prescription drug, vision and dental benefits. 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 per Participant and Eligible Dependent or entity to provide payments above and beyond the amounts in the Fund collected and available for such purpose. All of the types of benefits provided by the Plan for active Employees are set forth in this booklet. There is a Plan with its own Summary Plan Description covering benefits for retirees.

## I) Collective Bargaining Agreement

Contributions to the Fund are in accordance with Collective Bargaining Agreements between Employers and Southern California Pipe Trades District Council #16 of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry US and Canada (AFL-CIO). The United Association local unions affiliated with District Council #16 are Numbers 78, 114, 230, 250, 345, 364, 398, 403, 460, 484, 494, 582, and 761. The Trust Fund Office will provide the Participant, 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 Fund Administrator. The following are the Employer Associations with whom District Council #16 has a bargaining relationship which requires contribution to this Plan:

i) California Plumbing & Mechanical Contractors Association (CPMCA);
ii) Air-conditioning, Refrigeration and Mechanical Contractors Association of Southern California, Inc. (ARCA/MCA); and
iii) Mechanical Service Contractors of San Diego (MSCSD).

## J) Plan Termination

It is intended that the Health and Welfare Fund and the Plan 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 Fund result in a reversion of any assets to the Contributing Employers or the Union. The Trustees may terminate the 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 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 Fund may also be terminated if there are no Participants or Eligible Dependents 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 any reports required by law, and apply the Trust Fund in accordance with the Plan, including amendment adopted as part of the termination.

## K) 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.

## L) Identity of Source of Benefits

The source of benefits is the Southern California Trades Health and Welfare Fund, a self-insured plan.

## M) 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.

## N) 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.

## O) 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, you are obligated to reimburse the Fund for the payment made in error and the Trustees have the right to seek repayment from you through any legal means, including the right to reduce future benefit payments by the amount of the erroneous payment.

## P) 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.

## Q) 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.

## R) 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.

## S) 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.

## T) Plan Year

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

## U) ERISA Rights

As a Participant in the Southern California Pipe Trades Health & Welfare Active 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:

### i) Receive Information About Your Plan and Benefits

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, including 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 Benefits Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including 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 Trustees are required by law to furnish each Participant with a copy of this summary annual report.

### ii) Continue Group Health Plan Coverage

Continue health care coverage for yourself or Eligible Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Eligible Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

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, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 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. The Plan does not have a pre-existing condition limit.

## V) 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 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.

### W) Enforce Your Rights

If your claim for a welfare benefit is denied 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 materials 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 that 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.

### X) Assistance with 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 should need assistance obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security 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 Employee Benefits Security Administration.

# SECTION 22
# SCHEDULE OF DENTAL BENEFITS

The following is an abbreviated Schedule of Dental Benefits. All benefit payments are subject to Plan limits including the Calendar Year Deductible and any applicable co-insurance.

**DIAGNOSTIC AND PREVENTIVE**

| ADA CODE | PROCEDURE | ALLOWANCE |
|---|---|---|
| | **CLINICAL ORAL EVALUATIONS** | |
| D0120 | Periodic Oral Evaluation | $39.83 |
| D0140 | Limited Oral Evaluation - Problem Focused | $39.83 |
| D0145 | Oral Evaluation for a Patient Under 3 Years of Age & Counseling with Primary Caregiver | $39.83 |
| D0150 | Comprehensive Oral Evaluation - New or Established Patient | $39.83 |
| D0160 | Detailed and Extensive Oral Evaluation - Problem Focused | $39.83 |
| D0170 | Re-evaluation - Limited, Problem Focused (Established Patient NOT Post-Operative Visit) | $39.83 |
| D0180 | Comprehensive Periodontal Evaluation - New or Established Patient | $39.83 |

## DIAGNOSTIC AND PREVENTIVE

| ADA CODE | PROCEDURE | ALLOWANCE |
|---|---|---|
| | **RADIOGRAPHS** | |
| D0210 | Intraoral - Complete Series (allowed once every 12 months) | $74.21 |
| D0220 | Intraoral - Single Film | $18.33 |
| D0230 | Intraoral - Each Additional Film | $8.07 |
| D0240 | Intraoral - Occulusal Single First Film | $29.00 |
| D0270 | Bitewing - Single Film (allowed twice per calendar year) | $18.33 |
| D0272 | Bitewings - Two Films | $25.51 |
| D0273 | Bitewings - Three Films | $46.00 |
| D0274 | Bitewings - Four Films | $35.87 |
| D0277 | Vertical Bitewings - 7 to 8 Films | $35.87 |
| D0290 | Posterior-Anterior or Lateral Skull and Facial Bone Film | $35.00 |
| D0310 | Sialography | $49.00 |
| D0321 | Other Temporomandibular Joint Films | $79.67 |
| D0330 | Panoramic Film | $56.45 |
| D0340 | Cephalometric Film | $68.80 |
| D0350 | Oral/Facial Images (includes intra & extraoral imag | Not Covered |
| D0360 | Cone Beam Ct - Craniofacial Data Capture | Not Covered |
| D0362 | Cone Beam-2D Image Reconstruction using Existing Data (multiple images) | Not Covered |
| D0363 | Cone Beam-3D Image Reconstruction using Existing Data (multiple images) | Not Covered |
| | **ORAL PATHOLOGY LABORATORY** | |
| D0470 | Diagnostic Casts | $58.46 |
| D0472 | Accession of tissue, gross examination preparation of written report | $92.40 |
| D0473 | Accession of tissue, gross microscopic examination preparation & transmission of written report | $92.40 |
| D0474 | Accession of tissue, gross & microscopic examination including assessment of surgical margins for presence of disease, preparation and transmission of written report | $92.40 |
| D0480 | Accession of Cytologic Smears, Written Reports | Not Covered |
| D0486 | Accession of Brush Biopsy Sample | Not Covered |
| | **DENTAL PROPHYLAXIS** | |
| D1110 | Prophylaxis Adult (three times per calendar year) | $54.62 |
| D1120 | Prophylaxis Child (three times per calendar year) | $44.45 |
| | **FLUORIDE TREATMENT** | |
| D1203 | Topical Application of Fluoride (Prophylaxis not included) - Child | $35.50 |
| D1204 | Topical Application of Fluoride (Prophylaxis not included) - Adult | Not Covered |
| D1206 | Topical Fluoride Varnish | $35.50 |
| | **OTHER PREVENTIVE SERVICES** | |
| D1310 | Nutritional Counseling for the Control of Dental Disease | Not Covered |
| D1330 | Oral Hygiene Instruction | Not Covered |
| D1351 | Sealant - Per Tooth **(The benefit listed is the maximum benefit payable per quadrant.)** | $39.76 |
| D1352 | Preventive Resin restoration in a moderate to high caries risk patient - permanent tooth. | $39.76 |

## DIAGNOSTIC AND PREVENTIVE

| ADA CODE | PROCEDURE | ALLOWANCE |
|---|---|---|
| | **SPACE MAINTENANCE** (Allowances include all adjustments) | |
| D1510 | Space Maintainer - Fixed - Unilateral | $177.82 |
| D1515 | Space Maintainer - Fixed - Bilateral | $216.80 |
| D1525 | Space Maintainer - Removable - Bilateral | $216.80 |
| D1555 | Removal of Fixed Space Maintainer | Not Covered |

## ALL OTHERS EXCLUDING GOLD RESTORATIONS AND PROSTHETICS

| ADA CODE | PROCEDURE | ALLOWANCE |
|---|---|---|
| | **AMALGAM RESTORATIONS** | |
| D2140 | Amalgam - One Surface Primary or Permanent | $72.18 |
| D2150 | Amalgam - Two Surfaces Primary or Permanent | $82.66 |
| D2160 | Amalgam - Three Surfaces Primary or Permanent | $94.44 |
| D2161 | Amalgam - Four or More Surfaces Primary or Permanent | $103.15 |
| | **RESIN-BASED COMPOSITE RESTORATIONS** | |
| D2330 | Resin-Based Composite - One Surface, Anterior | $97.51 |
| D2331 | Resin-Based Composite - Two Surfaces, Anterior | $173.67 |
| D2332 | Resin-Based Composite - Three Surfaces, Anterior | $173.67 |
| D2335 | Resin-Based Composite - Four or More Surfaces Involving Incisal Angle (Anterior) | $225.77 |
| D2390 | Resin-Based Composite Crown Anterior | $103.15 |
| D2391 | Resin-Based Composite - One Surface Posterior | $72.18 |
| D2392 | Resin-Based Composite - Two Surfaces Posterior | $82.66 |
| D2393 | Resin-Based Composite - Three Surfaces Posterior | $94.44 |
| D2394 | Resin-Based Composite - Four or More Surfaces Posterior | $103.15 |
| | **OTHER RESTORATIVE SERVICES** | |
| D2910 | Recement Inlay, Onlay or Partial Coverage Restoration | $53.75 |
| D2920 | Recement Crowns | $47.74 |
| D2930 | Prefabricated Stainless Steel Crown - Primary tooth | $139.52 |
| D2931 | Prefabricated Stainless Steel Crown - Permanent tooth | $139.52 |
| D2932 | Prefabricated Resin Crown | $139.52 |
| D2933 | Prefabricated Stainless Steel Crown - Resin Window | $139.52 |
| D2934 | Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth | $139.52 |
| D2940 | Sedative Filling | $36.40 |
| D2952 | Post and Core, indirectly fabricated in Addition to Crown | $191.56 |
| D2953 | Each Additional Indirectly Fabricated Post, Same Tooth | Not Covered |
| D2954 | Prefabricated Post and Core in Addition to Crown | $170.61 |
| D2970 | Temporary Crown (Fractured Tooth) | Not Covered |
| D2980 | Crown Repair | $75.00 |

**ALL OTHERS EXCLUDING GOLD RESTORATIONS AND PROSTHETICS**

| ADA CODE | PROCEDURE | ALLOWANCE |
|---|---|---|
| | **PULPOTOMY** (Baby Teeth Only) | |
| D3220 | Therapeutic Pulpotomy | $81.48 |
| D3230 | Pulpay Therapy - Anterior Primary Tooth | $81.48 |
| D3240 | Pulpay Therapy - Posterior Primary Tooth | $81.48 |
| | **ROOT CANAL THERAPY** (Includes all Clinical Procedures) | |
| D3310 | Root Canal Therapy - Anterior (excludes final restoration) | $385.30 |
| D3320 | Root Canal Therapy - Bicuspid (excludes final restoration) | $436.74 |
| D3330 | Root Canal Therapy - Molar (excludes final restoration) | $552.50 |
| D3346 | Retreatment of Previous Root Cananl - Anterior | $385.30 |
| D3347 | Retreatment of Previous Root Cananl - Bicuspid | $436.74 |
| D3348 | Retreatment of Previous Root Cananl - Molar | $552.50 |
| D3351 | Apexification / Recalcification | $40.00 |
| | **APICOECTOMY / PERIRADICUALR SERVICES** | |
| D3410 | Apicoectomy / Periradicular Surgery - Anterior | $462.08 |
| D3421 | Apicoectomy - Bicuspid | $462.08 |
| D3425 | Apicoectomy - Molar | $462.08 |
| D3430 | Retrograde Filling Per Root | $67.50 |
| D3920 | Hemisection | $72.00 |
| D3450 | Root Amputation | $72.00 |
| | **PERIODONTAL SURGICAL SERVICES** | |
| D4210 | Gingivectomy or Gigivoplasty - 4 or More Teeth Per Quadrant | $340.00 |
| D4211 | Gingivectomy - 1 - 3 Teeth Per Quadrant | $108.47 |
| D4230 | Anatomical Crown Exposure - Quadrant | Not Covered |
| D4231 | Anatomical Crown Exposure - 1 to 3 Teeth | Not Covered |
| D4260 | Osseous Surgery - 4 or More Teeth Per Quadrant | $533.04 |
| D4261 | Osseous Surgery - 1 -3 Teeth Per Quadrant | $266.52 |
| D4263 | Bone Replacement Graft - First Site in Quadrant | $200.00 |
| D4264 | Bone Replacement Graft - Each Additional Site | $200.00 |
| D4270 | Pedicle Soft Tissue Graft Procedure | $750.00 |
| D4271 | Free Soft Tissue Graft | $750.00 |
| D4273 | Subepithelial connective Tissue Graft Procedure | $750.00 |
| D4275 | Soft Tissue Allograft | $750.00 |
| D4276 | Combined Connective Tissue & Double Pedicle Graft | $750.00 |
| | **NON-SURGICAL PERIODONTAL SERVICES** | |
| D4320 | Provisional Splinting - Intracoronal | $60.00 |
| D4321 | Provisional Splinting - Extracoronal | $60.00 |
| D4341 | Periodontal Scaling and Root Planning Four or More Teeth Per Quadrant | $122.86 |
| D4342 | Periodontal Scaling and Root Planning - 1 - 3 Teeth | $61.43 |

**ALL OTHERS EXCLUDING GOLD RESTORATIONS AND PROSTHETICS**

| ADA CODE | PROCEDURE | ALLOWANCE |
|---|---|---|
| | **OTHER PERIODONTIC SERVICES** | |
| D4910 | Periodontal Maintenance Procedure | $70.00 |

**ORAL and MAXILLOFACIAL SURGERY** (Extractions, routine - includes local anesthesia and postoperative care)

| ADA CODE | PROCEDURE | ALLOWANCE |
|---|---|---|
| | **EXTRACTIONS** | |
| D7111 | Coronal Remnants - Deciduous Tooth | $66.35 |
| D7140 | Extraction - Erupted Tooth or Exposed Roots | $71.38 |
| | **SURGICAL EXTRACTIONS** (Includes local anesthesia) | |
| D7210 | Surgical Removal of Erupted Tooth | $126.94 |
| D7220 | Removal of Impacted Tooth - Soft Tissue | $156.09 |
| D7230 | Removal of Impacted Tooth - Partially Bony | $197.33 |
| D7240 | Removal of Impacted Tooth - Completely Bony | $230.35 |
| D7241 | Removal of Impacted Tooth - Completely Bony with Unusual Complications | $230.35 |
| D7250 | Surgical Removal of Residual Tooth Roots (Not Exposed) | $127.93 |
| D7260 | Oral Antral Fistual Closure (and/or antral root recovery) | $129.00 |
| | **OTHER SURGICAL PROCEDURES** | |
| D7280 | Surgical Access of an Unerupted Tooth | $300.00 |
| D7281 | Surgical Exposure of impacted or unerupted tooth to aid eruption | $226.67 |
| D7285 | Biopsy of Oral Tissue - Hard (bone,tooth) | $92.40 |
| D7286 | Biopsy of Oral Tissue - Soft Tissue | $92.40 |
| D7290 | Surgical Repositioning of teeth | $800.00 |
| D7292 | Surgical Placement - Temporary Ancorage Device | Not Covered |
| D7293 | Surgical Placement - Temporary Ancorage Device with Flap | Not Covered |
| D7294 | Surgical Placement - Temporary Ancorage Device without Flap | Not Covered |
| | **ALVEOLOPLASTY** | |
| D7310 | Alveloplasty in Conjunction with Extractions - 4 or more Teeth per Quadrant | $151.00 |
| D7311 | Alveloplasty in Conjunction with Extractions - 1 to 3 Teeth per Quadrant | $75.50 |
| D7320 | Alveloplasty not in Conjunction with Extractions - 4 or more Teeth per Quadrant | $59.00 |
| D7321 | Alveloplasty not in Conjunction with Extractions - 1 to 3 Teeth per Quadrant | $29.50 |
| | **SURGICAL EXCISION** | |
| D7410 | Excision of Benign Lesion Up to 1.25 cm | $65.00 |
| D7411 | Excision of Benign Lesion Greater Than 1.25 cm | $367.50 |
| D7412 | Excision of Benign Lesion - Complicated | $367.50 |
| D7413 | Excision of Malignant Lesion Up to 1.25 cm | $152.00 |
| D7414 | Excision of Malignant Lesion Greater Than 1.25 cm | $367.50 |
| D7415 | Excision of Malignant Lesion – Complicated | $367.50 |

**ORAL and MAXILLOFACIAL SURGERY** (Extractions, routine - includes local anesthesia and postoperative care)

| ADA CODE | PROCEDURE | ALLOWANCE |
|---|---|---|
| | **REMOVAL OF TUMORS CYSTS AND NEOPLASMS** | |
| D7440 | Excision of Malignant Tumor - Lesion Diameter Up to 1.25 cm | $152.00 |
| D7441 | Excision of Malignant Tumor - Lesion Diameter Greater Than 1.25 cm | $152.00 |
| D7450 | Removal of Benign Odontogenic Cyst or Tumor - Lesion Diameter up to 1.25 cm | $135.00 |
| D7451 | Removal of Benign Odontogenic Cyst or Tumor - Lesion Diameter Greater Than 1.25 cm | $367.50 |
| D7460 | Removal of Benign Nonodontogenic Cyst or Tumor - Lesion Diameter up to 1.25 cm | $135.00 |
| D7461 | Removal of Benign Nonodontogenic Cyst or Tumor - Lesion Diameter Greater Than 1.25 cm | $367.50 |
| | **EXCISION OF BONE TISSUE** | |
| D7471 | Removal of Lateral Exostosis (Maxilla or Mandible) | $88.00 |
| D7472 | Removal of Torus Palatinus | $88.00 |
| D7473 | Removal of Torus Mandibularis | $88.00 |
| | **SURGICAL INCISION** | |
| D7510 | Incision & Drainage of Abscess - Intraoral Soft Tissue | $85.80 |
| D7511 | Incision & Drainage of Abscess - Intraoral Soft Tissue - Complicated | $85.80 |
| D7520 | Incision & Drainage of Abscess - Extraoral Soft Tissue | $47.00 |
| D7521 | Incision & Drainage of Abscess - Extraoral Soft Tissue - Complicated | $47.00 |
| D7530 | Removal of Foreign from Mucosa, Skin or Subcutaneous Alveolar Tissue | $70.00 |
| D7540 | Removal of Reaction Producing Foreign Bodies | $47.00 |
| D7550 | Partial Ostectomy/Sequestrectomy for Removal of Non-Vital Bone | $117.00 |
| D7560 | Maxillary Sinusotomy | $135.00 |
| | **TREATMENT OF FRACTURES** | |
| D7610 | Maxilla - Open Reduction | Not Covered |
| D7620 | Maxilla - Closed Reduction | |
| D7630 | Mandible - Open Reduction | |
| D7640 | Mandible - Closed Reduction | |
| D7650 | Malar and/or Zygomatic Arch - Open Reducton | |
| D7660 | Malar and/or Zygomatic Arch - Closed Reducton | |
| D7670 | Alevolus - Closed Reduction - May Include Stabilization of Teeth | |
| D7680 | Facial Bones - Complicated Reduction | |
| | **TREATMENT OF FRACTURES - COMPOUND** | |
| D7710 | Maxilla - Open Reduction | Not Covered |
| D7720 | Maxilla - Closed Reduction | |
| D7730 | Mandible - Open Reduction | |
| D7740 | Mandible - Closed Reduction | |
| D7750 | Malar and/or Zygomatic Arch - Open Reducton | |
| D7760 | Malar and/or Zygomatic Arch - Closed Reducton | |
| D7770 | Alevolus - Stabilization of Teeth | |
| D7780 | Facial Bones - Complicated Reduction | |

**ORAL and MAXILLOFACIAL SURGERY** (Extractions, routine - includes local anesthesia and postoperative care)

| ADA CODE | PROCEDURE | ALLOWANCE |
|---|---|---|
| | **REPAIR OF TRAUMATIC WOUNDS** | |
| D7910 | Suture of Small Wounds Up to 5 cm | Not Covered |
| | **COMPLICATED SUTURING** | |
| D7911 | Complicated Suture - Up to 5 cm | Not Covered |
| D7912 | Complicated Suture - Greater Than 5 cm | |
| | **OTHER REPAIR PROCEDURES** | |
| D7920 | Skin Graft | $94.00 |
| D7950 | Osseous, Osteoperiosteal or Cartilage Graft of Mandible or Maxilla - Autogenous or Nonautogenous by Report | Not Covered |
| D7951 | Sinus Augmentation with Bone | Not Covered |
| D7953 | Bone Replacement Graft for Ridge Preservation - per Site | Not Covered |
| D7955 | Repair of Maxillofacial Soft and Hard Tissue Defect | $53.00 |
| D7981 | Excision of Salivary Gland | $205.00 |
| D7982 | Sialodochoplasty | $322.00 |
| D7983 | Closure of Salivary Fistula | $351.00 |
| D7990 | Emergency Tracheotomy | $234.00 |
| D7998 | Intraoral Placement of a Fixation Device | Not Covered |
| | **ADJUNTIVE GENERAL SERVICES**<br>**INTERCEPTIVE ORTHODONTIC TREATMENT** | |
| D8050 | Interceptive Orthodontic Treatment of the Primary Dentition | $200.00 |
| D8060 | Interceptive Orthodontic Treatment of the Transitional Dentition | $200.00 |
| D8210 | Appliance Removal | $307.50 |
| D8220 | Fixed Appliance Therapy | $193.33 |
| D8693 | Rebonding or Recementing or Repairing of Fixed Retainers | Not Covered |
| | **UNCLASSIFIED TREATMENT** | |
| D9110 | Palliative Treatment of Dental Pain | $62.47 |
| D9120 | Fixed Partial Denture Sectioning | Not Covered |
| | **ANESTHESIA** | |
| D9220 | Deep Sedation/General Anesthesia - First 30 Minutes | $183.94 |
| D9221 | Deep Sedation/General Anesthesia - Each Additional 15 Minutes | $45.99 |
| D9241 | Intravenous Sedation/Analgesia - First 30 Minutes - up to age 14 | $183.94 |
| | **PROFESSIONAL VISITS** | |
| D9310 | Specialist Consultation | $39.83 |
| D9410 | House / Extended Care Facility Call | Not Covered |
| D9420 | Hospital Call | Not Covered |
| D9430 | Office Visits for obersvation (during regularly scheduled hours) - no other services performed | $39.83 |
| D9440 | Office Visit - After Regularly Scheduled Hours | $80.20 |

**ORAL and MAXILLOFACIAL SURGERY** (Extractions, routine - includes local anesthesia and postoperative care)

| ADA CODE | PROCEDURE | ALLOWANCE |
|---|---|---|
| | **MISCELLANEOUS** | |
| D9610 | Therapeutic Parenteral Drug | Not Covered |
| D9612 | Therapeutic Parenteral Drugs | Not Covered |
| D9940 | Occlusal Guard | $248.60 |
| D9951 | Occlusal Adjustment - Limited | $52.36 |
| D9952 | Occlusal Adjustment - Complete | $96.00 |

**GOLD RESTORATIONS, CROWNS AND PROSTHETICS**

| ADA CODE | PROCEDURE | ALLOWANCE |
|---|---|---|
| | **INLAY / ONLAY RESTORATIONS** | |
| D2510 | Inlay - Metallic - one surface | $290.00 |
| D2520 | Inlay - Metallic - two surfaces | $300.00 |
| D2530 | Inlay - Metallic - three or more surfaces | $450.00 |
| D2542 | Onlay - Metallic - two surfaces | $576.67 |
| D2543 | Onlay - Metallic - three surfaces | $656.50 |
| D2544 | Onlay - Metallic - four or more surfaces | $656.50 |
| D2610 | Inlay Porcelain/Ceramic - one surface | $290.00 |
| D2620 | Inlay Porcelain/Ceramic - two surfaces | $300.00 |
| D2630 | Inlay Porcelain/Ceramic - three or more surfaces | $450.00 |
| D2642 | Onlay Porcelain/Ceramic - two surfaces | $576.67 |
| D2643 | Onlay Porcelain/Ceramic - three surfaces | $656.50 |
| D2644 | Onlay Porcelain/Ceramic - four or more surfaces | $656.50 |
| D2650 | Inlay Resin Based Composite - one surfaces | $232.00 |
| D2651 | Inlay Resin Based Composite - two surfaces | $240.00 |
| D2652 | Inlay Resin Based Composite - three or more surfaces | $360.00 |
| D2662 | Onlay Resin Based Composite - two surfaces | $576.67 |
| D2663 | Onlay Resin Based Composite - three surfaces | $656.50 |
| D2664 | Onlay Resin Based Composite - four or more surfaces | $656.50 |
| | **CROWNS - SINGLE RESTORATIONS ONLY** | |
| D2710 | Crown - Resin (Laboratory) | $350.00 |
| D2712 | Crown - 3/4 Resin (Laboratory) | $350.00 |
| D2720 | Crown - Resin with High Noble Metal | $563.86 |
| D2721 | Crown - Resin with Base Metal | $443.33 |
| D2722 | Crown - Resin with Noble Metal | $556.55 |
| D2740 | Crown - Porcelain/Ceramic Substrate | $608.33 |
| D2750 | Crown - Porcelain Fused to High Noble Metal | $563.86 |
| D2751 | Crown - Porcelain Fused Base Metal | $443.33 |
| D2752 | Crown - Porcelain Fused to Noble Metal | $556.55 |
| D2780 | Crown - ¾ Cast High Noble Metal | $563.86 |
| D2781 | Crown - ¾ Cast Predominantly Base Metal | $443.33 |
| D2782 | Crown - ¾ Cast Noble Metal | $556.55 |
| D2783 | Crown - ¾ Porcelain / Ceramic | $608.33 |

## GOLD RESTORATIONS, CROWNS AND PROSTHETICS

| ADA CODE | PROCEDURE | ALLOWANCE |
|---|---|---|
| | **CROWNS - SINGLE RESTORATIONS ONLY** | |
| D2790 | Crown - Full Cast High Noble Metal | $563.86 |
| D2791 | Crown - Full Cast Predominantly Base Metal | $443.33 |
| D2792 | Crown - Full Cast Noble Metal | $556.55 |
| D2794 | Crown - Titanium | $563.86 |
| | **The Trust does not pay for facings on crowns prosterior to and bicuspids. (If placed, expense must be borne by patient.)** | |
| | **PROSTHODONTICS - REMOVABLE PROSTHETICS** (Including Adjustments) | |
| D5110 | Complete Denture - Maxillary | $754.96 |
| D5120 | Complete Denture - Lower | $786.20 |
| D5130 | Immediate Denture - Maxillary | $788.00 |
| D5140 | Immediate Denture - Mandibular | $781.50 |
| | **PARTIAL DENTURES** (Including Adjustments) | |
| D5213 | Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases | $1,209.32 |
| D5214 | Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases | $1,209.32 |
| D5211 | Maillary Partial Denture - Resin Base | $890.00 |
| D5212 | Mandibular Partial Denture - Resin Base | $817.50 |
| D5225 | Maxillary Partial Denture - Flexible Base | $890.00 |
| D5226 | Mandibular Partial Denture - Flexible Base | $817.50 |
| | **ADJUSTMENTS TO DENTURES** | |
| D5410 | Adjust Complete Denture - Maxillary | $25.00 |
| D5411 | Adjust Complete Denture - Mandibular | $25.00 |
| D5421 | Adjust Partial Denture - Maxillary | $19.00 |
| D5422 | Adjust Partial Denture - Mandibular | $19.00 |
| | **REPAIRS TO DENTURES** | |
| D5510 | Repair Broken Complete Denture Base | $83.92 |
| D5520 | Replace Missing or Broken Teeth - Complete Denture (each tooth) | $67.25 |
| D5610 | Repair Resin Partial Denture Base | $83.92 |
| D5620 | Repair Cast Framework | $50.00 |
| D5630 | Repair or Replace Broken Clasp | $50.00 |
| D5640 | Replace Broken teeth - per tooth | $82.43 |
| D5650 | Add Tooth to Existing Partial Denture | $98.44 |
| D5660 | Add Clasp to Existing Partial Denture | $91.75 |
| D5670 | Replace All Teeth & Acrylic on Cast Metal Framwork (Maxillary) | $329.72 |
| D5671 | Replace All Teeth & Acrylic on Cast Metal Framwork (Mandibular) | $329.72 |

## GOLD RESTORATIONS, CROWNS AND PROSTHETICS

| ADA CODE | PROCEDURE | ALLOWANCE |
|---|---|---|
| | **REPAIRS TO DENTURES** | |
| D5730 | Reline Complete Maxillary Denture (chairside) | $99.00 |
| D5731 | Reline Complete Mandibular Denture (chairside) | $99.00 |
| D5740 | Reline Maxillary Partial Denture (chairside) | $99.00 |
| D5741 | Reline Mandibular Partial Denture (chairside) | $99.00 |
| D5750 | Reline Complete Maxillary Denture (laboratory) | $100.00 |
| D5751 | Reline Complete Mandibular Denture (laboratory) | $100.00 |
| D5760 | Reline Maxillary Partial Denture (laboratory) | $100.00 |
| D5761 | Reline Mandibular Partial Denture (laboratory) | $100.00 |
| | **INTERIM PROSTHESIS** | |
| D5820 | Interim Partial Denture (maxillary) | $304.42 |
| D5821 | Interim Partial Denture (mandibular) | $304.42 |
| | **OTHER REMOVALBE PROSTHETIC SERVICES** | |
| D5850 | Tissue Conditioning - Maxillary | $67.50 |
| D5851 | Tissue Conditioning - Mandibular | $67.50 |
| D5860 | Overdenture - Complete | Not Covered |
| D5861 | Overdenture - Partial | Not Covered |
| D6012 | Surgical Placement of Interim Implant Body | Not Covered |
| D6091 | Replacement of Semi Precious or Precision Attachment | Not Covered |
| D6092 | Recement Implant/Abutment Supported Crown | $47.74 |
| D6093 | Recement Implant/Abutment Supported Fixed Partial Denture | $83.46 |
| | **PROSTHODONTICS - FIXED** | |
| | **FIXED PARTIAL DENTURE PONTICS** | |
| D6210 | Pontic - Cast High Noble Metal | $592.50 |
| D6211 | Pontic - Cast Predominantly Base Metal | $385.00 |
| D6212 | Pontic - Cast Noble Metal | $385.00 |
| D6214 | Pontic - Titanium | $592.50 |
| D6240 | Pontic - Porcelain Fused to High Noble Metal | $543.74 |
| D6241 | Pontic - Porcelain Fused to Predominantly Base Metal | $543.74 |
| D6242 | Pontic - Porcelain Fused to Noble Metal | $543.74 |
| D6245 | Pontic - Porcelain / Ceramic | $543.74 |
| D6250 | Pontic - Resin with High Noble Metal | $543.74 |
| D6251 | Pontic - Resin with Predominantly Base Metal | $543.74 |
| D6252 | Pontic - Resin with Noble Metal | $543.74 |

**GOLD RESTORATIONS, CROWNS AND PROSTHETICS**

| ADA CODE | PROCEDURE | ALLOWANCE |
|---|---|---|
| | **FIXED PARTIAL DENTURE RETAINERS** | |
| D6545 | Retainer - Cast Metal, Resin Bonded | $300.00 |
| D6548 | Retainer - Porcelain, Resin Bonded | $300.00 |
| D6720 | Crown - Resin with High Noble Metal | $575.16 |
| D6721 | Crown - Resin with Predominantly Bast Metal | $575.16 |
| D6722 | Crown - Resin with Noble Metal | $575.16 |
| D6740 | Crown - Porcelain | $575.16 |
| D6750 | Crown - Porcelain Fused to High Noble Metal | $575.16 |
| D6751 | Crown - Porcelain Fused to Predominantly Base Metal | $575.16 |
| D6752 | Crown - Porcelain Fused to Noble Metal | $575.16 |
| D6780 | Crown - ¾ Cast High Noble Metal | $575.16 |
| D6781 | Crown - ¾ Cast Predominantly Base Metal | $575.16 |
| D6782 | Crown - ¾ Cast Noble Metal | $575.16 |
| D6783 | Crown - ¾ Porcelain / Ceramic | $575.16 |
| D6790 | Crown - Full Cast High Noble Metal | $575.16 |
| D6791 | Crown - Full Cast Predominantly Base Metal | $575.16 |
| D6792 | Crown - Full Cast Noble Metal | $575.16 |
| D6794 | Crown - Titanium | $575.13 |
| | **OTHER FIXED PARTIAL DENTURE SERVICES** | |
| D6930 | Recement Fixed Partial Denture | $83.46 |
| D6970 | Post and Core, Indirectly Fabricated, in Addition to Fixed Partial Denture Retainer | $170.61 |
| D6972 | Prefabricated Post and Core in Addition to Retainer | $170.61 |
| D6976 | Each Additional Indirectly Fabricated Post - Same Tooth | Not Covered |
| D6980 | Bridge Repair | $75.00 |

# SECTION 23
# DEFINITIONS

## Accident
An unforeseen and unavoidable event resulting in an Injury, such as tripping over a step, falling off a ladder or a dog bite.

## Allowable Charges
The scheduled amounts for any and all services and supplies established by the Board of Trustees for services by non-Blue Shield of California providers. 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 the Allowable Charges, the Patient is responsible for the balance.

## Allowed Amounts
The dollar benefit equal to either the Blue Shield of California Contract Rate or the Allowable Charge.

## Annual Maximum Benefit Limit
The total dollar amount payable for a Participant, or Eligible Dependent during a Calendar Year for benefits issued by the Fund.

## Beneficiary
Beneficiary means the person entitled to receive Death and/or Accidental Death benefits from this Plan pursuant to the Participant's designation on the Enrollment & Beneficiary Form or pursuant to the Terms of the Plan.

## Blue Shield of California
Blue Shield of California is a non-profit organization created to contract with health care providers to offer you quality health care services with lower Out-of-Pocket expense. (See Blue Shield of California in Section 10)

## Blue Shield of California Contract Rate
The fee charged for services rendered by participating providers with Blue Shield of California. The rate is set by contractual agreement among the Fund, Affiliated Health Funds and participating providers.

## Board of Trustees
All of the Trustees established as one body pursuant to the Trust Agreement.

## 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 of the Patient.

## Claim Form
The form required by the Fund to provide information necessary to process claims. One complete routine Claim Form is required per Patient per Calendar Year.

## COBRA
The Consolidated Omnibus Budget Reconciliation Act of 1985 that may provide for continuation coverage when a Participant or Eligible Dependent loses coverage under the Plan.

## Coinsurance
Coinsurance is a predetermined percentage of the Contract Rate or Allowable Charge that the Patient must pay out of pocket for Covered Services and is applicable after the Patient's deductible has been met.

## Collective Bargaining Agreement
Any and all negotiated labor agreements between a Signatory Employer, or Employers Association acting on behalf of a Signatory Employers, and United Association of Plumbers, Pipefitters and Steamfitters of the United States and Canada, or any Local Union or District Council affiliate, that requires contributions to the Southern California Pipe Trades Health and Welfare Fund, Retirement Fund, Defined Contribution Fund, Vacation & Holiday Fund or Christmas Bonus Fund.

## Contributing Employer
An Employer signed to a Collective Bargaining Agreement or Participation Agreement that requires contributions to the Fund.

## Co-Payment
A Copayment is the fixed dollar amount that a Patient must pay out of pocket for Covered Services covered by his/her health plan that are a portion of the Contract Rate or Allowable Charge.

## Covered Employment
Covered Employment is work by an Employee under a Collective Bargaining Agreement.

## Covered Services
Services that are expressly listed as allowable by the Plan.

## CPT Codes
"Current Procedural Terminology" is the numerical identifier of the medical service being performed.

## 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 Deductible applies separately to each covered person, except that the family Deductible applies collectively to all covered persons in the same family. Separate Deductibles apply to the prescription drug benefit and the hearing aid benefit.

## 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 of the Employee, Dependent Spouse, or the Patient.

## 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 Non-durable; and
5) Is used by the Patient only.

## Eligibility Bank
The Eligibility Bank is funded by contributions received from Contributing Employers on the Participant's behalf. Contribution amounts are credited and debited to and from the Eligibility Bank as set forth in Section 5.

## Eligible Dependent
The Participant's lawful Spouse or child(ren) up to and including age 25, who satisfy requirements of the Plan.

## 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 function; or

3) Serious dysfunction of any bodily organ or part.

## Employee

An Employee is anyone employed by a Contributing Employer in a position for which the Employer makes contributions to the Fund under a Collective Bargaining Agreement or a Participation Agreement.

## ERISA

Employee Retirement Income Security Act of 1974, as amended. See Section 21 for an explanation of your ERISA rights.

## Exclusions

Any medical, dental or vision services or supplies that are not covered by the Plan. Services or supplies not expressly covered by the Plan are excluded and will not be paid for.

## Experimental Treatment

Any services or procedures that are Experimental Treatments or investigational in nature or are not within the standards of generally accepted medical practice. Medical services or supplies, including Prescription Drugs, considered educational, investigational, or experimental. A drug, device or medical treatment or procedure is considered experimental or investigational if:

1) It is a drug or device that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2) Reliable evidence shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
3) Reliable evidence shows that the consensus of opinion among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis. For this purpose, reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

This Plan does not cover Experimental 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 a Participant or Eligible Dependent 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 Prescription Drugs;
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.

## FMLA

The Family and Medical Leave Act of 1993.

## Fund

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

## Fund Office

Southern California Pipe Trades Administrative Corporation
501 Shatto Place, 5th Floor
Los Angeles, CA 90020
800-595-7473
213-385-6161
www.scptac.org
info@scptac.org

## HIPAA

The Health Insurance Portability and Accountability Act of 1996.

## Home Health Care Agency

A licensed Home Health Care Agency that must:

1) Primarily provide skilled nursing services and other therapeutic services under the supervision of Physicians or Registered Nurses;
2) Be run according to rules established by a group of medical professionals, including Physicians and Nurses;
3) Maintain clinical records on all Patients;
4) Be licensed by the jurisdiction where it is located, if licensure is required, and run according to applicable law; and
5) 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 are 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 people recovering from alcohol dependency, 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. Congenital abnormalities of a newborn child are included in this definition. Pregnancy is considered an Illness.

## 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 Physician 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 or Nervous Disorder
A condition, Illness, disease or disorder listed in the most recent edition of International Classification of Diseases (ICD) as a psychosis, neurotic disorder, or personality disorder; and other non-psychotic disorders listed in the ICD, to be determined by the Plan. A Mental or Nervous disorder includes any Mental or Nervous disorder manifested by physical symptoms, any physical disorder manifesting Mental or Nervous symptoms, and any condition involving a combination of physical and Mental or Nervous causes and/or physical and Mental or Nervous symptoms.

## Monthly Deduction Amount
Amount of money deducted from the Eligibility Bank to fund eligibility for a month.

## Military Service
Active duty in the armed forces of the United States.

## Non-durable
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.

## Non-Eligible Dependent
Stepchild(ren), parents, siblings, grandchildren or other relatives or persons, even if the Participant is financially responsible due to guardianship.

## Normal Retirement Age
Normal Retirement Age, pursuant to the rules of the related Southern California Pipe Trades Retirement Plan, generally means age 65.

## 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.) or Certified Nurse Midwife (CNM) and who is not a family member of the patient.

## 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 Participant or Eligible Dependent is covered by workers' compensation insurance.

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

## Out-of-Pocket (OOP)
The amount the Patient must pay over and above what the Fund has paid. This includes Deductibles, non-covered charges and expenses over the Allowed Amount.

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

## Participant
An Employee who has satisfied the rules to become eligible for benefits under the terms of the Plan.

## Participation Agreement
An agreement approved by the Board of Trustees allowing a

Signatory Employer or a related organization, whose participation in the Fund has been approved by the Board of Trustees, to pay contributions to the Plan for Employees who are not covered by a Collective Bargaining Agreement.

## Patient
The Participant or Eligible Dependent receiving medical or dental care, treatment, equipment, and prescriptions.

## Pensioner
A retired Employee who has satisfied the rules to become eligible under the terms of the Southern California Pipe Trades Pensioners & Surviving Spouses Health Plan, in lieu of participation in this Plan.

## 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.) or 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. Homeopathic Practitioners, Naturopaths (N.P.) and Oriental Medical Doctors (O.M.D.) are not included.

## Plan
The benefits, rules, limitations, exclusions and other provisions described in this document.

## Plan Year
Plan Year means January 1 through December 31 of each year.

## 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.

## Premium
The monthly charge for coverage under the Pensioners and Surviving Spouses Health Plan.

## Prescription Drugs
Medications prescribed by a Physician, Nurse Practitioner, Dentist or Podiatrist that can only be purchased and dispensed at a licensed pharmacy.

## Psychiatrist
A Physician who provides care and treatment for a Mental or Nervous disorder.

## Psychologist
A person trained in the care of Mental and Nervous Disorders.

## Qualified Beneficiary
Qualified Beneficiary means the Participant or Eligible Dependent who is entitled to elect COBRA Continuation Coverage after the loss of coverage under the Plan due to a Qualifying Event.

## Qualified Medical Child Support Order (QMCSO)
An order issued by a court or authorized state or other governmental agency providing for benefit payments to an alternate recipient. The order must meet all of the requirements of ERISA, including approval as a qualified order by the Fund.

## Qualifying Event
A circumstance that permits a Participant or Eligible Dependent to elect COBRA Continuation Coverage. Qualifying Events may include, but are not limited to, the loss of coverage due to a reduction in hours of employment, divorce from the Participant, death of the Participant, or an Eligible Dependent child turning age 26.

## Reciprocity
Transfer of contributions from this Fund to another health benefit fund, or from another health benefit fund to this Fund pursuant to the terms of the United Association Reciprocity Agreement.

## Registered Physical Therapist
A person licensed to provide therapy for the treatment of an Injury or dysfunction with exercises and other physical treatments of the disorder and who is qualified to prescribe treatment plans for the therapy.

## Registered Physical Therapist Assistant
A person that assists a Registered Physical Therapist and works under their direction. Is not authorized to prescribe treatment plans.

## Signatory Employer
An Employer that has signed a Collective Bargaining Agreement.

## Spouse
A person of the opposite sex to whom the Participant was married as husband or wife as of the date of the Participant's death. Because the Plan is governed by federal law, including ERISA, the Plan is not required to and will not recognize same sex marriages, even if those marriages are permitted and legally recognized under state law. This definition of Spouse applies regardless of the date a Participant was married.

## 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 Spouse of a deceased Participant who continues to participate in this Plan under the Participant's Eligibility Bank or COBRA or who satisfies the eligibility requirements for the Southern California Pipe Trades Pensioner & Surviving Spouses Health Plan upon losing coverage under this Plan.

### 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 an Eligible Dependent child, totally unable to perform the daily living activities of a person of comparable age.

### Trustees
Employer and Union representatives that manage the funds of the Trust and administer the provisions of the Plan.

### Union(s)
Southern California Pipe Trades District Council #16 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada, AFL-CIO and its affiliated local unions, and such other unions which have or may hereafter become parties to and agree to be bound by the Trust Agreement.

### USERRA
Uniformed Services Employment and Reemployment Rights Act of 1994.

### Well Child Services
Routine examinations, laboratory testing, and immunizations for children after discharge from the hospital at birth to age 17 years.

### Worker's Compensation
Benefits required by law for an employee injured in the course of work.

# SECTION 24
# TRUSTEES

## A) Employer Trustees

**WALTER SCOTT BAKER**
University Mechanical & Engineering Contractors, Inc.
1000 North Kraemer Place
Anaheim, CA 92806

**DON CHASE**
Muir-Chase Plumbing Co., Inc.
4530 Brazil Street
Los Angeles, CA 90039

**STEVE DARNELL**
ARB, Inc.
26000 Commercentre Drive
Lake Forest, CA 92630

**ROBERT FELIX**
All Area Plumbing, Inc.
1560 W. Industrial Park Street
Covina, CA 91722

**MILTON GOODMAN**
ACCO Engineered Systems
6265 San Fernando Road
Glendale, CA 91201

**CHARLES MARTIN**
CPMCA
645 West 9th Street, Suite 700
Los Angeles, CA 90015

**JOHN ODOM**
Murray Company
18414 S. Santa Fe Avenue
Rancho Dominguez, CA 90221

**RICHARD SAWHILL**
ARCA/MCA
3602 Inland Empire Blvd., #B-206
Ontario, CA 91764

**STEVE SHIRLEY**
University Mechanical & Engineering Contractors
1168 Fesler Street
El Cajon, CA 92020

**BRYAN SUTTLES**
Suttles Plumbing
21541 Nordoff Street, Unit C
Chatsworth, CA 91311

**DAVID ZECH**
Pacific Plumbing Company
615 E Washington Avenue
Santa Ana, CA 92701

## B) Union Trustees

**RODNEY COBOS**
U.A. Local No. 484
1955 N. Ventura Avenue
Ventura, CA 93001

**GARY L. COOK**
U.A. Local No. 78
1111 James M. Wood Blvd.
Los Angeles, CA 90015

**KIRK CROSSWHITE**
U.A. Local No. 230
6313 Nancy Ridge Drive
San Diego, CA 92121

**VINCENT DIAZ**
U.A. Local No. 345
1430 Huntington Drive
Duarte, CA 91010

**RICHARD EDWARDS**
U.A. Local No. 364
223 S. Rancho Avenue
Colton, CA 92324

**MARK FOREMAN**
U.A. Local No. 114
93 Thomas Road
Buellton, CA 93427

**WALT FRENCH**
U.A. Local No. 403
3710 Broad Street
San Luis Obispo, CA 93401

**KEN JENKINS**
U.A. Local No. 761
1305 North Niagara Street
Burbank, CA 91505

**RAY LEVANGIE, JR.**
U.A. Local No. 398
8590 Utica Avenue, Suite 200
Rancho Cucamonga, CA 91730

**RUBEN MAGAÑA**
U.A. Local No. 494
2740 East Spring Street
Long Beach, CA 90806

**GLEN NOLTE**
U.A. Local No. 582
3904 W. First Street
Santa Ana, CA 92703

**MIKE ROCK**
U.A. Local No. 460
6718 Meany Avenue
Bakersfield, CA 93308

**GLENN SANTA CRUZ**
U.A. Local No. 250
18355 South Figueroa Street
Gardena, CA 90248

**SID STOLPER**
District Council No. 16
501 Shatto Place, Suite 400
Los Angeles, CA 90020