

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

**PENSIONERS  
& SURVIVING SPOUSES  
HEALTH  
Fund**

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## **SECTION 1 INTRODUCTION**

This Summary Plan Description / Plan Rules and Regulations ("SPD") describes the benefits offered by the Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund ("Fund" or "Plan"). This retiree-only Plan was established effective January 1, 2011. This booklet sets forth the terms of the Plan as of January 1, 2013.

This Plan does not cover Active Participants, whose benefits are covered under another plan and set forth in a separate booklet. 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 Pensioner, Surviving Spouse, 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 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 services and procedures covered by the Plan. The Plan pays claims only for benefits provided under the Plan.

The SPD also identifies a number of services and procedures that are not covered under the Plan. These services and procedures are set forth in the Exclusions and Limitations found in Section 15. 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 benefits, the Pensioner and/or Surviving Spouse 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 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 important changes will be sent to all Participants. Please be sure to read all Plan communications and keep them with this booklet.

Generally, terms defined in Section 20 are capitalized throughout this document.

## **SECTION 2 PURPOSE OF THE PLAN**

The Plan was established through the negotiating efforts of District Council #16 and Employers in the plumbing and piping industry in Southern California. The Plan currently provides Medical and Prescription Drug benefits for Pensioners and Surviving Spouses.

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, 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 PENSIONERS & SURVIVING SPOUSES PLAN BENEFITS**

### **CALENDAR YEAR DEDUCTIBLES**

1. \$250 individual medical Deductible with \$750 maximum family medical Deductible.
2. \$50 Prescription Drug Benefit Calendar Year Deductible per person.
3. \$50 Emergency Room non-Accident Deductible.

### **USEFUL DEFINITIONS**

#### **Allowable Charge(s)**

The scheduled amounts for medical services and supplies are established by the Board of Trustees and/or 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 Copayment amount, if any, and any charges that exceed the Allowable Charge.

#### **Active Plan**

The Southern California Pipe Trades Health and Welfare Fund for active employees and their Dependents.

#### **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 PENSIONERS & SURVIVING SPOUSES PLAN BENEFITS

Please see relevant section for details.

TYPE OF SERVICE	BLUE SHIELD OF CALIFORNIA (BSC) CONTRACTING PROVIDER  Plan Pays:	NON-BLUE SHIELD OF CALIFORNIA CONTRACTING PROVIDER  Any charges that exceed the Allowable Charge are Out-of-Pocket expenses to the Patient.  Plan Pays:
<b>AMBULANCE (Air and Ground)</b>	80% of the Allowable Charges for professional ambulance services deemed Medically Necessary by the Plan up to a maximum of \$150.	
<b>ANESTHESIA</b>	85% of the BSC Contract Rate.	80% of the Allowable Charge.
<b>CHEMOTHERAPY</b>	80% of the BSC Contract Rate.	80% of the Allowable Charge.
<b>CHIROPRACTOR</b>	<b>Maximum 3 visits per week.</b>	
	80% of the BSC Contract Rate up to \$600 per year.	80% of the Allowable Charge up to a maximum of \$600 per year.
<b>DURABLE MEDICAL EQUIPMENT</b>	<b>Benefits paid on a rental-to-purchase basis based on monthly eligibility of Patient.</b>	
	80% of the BSC Contract Rate.	80% of the Allowable Charge.
<b>HEARING AID</b>	80% of the charge up to a maximum of \$400 per device. If the Plan paid benefit for the existing device, replacement will not be covered until 36 months have elapsed from the date the expense was incurred for the existing device.	

# SUMMARY OF PENSIONERS & SURVIVING SPOUSES PLAN BENEFITS

Please see relevant section for details.

TYPE OF SERVICE		BLUE SHIELD OF CALIFORNIA (BSC) CONTRACTING PROVIDER  Plan Pays:	NON-BLUE SHIELD OF CALIFORNIA CONTRACTING PROVIDER  Any charges that exceed the Allowable Charge are Out-of-Pocket expenses to the Patient.  Plan Pays:
<b>HOSPITAL</b>	<b>Hospital Inpatient</b>	85% of the BSC Contract Rate for all room and board and Medically Necessary services.	80% of the Allowable Charge for room and board and other Medically Necessary services and supplies, up to a maximum of \$1,080 per day.
	<b>Inpatient Psychiatric</b>	85% of the BSC Contract Rate for all room and board and Medically Necessary services.	80% of the Allowable Charge for room and board and other Medically Necessary services and supplies, up to a maximum of \$1,080 per day.
		Coverage is provided up to a maximum of 10 days per Calendar Year and 60 days per lifetime.	Coverage is provided up to a maximum of 10 days per Calendar Year and 60 days per lifetime.
	<b>Hospital Outpatient</b>	85% of the BSC Contract Rate for all room and board and Medically Necessary services.	80% of the Allowable Charge for Medically Necessary services and supplies.
<b>LABORATORY</b>		80% of the BSC Contract Rate.	80% of the Allowable Charge.
<b>MEDICAL SUPPLIES</b>		80% of the BSC Contract Rate.	80% of the Allowable Charge.
<b>NON-PRESCRIPTION AND OVER-THE-COUNTER DRUGS</b>		<b>NOT COVERED</b>	
<b>PAIN MANAGEMENT</b>		\$10,000 Lifetime Maximum Benefit 80% of Hospital facility fee up to a maximum of \$900. 80% of surgery center facility fee up to a maximum of \$800. 80% of Physician's office/surgical suite facility fee up to a maximum of \$700. 80% of charges up to a maximum of \$250 per surgical injection. Maximum of 3 Surgical injections per day.	
<b>PHYSICAL THERAPY</b>		80% of the BSC Contract Rate up to \$600 per Calendar Year.	80% of the Allowable Charge up to a maximum of \$600 per Calendar Year.

# SUMMARY OF PENSIONERS & SURVIVING SPOUSES PLAN BENEFITS

Please see relevant section for details.

<b>TYPE OF SERVICE</b>		<b>BLUE SHIELD OF CALIFORNIA (BSC) CONTRACTING PROVIDER</b>  Plan Pays:	<b>NON-BLUE SHIELD OF CALIFORNIA CONTRACTING PROVIDER</b>  Any charges that exceed the Allowable Charge are Out-of-Pocket expenses to the Patient.  Plan Pays:
<b>PHYSICIAN</b>	<b>Physician Visit</b>	80% of the BSC Contract Rate.	80% of the Allowable Charge.
	<b>Inpatient Psychiatric Physician Visit</b> (Must be performed by a Physician)	80% of the BSC Contract Rate.	\$55 per visit, maximum of 2 visits per day for 1 day per Calendar Year paid at 80% of the Allowable Charge.
	<b>Acupuncture</b> (Must be performed by a Physician)	Office visit only. 80% of the BSC Contract Rate.	Office visit only. 80% of the Allowable Charge.
<b>PRESCRIPTION</b>  Benefits per Calendar Year		Maximum Calendar Year prescription benefit is \$600 per eligible individual.  \$50 Prescription Deductible (does not apply to the Calendar Year Deductible).  Drugs or medication include oral contraceptives and up to 30 pills annually for the treatment of erectile dysfunction.	
<b>PSYCHIATRIC</b>	<b>OUTPATIENT PSYCHIATRIC</b> (licensed Psychologist, clinical social worker, master social worker or marriage counselor who is practicing within the scope of his/her license in the state in which he/she practices)	100% of the BSC Contract Rate, up to a maximum of 9 visits per Calendar Year.	100% of Allowable Charge up to a maximum of 25 visits per Calendar Year.
	<b>Cannot be a combination of both.</b>		
	<b>INPATIENT PSYCHIATRIC</b> Must be performed by a Physician. (Refer to Hospital benefits.)	80% of the BSC Contract Rate. Maximum of 1 visit per day for 10 days per Calendar Year.	80% of the Allowable Charge. Maximum of 1 visit per day for 10 days per Calendar Year.
		<b>Maximum not to exceed 10 days.</b>	

# SUMMARY OF PENSIONERS & SURVIVING SPOUSES PLAN BENEFITS

Please see relevant section for details.

TYPE OF SERVICE		BLUE SHIELD OF CALIFORNIA (BSC) CONTRACTING PROVIDER  Plan Pays:	NON-BLUE SHIELD OF CALIFORNIA CONTRACTING PROVIDER  Any charges that exceed the Allowable Charge are Out-of-Pocket expenses to the Patient.  Plan Pays:
<b>RADIATION THERAPY</b>		80% of the BSC Contract Rate.	80% of the Allowable Charge.
<b>RADIOLOGY</b> (X-rays, CT scans, MRI/CAT scans, etc.)	<b>Performed in an outpatient radiology facility or Physician's office</b>	80% of the BSC Contract Rate.	80% of the Allowable Charge.
	<b>Performed in a Hospital</b>	85% of the BSC Contract Rate.	85% of the Allowable Charge.
<b>RENAL DIALYSIS</b>		80% of the BSC Contract Rate.	Up to a maximum of \$200 per treatment at 80% for facility charges.  80% of the Allowable Charge for supplies.
<b>SURGERY</b>	<b>Primary Surgeon</b>	Inpatient: 80% of the BSC Contract Rate.  Outpatient: 85% of the BSC Contract Rate.	Inpatient: 80% of the Allowable Charge.  Outpatient: 85% of the Allowable Charge.
	<b>Assistant Surgeon</b>	20% of the BSC Surgeon's Contract Rate.	20% of the Primary Surgeon's Allowable Charge.
	<b>Certified Assistant Surgeon</b>	10% of the BSC Surgeon's Contract Rate.	10% of the Primary Surgeon's Allowable Charge.
<b>VISION CARE</b>		<b>NOT COVERED</b>	



## **SECTION 4**

### **ENROLLMENT OF PENSIONERS**

#### **A) Enrollment & Beneficiary Form**

Pensioners must complete an Enrollment & Beneficiary Form in order to receive Plan identification cards if a current Enrollment & Beneficiary is not on file. The Enrollment & Beneficiary Form must list the Pensioner and any Eligible Dependent.

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

An updated Enrollment & Beneficiary Form must be submitted to the Fund Office when the Fund Office requests it or if the Pensioner wishes to:

- i) Change marital status;
- ii) Add an Eligible Dependent; or
- iii) Remove an Eligible Dependent.

Pensioners may obtain an Enrollment & Beneficiary Form from the Local Union Office, the Fund Office or the Fund Office website at [www.scptac.org](http://www.scptac.org).

#### **B) Required Documents**

In order to add or remove an Eligible 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 death certificate; or
- iii) 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 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, your new Spouse will not be eligible for coverage under the Pensioners and Surviving Spouses Plan.

##### **ii) Death Certificate**

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

##### **iii) Final Divorce Decrees**

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

#### **D) Change of Address Form**

If the Pensioner or Surviving Spouse wishes to change his/her address, a Change of Address form may be obtained from a Local Union office, the Fund Office or the Fund Office website at [www.scptac.org](http://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 Pensioners & Surviving Spouses.

#### **A) When to Elect Coverage**

The Pensioner may elect coverage under the Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund if ALL of the following criteria have been met:

- i) The Pensioner is receiving a monthly pension from the Southern California Pipe Trades Retirement Fund based on twelve (12) or more years of Pension Credit; and
- ii) The Pensioner has been eligible for Health & Welfare benefits under the Active Plan as an Employee for at least one (1) month during the 24 months prior to the initial effective date of retirement; and
- iii) The Pensioner has been eligible for Health & Welfare benefits under the Active Plan as an Employee or for at least sixty (60) of the 120 months preceding the initial effective date of retirement; and
- iv) Coverage is elected at the time of initial retirement; and
- v) The applicable monthly Premium is made on a timely basis; and
- vi) A fully completed Enrollment & Beneficiary Form is timely filed.

#### **NOTE:**

Retiring Pensioners who are eligible to participate in the Pensioners and Surviving Spouses Health Fund, but initially elect COBRA Continuation Coverage under the Active Plan, may not subsequently elect or receive coverage under the Pensioners and Surviving Spouses Plan. Similarly, eligible retiring Pensioners who initially elect coverage under the Pensioners and Surviving Spouses Plan may not subsequently elect or receive COBRA coverage under the Active Plan.



## B) When Eligibility Begins

Eligibility generally begins on the later of:

- i) The first day of the month for which a monthly pension benefit is received; or
- ii) The first day of the month in which eligibility is lost under the Active Plan.

All Pensioners are required to pay monthly Premiums set by the Board of Trustees. Most Pensioners fulfill this self-pay obligation by electing to have the Premium amount deducted from the monthly pension check. If automatic deduction is elected, the correct amount will automatically be paid each month to the Fund, and coverage under the Pensioners & Surviving Spouses Plan will continue. If a Pensioner does not elect to have the applicable Premium deducted from his/her monthly pension benefit, the Pensioner must personally make payments directly to the Fund in order to retain coverage under the Plan. Direct self-payments are due by the 20th of the month before the month of coverage, and an additional grace period of 30 days is provided from the beginning of the month of coverage. However, no coverage will be provided until payment is received. A Pensioner may also have his/her monthly Premium deducted from his/her checking account electronically.

### **DIRECT PAYMENTS**

**If the Pensioner fails to make timely contributions, he/she will permanently lose coverage from the Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund.**

## C) Dependent Eligibility

### i) Eligible Dependent

The Pensioner's lawful Spouse is the only Eligible Dependent under this Plan.

Other relatives, including children, stepchildren, grandchildren and/or persons for whom the Pensioner is responsible due to guardianship, will not be covered even though the Pensioner may be financially responsible for them.

### ii) Dual Coverage

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

### iii) When Eligible Dependent Coverage Starts

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

- a) The date the Pensioner becomes eligible for coverage under the Plan; or
- b) The date the Spouse becomes the Pensioner's Eligible Dependent, so long as the Spouse is enrolled in the Plan within 90 days of the date of marriage.

## iv) Extension of Coverage for Total Disability

If the Eligible Dependent's eligibility terminates while he/she is Totally Disabled, medical expense benefits will be available for that disabling condition up to a maximum of three months after the loss of eligibility. The disability extension is for the disabled Eligible Dependent only. A statement from the attending Physician is required.

This benefit is not included in COBRA coverage.

### **EXAMPLE**

**The Eligible Dependent is Totally Disabled due to a stroke and eligibility terminates due to divorce. The Eligible Dependent then receives treatment for a cold. No benefit is payable for the cold because it is not related to the disabling condition of a stroke.**

This extension must be requested by the Totally Disabled Eligible Dependent, the Pensioner or a duly appointed representative who is appointed in writing.

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 17 for a general discussion of the Plan's appeals procedures.

## **SECTION 6** **MONTHLY PREMIUM**

### **A) Premium Classifications and Range Classes**

Pensioner monthly Premiums are set forth in the chart below. This section describes how the Fund determines the classifications and range classes cited in the charts.

#### **i) Premium Classifications**

Pensioners are grouped into the following categories, based on Medicare eligibility, marital status, and the Spouse's Medicare eligibility. An individual's classification will be evaluated each month.

<b>Classification</b>	<b>Definition</b>
MM	Member (Pensioner) is Medicare-eligible; no Spouse is covered under the Plan
MMSM	Member (Pensioner) is Medicare-eligible; covered Spouse is Medicare eligible
MMSN	Member (Pensioner) is Medicare-eligible; covered Spouse is Not Medicare-eligible
MN	Member (Pensioner) is Not Medicare-eligible; no Spouse is covered under the Plan
MNSM	Member (Pensioner) is Not Medicare-eligible; covered Spouse is Medicare-eligible
MNSN	Member (Pensioner) is Not Medicare-eligible; covered Spouse is Not Medicare-eligible

## ii) Premium Score and Range Class

Pensioners are given a score under a combination point system called the "Rule of 100." The "Rule of 100" score of a Pensioner is based upon the Pensioner's age plus years of service (based on Pension Credits accrued under the Southern California Pipe Trades Retirement Plan) at the time of initial retirement under the Retirement Plan. For example, an individual who retires at age 65 with 35 years of service will receive a score of 100. An individual who retires at age 60 with 25 years of service will receive a score of 85.

Scores will be reduced by four (4) points for every year (or portion of a year) worked in the plumbing and pipefitting industry for an Employer that is not signed to a United Association Master Labor Agreement. Years prior to the first year of Pension Credit will not count for this purpose. However, Pensioners who return to work in Covered Employment can restore points lost for working in non-Covered Employment. In addition to earning points, one (1) point of lost coverage can be restored for working in non-Covered Employment for every two (2) service points earned after returning to Covered Employment. Years prior to a permanent break in service under the Retirement Plan cannot be restored.

If the Pensioner is receiving a Disability Pension, in determining the number of points, it will be assumed that Normal Retirement Age has been attained under the Southern California Pipe Trades Retirement Plan

when retired (age 65).

Under the "Rule of 100," a Pensioner's score is then converted to a "Range Class" based on the scale below:

<b>Range Class</b>	<b>Score From</b>	<b>Score To</b>
A	100	and above
B	95	99.99
C	90	94.99
D	85	89.99
E	80	84.99
F	75	79.99
G	below 75	

## B) Pensioner Premium Rates

The following chart shows the monthly Premium amounts effective from January 1, 2013 through December 31, 2013. For example, if a Pensioner who is Medicare-eligible, but whose Spouse is not Medicare-eligible (MMSN), retires at age 65 with 25 years of service (Range Class "C"), the Pensioner's monthly Premium is \$271. Under the chart, the monthly Premium for an unmarried Pensioner (MM) who retired at age 65 with 35 years of service (range class "A") is \$107. The Premiums will be adjusted automatically each year to reflect changes in the cost of coverage.

The monthly Premium for eligible Surviving Spouses is \$140 per month. This amount, which is effective from January 1, 2013 through December 31, 2013, is subject to increase in the future.

The reduced monthly Premium amount paid by a Pensioner or Spouse who becomes Medicare-eligible shall be effective on the first of the month in which the Pensioner or Spouse becomes Medicare-eligible.

In the case of Medicare eligibility based on a Social Security disability award, the Premium will begin in the month following the month in which the Pensioner or Spouse receives written notice of an award of a Social Security disability benefit or in the Social Security disability entitlement month, whichever is later.

**EXAMPLE**  
**Premium for a Pensioner who becomes eligible for Medicare on March 15 will be reduced effective March 1.**

Classification	Range Class						
	A	B	C	D	E	F	G
	100 +	95 - 99	90 - 94	85 - 89	80 - 84	75 - 79	< 75
MM	\$107	\$107	\$107	\$107	\$122	\$141	\$164
MMSM	\$107	\$107	\$130	\$158	\$198	\$231	\$267
MMSN	\$151	\$211	\$271	\$331	\$414	\$482	\$557
MN	\$268	\$268	\$268	\$288	\$360	\$419	\$485
MNSM	\$268	\$268	\$271	\$331	\$414	\$482	\$557
MNSN	\$268	\$268	\$315	\$385	\$482	\$561	\$648

### C) Making a Payment

As discussed in Section 5, in order to keep coverage under the Pensioners and Surviving Spouses Plan, Pensioners and Surviving Spouses must:

- i) Authorize a deduction from the monthly pension check, or
- ii) Authorize automatic electronic payment from a checking account (via ACH), or
- iii) Make direct payments to the Pensioners & Surviving Spouses Health Fund via check or money order.

#### NOTE:

Premiums are due by the 20th of the month before the month of coverage, and an additional grace period of 30 days is provided from the beginning of the month of coverage. However, no coverage will be provided until payment is received.

#### EXAMPLE

The payment for July 2013 coverage is due no later than June 20, 2013. No coverage will be provided until payment is received.

## SECTION 7 SUSPENSION & TERMINATION OF ELIGIBILITY

### A) Suspension of Coverage Due to Returning to Work for a Contributing Employer

Coverage under the Plan is suspended, including the obligation to pay a Premium to the Plan, effective on the date a Pensioner returns to work for a Contributing or Signatory Employer as follows:

- i) Return to Work Under the Waiver Program. A Pensioner who returns to work under the Temporary Waiver Program loses coverage under this Plan but may continue coverage under the Southern California Pipe Trades Health & Welfare Fund ("Active Plan") by paying the same Premium amount the Pensioner would be required to pay under this 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 this 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. A Pensioner age 65 to age 70½ who returns to Covered Employment will lose coverage under this Plan but may continue coverage under the Active Plan by paying the same Premium amount the Pensioner would be required to pay under this 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 this Plan but may continue coverage under the Active Plan by paying the same Premium amount the Pensioner would be required to pay under this 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 in a Non-Bargaining Unit Position. A Pensioner who returns to work in non-Covered

Employment (a position not covered under the collective bargaining unit or agreement, e.g. estimator, detailer, management or corporate officer) will lose coverage under this Plan for the length of the non-Covered Employment.

- vi) 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 this Plan but may continue coverage under the Active Plan by paying the same Premium amount the Pensioner would be required to pay under this Plan.

#### **Reinstatement Upon Return to Covered Employment.**

A Pensioner who previously was enrolled in this Plan and who returned to work under (i) through (vi) above may re-enroll in this Plan when he/she ceases employment. If the Pensioner established an Eligibility Bank in the Active Plan this will first be used to continue coverage under the Active Plan until it is exhausted. If a Pensioner elects not to re-enroll in the Pensioners Plan and pay the applicable Premium, he/she will be barred from establishing eligibility at a later date.

### **B) Termination of Health & Welfare Coverage for Pensioner**

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

- i) The first day of the month following 30 days from the date the Fund Office received a written request by the Pensioner to terminate coverage. If coverage is terminated for this reason, the Pensioner and Eligible Dependent will not be permitted to re-enroll in the Plan, unless the Pensioner and Spouse is continuously enrolled in an HMO Medicare-at-Risk or Medicare Advantage program or other Medicare managed care plan (for example: Secure Horizons, Kaiser Medicare, or SCAN); or
- ii) Whenever payment is not received timely; or
- iii) The first day of the month in which the monthly pension benefit from the Southern California Pipe Trades Retirement Fund stops; or
- iv) The date the Pensioner starts performing work in the plumbing, heating, and piping industry which is not pursuant to recognized Collective Bargaining Agreement (see Section 7(A)); or
- v) The date the Plan terminates.

A Pensioner whose Retirement benefits were suspended for performing work in the plumbing, heating, and piping industry which is not pursuant to a recognized Collective Bargaining Agreement may reestablish eligibility under the Plan, but only if the Pensioner has worked enough hours in Covered Employment to earn at least a quarter Pension Credit under the Southern California Pipe Trades Retirement Plan for each calendar quarter in which the Pensioner worked at least one hour in non-Covered Employment. If this condition is met, coverage must be elected at the time of re-instatement under the Southern

California Pipe Trades Retirement Plan and timely monthly self-payment must be made.

### **C) When Eligible Dependent Coverage Terminates**

Eligible Dependent coverage will terminate on the earliest of the following dates:

- i) The date the Pensioner's eligibility terminates; or
- ii) The date the Eligible Dependent no longer qualifies as an Eligible Dependent (e.g., upon divorce); or
- iii) The date of death of the Eligible Dependent; or
- iv) The date a Pensioner and Eligible Dependent requests termination. An Eligible Dependent will not be allowed to return to the Plan if he/she does not elect coverage at the time of the Pensioner's initial retirement or if an Eligible Dependent's coverage is subsequently terminated at any time thereafter. Both the Pensioner and Eligible Dependent must sign the request to terminate coverage; or
- v) The date the Plan terminates.

### **D) Surviving Spouse**

Surviving Spouse coverage may be continued indefinitely unless the Surviving Spouse remarries. In this case, coverage will terminate on the last day of the month in which the Surviving Spouse remarries. All benefits paid after the date of remarriage must be reimbursed to the Fund. Legal action may be taken to recover such benefits.

## **SECTION 8 EXTENDING COVERAGE**

### **A) Extension of Coverage for Total Disability of a Pensioner**

If the Pensioner's eligibility terminates while the Pensioner is Totally Disabled, medical expense benefits will be available, for that disabling condition only, for three months after the loss of eligibility.

#### **EXAMPLE**

**The Pensioner is Totally Disabled due to a stroke, eligibility terminates, and he/she receives treatment for a broken leg. No benefit is payable for the broken leg because it is not related to the disabling condition of the stroke.**

This extension is for the disabled Pensioner only.

### **B) Special Extension Period for Surviving Spouses of Pensioners and Active Participants**

In the event of the Pensioner's death, coverage for the Surviving Spouse will be provided under this Plan, at no cost, for three months following the month in which the Pensioner died. This three-month period is called the "Special Extension Period".



Surviving Spouses of Active Participants are eligible for the Special Extension Period under the Pensioners & Surviving Spouse Plan if, at the time of the Active Participant's death, the number of months in the Participant's Eligibility Bank is less than three. The length of the Special Extension period is the number of months necessary, in combination with the months remaining in the Active Participant's Eligibility Bank, to give the Surviving Spouse coverage for three months following the month in which the Active Participant died.

At the end of the Special Extension period, Surviving Spouses may choose to continue coverage either in the Active Plan through COBRA or in the Pensioners & Surviving Spouse Health Plan through the Surviving Spouse Self-Pay Program. If the Surviving Spouse elects COBRA, the Surviving Spouse will not be eligible to enroll in the Pensioner & Surviving Spouses Health Plan.

Once this election is made, the Surviving Spouse has 90 days from the date of election to pay the retroactive Premium for the second three-month period (e.g., the period beginning after the Special Extension Period).

### **C) Surviving Spouse Self-Pay Program**

There are two types of Surviving Spouses who can qualify for the Surviving Spouse Self-Pay Program and choose to continue coverage under the Southern California Pipe Trades Pensioners & Surviving Spouses Health Plan.

- i) Surviving Spouse of a deceased Pensioner; or
- ii) Surviving Spouse of deceased Active Participant who was covered on the Active Participant's date of death. (For additional information regarding this category of Surviving Spouses, see the Summary Plan Description for the Southern California Pipe Trades Health & Welfare Fund (Active Plan)).

The Trust Fund will provide the eligible Surviving Spouse with the Application for the Surviving Spouse Self-Pay Program.

### **D) Application & Payment**

#### **i) Deadline**

The Fund Office must receive the completed application, together with the self-payment, no later than 180 days from the date the Surviving Spouse's coverage terminated due to the death of the Pensioner or Active Participant.

#### **ii) Payment Amount**

The amount of the Surviving Spouse Self-Payment is currently \$140 per month. The Trustees may change the amount from time to time.

#### **iii) Timely Contributions**

Subsequent self-payments are due by the 20th of the month before which coverage is desired so that coverage will be maintained continuously in effect. A Surviving Spouse who fails to maintain continuous

coverage through timely self-payments shall not be permitted to reinstate coverage.

#### **NOTE:**

Premiums are due by the 20th of the month before the month of coverage, and an additional grace period of 30 days is provided from the beginning of the month of coverage. However, no coverage will be provided until payment is received.

#### **iv) Coverage Limitations**

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

## **SECTION 9 PLAN PROVISIONS**

### **A) Lifetime Maximum Benefit (LMB)**

Members who retired on or before December 31, 2008 have a Lifetime Maximum Benefit of \$2,000,000.

Members who retired on or after January 1, 2009 will have the same level of Lifetime Maximum benefit as they had under the Active Plan as of their retirement effective date up to a maximum benefit of \$2,000,000 per Lifetime. For example, an Active member with an Annual Maximum Benefit of \$1,000,000 who retires will have a Lifetime Maximum benefit of \$1,000,000.

Surviving Spouses whose Spouse died on or before December 31, 2008 have a Lifetime Maximum Benefit of \$500,000. Surviving Spouses whose Spouse died on or after January 1, 2009 have the same level of Lifetime Maximum Benefit as they had under the Active or Pensioners & Surviving Spouses Plan as of the date of death, up to a maximum benefit of \$2,000,000 per lifetime.

The Lifetime Maximum Benefit for individuals who become eligible to participate in the Plan for the first time, or who reestablish eligibility after a 24 month interruption in coverage, on or after January 1, 2009 is set forth below:

- i) If the individual has been covered under either the Active or Pensioners and Surviving Spouses Plan for 12 or fewer months, this Plan will pay no more than \$100,000 in benefits for each eligible individual.
- ii) If the individual has been covered under either the Active Plan or Pensioners and Surviving Spouses Plan for more than 12 months, but fewer than 24 months, this Plan will pay no more than \$250,000 in benefits for each eligible individual.
- iii) If the individual has been covered under either the Active Plan or Pensioners and Surviving Spouses Plan for more than 24 months, but fewer than 60

months, the Plan will pay no more than \$500,000 in benefits for each eligible individual.

- iv) If the individual has been covered under either the Active Plan or Pensioners and Surviving Spouses Plan for more than 60 months but fewer than 120 months, the plan will pay no more than \$1,000,000 in benefits for each eligible individual.
- v) If the individual has been covered under either the Active Plan or Pensioners and Surviving Spouses Plan for more than 120 months, the plan will pay no more than \$2,000,000 in benefits for each eligible individual.

Any eligibility under the Pensioners & Surviving Spouses Plan or the Active Plan is combined to determine which Lifetime Maximum Benefit 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 Plan self-payment.

Interruptions in coverage of fewer than 25 months do not affect your LMB. 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 LMB) your LMB will revert to the next lower LMB in effect before the interruption. For example, if your LMB is \$500,000 before a 25-month coverage interruption then, when your coverage is established, your LMB will revert to \$250,000, and 12 additional months of coverage will be required to restore your LMB to \$500,000.

On January 1 of each year, up to \$2,500 will automatically be restored if the remaining Lifetime Maximum Benefit is less than the maximum amount. Restored amounts cannot be used for claims incurred in previous years.

If the eligible Pensioner or Eligible Dependent qualifies as both a Pensioner and as an Eligible Dependent of a Pensioner, separate Lifetime Maximums apply.

## **B) Calendar Year Deductible**

The Pensioner is responsible for the first \$250 in Allowed Amounts that are incurred in a Calendar Year. This is the "Calendar Year Deductible." The Calendar Year Deductible applies separately to both the Pensioner and Eligible Dependent.

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

The Calendar Year Deductible does not apply to the:

- 1) Prescription Drug Benefit: There is a separate \$50 Calendar Year Deductible for Prescription Drugs.

- 2) Emergency Room Deductible: The Patient is responsible for the first \$50 of non-Accident covered charges incurred in the emergency room of a Hospital. This Deductible applies every time the Patient receives care in the emergency room and incurs non-Accident related 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 Pensioners & Surviving Spouse Health 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 a reasonable cost.

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

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

When it is necessary to seek medical care, select a provider from the Blue Shield of California network to receive the maximum benefit under this Plan at the lowest cost to you. A list of Blue Shield of California providers can be found at [www.blueshieldca.com](http://www.blueshieldca.com).

#### **IMPORTANT:**

To verify that the provider of service is participating in the Blue Shield of California network 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 to 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 Pensioners & Surviving Spouses Health 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.

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

If the Patient utilizes a Non-Blue Shield of California contracting service provider, the Plan'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.

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

### **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 Pensioners and Surviving Spouses Health 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 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 entire bill for your medical care and submit a Claim Form to the local Blue Cross and/or Blue Shield plan, or to the Fund for payment. The 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 entire 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*<sup>®</sup> at 1-800-810-BLUE (2583) to locate providers that participate with the local Blue Cross and/or Blue Shield plan, or go on-line to [www.bcbs.com](http://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 world-wide or you can go on-line to [www.bcbs.com](http://www.bcbs.com) and select "Find a Doctor or Hospital" and "BlueCard Worldwide."

#### **ii) BlueCard Program**

Under the BlueCard<sup>®</sup> 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 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 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 85% of the Blue Shield of California Contract Rate for all room and board and other Medically Necessary supplies and services. The Patient is responsible for the remaining 15% and for 100% for 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.

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

The Plan will pay 80% of the Allowable Charges for room and board and other Medically Necessary services and supplies, up to a maximum of \$1,080 per day.

The Patient is responsible for the balance and 100% of non-Covered Services which may include, but are not limited to, such items as guests expenses, telephone charges, pregnancy testing, 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 covered benefits 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.

### **B) Inpatient Mental or Nervous Disorder**

The Plan covers Pensioners and Eligible Dependents who are confined to a Hospital as a registered bed Patient for a Mental or Nervous (psychiatric) Disorder, with the approval of a Physician, as follows:

#### **i) Blue Shield of California Hospital**

The Plan will pay 85% of the Blue Shield of California Contract Rate for all room and board and Medically Necessary services. The Patient is responsible for the remaining 15%. Coverage is provided up to a maximum of:

- a) 10 days per Calendar Year; and
- b) 60 days per lifetime.

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.

The Patient is responsible for any balance and 100% of any non-Covered Services which may include such items as guest expenses, telephone charges, pregnancy testing, tests or treatment not related to the diagnosis, and drug testing.

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

The Plan will pay 80% of the Allowable Charges for room and board and other Medically Necessary services and supplies, up to a maximum of a) 10 days per Calendar Year, and b) 60 days per lifetime. The Patient pays the balance.

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

#### **NOTE:**

- a) A fully itemized bill is required from the facility.
- b) A bill listing an "all inclusive" daily rate will not be paid the Fund.
- c) Outpatient "day care," "1/2 day care," residential treatment care, etc. are not covered by the Plan.

### **C) 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, Psychiatrist 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:
  - a) 100% of the Blue Shield of California Contract Rate
  - b) Up to a maximum of nine (9) visits per Calendar Year
- ii) Non-Blue Shield of California Contracting Providers;
  - a) 100% of the Allowable Charge
  - b) Up to a maximum of twenty five (25) visits per Calendar Year

Pharmacologic management visits to a Physician are allowed at \$50 per visit not to exceed six (6) visits per year. This does not reduce the Mental and Nervous maximum visits per Calendar Year.

Psychiatric or neuro-psychiatric testing is limited to a maximum of \$100 per Calendar Year. This includes the testing, interpretation, evaluation and written reports.

#### **D) Outpatient Hospital**

The Plan covers expenses that the Pensioner 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;
- 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 which lists services 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 85% of the Blue Shield of California Contract Rate. The Patient is responsible for the remaining 15% of the Blue Shield of California Contract Rate.

Non-Blue Shield of California Hospital: The Plan will pay 80% of Allowable Charges. The Patient is responsible for the remaining balance.

#### **E) Physician Visits/Professional Services**

##### **i) In the Hospital**

If a Pensioner or Eligible Dependent incurs Physician or surgical expenses in a Hospital, the Plan will pay 80% of the Blue Shield of California Contract Rate or 80% of the Allowable Charge, whichever is applicable. For anesthesia services rendered in a Hospital, the Plan will pay 85% of the Blue Shield of California Contract Rate or 85% of the Allowable Charge, whichever is applicable. The services must be authorized and performed in a Hospital by a licensed Physician, Podiatrist, or Dentist.

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

- a) A trauma team in the Emergency room; or
- b) A "standby" surgeon or anesthesiologist during a surgical procedure.

##### **ii) In the Physician's Office**

###### **a) Blue Shield of California Contracting Physician**

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

Physician Visits	80%
Surgery	80%
Anesthesia	80%
Laboratory Tests	80%
X-Rays	80%
Injections	80%
Radiation Therapy	80%
Radiation Treatment Planning	80%
Chemotherapy	80%

###### **b) Non-Blue Shield of California Contracting Physician**

The Plan will pay the percentage of the non-Blue Shield of California Allowable Charges listed below.

Physician Visits	80%
Surgery	80%
Anesthesia	80%
Laboratory Tests	80%
X-Rays	80%
Injections	80%
Radiation Therapy	80%
Radiation Treatment Planning	80%
Chemotherapy	80%
Administration & Infusion	80%

The Plan does not cover "standby" charges. These are charged 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 trauma team in the Emergency room; or
- b) 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 80% of the Blue Shield of California Contract Rate or Allowable Charge, whichever is applicable. The Plan covers only one 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.

### F) 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 Pensioner or Eligible Dependent and up to 30 pills annually for the treatment of erectile dysfunction.

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

**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 eligible Pensioner or Eligible Dependent submits proof of residency in the country where the services were rendered.**

A claim for reimbursement may be submitted each time within a Calendar Year when the charges for covered drugs or medication, per individual, total \$200 or more.

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 \$600 per Pensioner 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:

- a) Name of Patient;
- b) Name of medication;
- c) Date dispensed;
- d) Name, address, and phone number of Pharmacy;
- e) Name of prescribing Physician;
- f) National Drug Code (NDC) Number; and
- g) 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 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.

### G) Chiropractic Care

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

### H) Vision Benefits

Vision services are not a covered benefit under this Plan.

### I) Allergy Treatment

The Plan will pay up to \$75 per vial of antigens, including the charges for the injection, payable at 80% not to exceed a maximum of \$750 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 twelve-month period. There is no benefit for the administration of the antigen.

The Plan does not provide benefits for food allergy testing.

### J) Hearing Aid Benefit

The Plan will pay 80% of the charge up to a maximum of \$400 per device and not to exceed one device per ear in a 36-month period.

Replacement will not be covered until 36 months have elapsed from the date the expense was incurred for the existing device.

Any portion of this 36-month period will be carried over from the Health & Welfare Active Plan, if applicable.



### EXAMPLE

If a right ear device was dispensed on March 21, 2013, no additional benefits will be allowed until March 22, 2016. If a left ear device was dispensed on October 14, 2014, no additional benefits will be allowed until October 15, 2017.

The \$250 Calendar Year Deductible does apply to the Hearing Aid Benefit.

### K) 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 up to a maximum payment of \$150 per trip.

- i) The Plan will pay for:
  - a) Ground ambulance services to or from a Hospital or Extended Care Facility in connection with a confinement;
  - b) Ground ambulance services to the airport and from the airport to the destination medical facility; and
  - c) Intrastate or interstate air ambulance services to a medical facility.
- ii) The Plan will not 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 contracting Blue Shield of California 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.

### L) Outpatient Physical Therapy

If the Patient incurs charges for outpatient physical therapy, by a licensed Physical Therapist, the Plan will pay 80% of the Allowable Charges up to a maximum of \$600 per Calendar Year - including Occupational Therapy for hand Injuries only.

### M) Pain Management

The Plan will pay 80% of Allowable Charges or 80% of the Blue Shield of California Contract Rate, whichever is applicable, up to a maximum of \$10,000 per lifetime, 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.

### N) Outpatient Speech Therapy Benefits

Outpatient Speech Therapy is not a covered benefit under this Plan.

### O) Outpatient Cardiac Rehabilitation

Outpatient Cardiac Rehabilitation is not a covered benefit under this Plan.

### P) Temporomandibular Joint Dysfunction (TMJ)

Treatment for TMJ is not a covered benefit under this Plan.

### Q) Hospice

Hospice is not a covered benefit under this Plan.

### R) Extended Care Facility/Convalescent Hospital - Skilled Nursing Care Facility

The Plan will pay 80% of the Allowable Charges for a maximum of 120 days per Calendar Year. Extended Care Benefits follow Medicare Guidelines which require care to be provided within 3 days of a 4-day inpatient Hospital confinement. Home visits by a Nurse reduce the 120 days. Extended Care does not include Custodial Care, companion care, etc.

### S) Other Services and Supplies

The Plan will pay 80% of the Blue Shield of California Contract Rate for Blue Shield of California contracting providers, or 80% of Allowable Charges for non-Blue Shield of California contracting providers, for the items listed below, but only when authorized by a licensed Physician or Podiatrist:

- i) Services of a Nurse, not to exceed \$75 per day 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 oxygen 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 wheelchairs, sports wheel chairs, electric scooters, or electric hospital beds);
- vi) Artificial Durable Medical Devices;
- vii) Trusses, braces, or crutches; or
- viii) Diabetic supplies, including glucose monitors, test strips, and other testing supplies;
- 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 to a maximum of \$150;

- 4) Supplies allowed monthly with a maximum allowable of \$160.
- b) C-pap device
  - 1) Benefit limited to Medicare Allowable Charge;
  - 2) Replacement allowed once every 72 months;
  - 3) Repairs allowed once every 36 months;
  - 4) Supplies allowed once every 12 months with a maximum of \$150.

## T) Transplants

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

- i) Kidney transplant;
- ii) Liver transplants for congenital biliary atresia only;
- iii) Transplants of organ parts limited to corneas, skin, bones and tendons; and
- iv) Bone marrow transplants (including stem cell transfers/transplants) but only if the diagnosis is severe aplastic anemia, provided such anemia is not intentionally induced for treatment of another disease or acute leukemias.

Artificial parts transplants are limited to:

- i) Joint replacement for functional reasons;
- ii) Skin;
- iii) Heart valves;
- iv) Vascular grafts and patches;
- v) Pacemakers;
- vi) Metal plates; and
- vii) Eye after cataract Surgery.

The maximum benefit in connection with any one-organ transplant is \$100,000, including any pre-care or follow-up care. This maximum benefit in connection with any one-organ transplant (\$100,000) is included in the Pensioner's Lifetime Maximum Benefit. This benefit includes all pre and post transplant care, including but not limited to chemotherapy, radiation, 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) Intrauterine Device

The Plan covers benefits for Intrauterine Devices (IUDs) for eligible Participants and Dependents in this 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.

## SECTION 12 PROCESSING CLAIMS FOR BENEFITS

### A) How to File a Claim for Payment

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 are also not claims under these procedures. The Fund does not require pre-authorization as a condition for the receipt of benefits under the Plan. Therefore, requests for pre-authorizations will not be considered claims under these procedures.

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.

#### 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 Claim for Payment

Please send prescription claims to:

**Southern California Pipe Trades  
Pensioners & Surviving Spouses  
Health Fund  
Claims Department  
501 Shatto Place, 5th Flor  
Los Angeles, CA 90020**

Claims must not be submitted by phone, fax or e-mail. Medical providers must file electronic claims via Electronic Data Interface ("EDI") to Blue Shield of California. 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 or prescription 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 is not required and will not be treated as a claim for benefits. 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 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](http://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 have 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.), or being hit by a projectile or by another person, automobile Accidents, bicycle Accidents, food poisoning, any unforeseen or unavoidable occurrences.

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, or 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 at the above address within 90 days after the date services were provided. Claims submitted more than 12 months after the date of service will be 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 to the above address within 90 days of the request. Replies submitted more than 12 months from the date of request will not be accepted.

### **C) 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) or reasons 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, 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 given free of charge upon request, will be provided.

## **SECTION 13 COORDINATION OF BENEFITS**

### **A) General Rules**

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

For any expense allowable under the Plan, the claimant 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) Any coverage provided through an Employer that provides care at a reduced rate (e.g., employed by a Hospital or Physician and care is received at that facility at no charge or a reduced rate) the lesser of the Plan's regular benefit of the reduced charge.

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

- i) Group insurance or any other arrangement of coverage for the Pensioner and Eligible Dependent in a group whether or not enrolled; or
- ii) Blue Cross, Secure Horizon, 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 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 a 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 one Spouse is retired and the other is actively employed:

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

If a Pensioner is retired but is using his/her Active Eligibility Bank, and his/her Spouse is actively employed:

- i) The plan providing coverage for the active Employee is the primary payer.
- ii) The plan providing coverage using the eligibility bank is secondary payer.

If an Eligible Dependent is covered by an HMO or another 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 people to apply for Medicare 90 days prior to 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 apply with Medicare.

Pensioner and Spouse are both employed with coverage and eligible for Medicare:

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

If the Employee 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 Employee 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 Trustees have determined with the assistance of an actuary, that the Pensioner & Surviving Spouses Health Plan prescription drug program for Medicare-eligible Pensioners is **not** "actuarially equivalent" to Medicare Part D. This means that, on average, the standard Medicare Part D drug plan provides better benefits than

this Plan. Since Medicare Part D provides better benefits, you should consider enrolling in a Medicare prescription drug plan.

A Pensioner or Surviving Spouse can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. The Pensioner or Surviving Spouse should note, however, that if they do not sign up for Medicare Part D when they first become eligible they may have to pay a higher Premium for their Medicare Part D coverage. The Pensioner or Surviving Spouse will have to pay this higher Premium for as long as they are covered under Medicare Part D. They can avoid this increase in Premium by not going more than 63 days without coverage that is at least as good as the coverage that is available under Medicare Part D. This is called "creditable coverage." However, since the coverage that is available under the Plan is not as good as the coverage that is available under Medicare Part D, it will not be considered "creditable coverage." Thus, we recommend that they seriously consider enrolling in a Medicare Part D Plan.

Beginning on January 1, 2006, if the Pensioner or Surviving Spouse is eligible for Medicare, the Southern California Pipe Trades Pensioners & Surviving Spouses Health Plan will reimburse them for 100% of the first \$250 of their prescription drug expenses after they have satisfied the \$50 deductible, plus 25% of the next \$1,400 of their prescription drug expenses. The maximum reimbursement from the Plan will continue to be \$600 per year. If they do not enroll in Medicare Part D, they will be responsible for any prescription drug expenses over \$600.

Detailed information about Medicare plans that offer prescription drug coverage is available through the "Medicare & You" handbook from Medicare. If the Pensioner or Surviving Spouse has not received a copy, they can download it from [www.medicare.gov/publications](http://www.medicare.gov/publications). They can also get more information about Medicare prescription drug plans from: (a) [www.medicare.gov](http://www.medicare.gov); (b) California Health Advocates at (800) 434-0222; or (c) 1-800MEDICARE, (TTY users should call 1-877-486-2048).

**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 14 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 cooperate fully 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 15 MEDICAL EXCLUSIONS AND LIMITATIONS**

Although an attempt has been made to be as complete as reasonably possible, it is not always possible to list every excluded service or 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 the 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 of treatment of bodily Illnesses or Injuries as determined by the Fund, except for routine physical examinations expressly covered by the Plan;
- 3) Any claim for treatment, services and/or supplies, including any additional information requested, that is not



filed within 12 months from the date the expense is incurred;

- 4) Vitamins, including prenatal vitamins (prescription and over the counter);
- 5) "Standby" charges (those charges in which a Physician is present but is not providing care, treatment or a diagnosis) This includes, but is not limited to, anesthesiologists, pediatricians, and trauma teams;
- 6) Additional charges for "after hours" and weekend services by a Physician;
- 7) Charges for obtaining, testing, and storing the Patient's blood prior to a medical procedure of any kind;
- 8) Prescription Drugs dispensed in a Physician's office;
- 9) Services, prescriptions, medications, and supplies received outside of the United States and its territories unless (1) the services, medications, or supplies were the result of an Accident or life-threatening Emergency or (2) the eligible Pensioner or Eligible Dependent submits proof of residency in the country where the services were rendered;
- 10) Nutritional counseling regardless of the diagnosis, including, but not limited to, diabetes, hypertension and obesity;
- 11) Over the counter medications and medical supplies, such as gauze, bandages, shoe inserts and herbal medications;
- 12) Care or treatment for drug addiction, and/or alcoholism or resultant mental conditions;
- 13) 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;
- 14) Reversal or attempted reversal of an elective sterilization procedure;
- 15) Tissue testing for infertility;
- 16) Genetic screening/testing or chromosome analysis for any reason and/or diagnosis, including a family history or a disease or condition;
- 17) Family Planning (except Prescription Drug benefit for birth control pills for Participant or Eligible Dependent only);
- 18) Care or treatment for pregnancy or related conditions and/or complications;
- 19) Any charges or medical claims for which a third party may be liable or legally responsible;
- 20) Any services or procedures that are Experimental Treatments or investigational in nature or are not within the standards of generally accepted medical practice, or medical services or supplies, including Prescription Drugs, considered educational, investigational, or experimental. A drug, device, or medical treatment of 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).

- 21) Radial keratotomy and any other type of refractive eye surgery, (e.g. laser or Lasik Surgery), regardless of the diagnosis;
- 22) Expenses for travel or transportation, except as provided under ambulance benefits;
- 23) Any Illness, Injury, or disability covered by any worker's compensation laws;
- 24) Replacement of Durable Medical Equipment within 36 months not to exceed \$150 annually for repair or replacement, including prosthetics;
- 25) 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);
- 26) Hospital or Extended Care Facility charges for personal items such as charges for radio, television, telephone, guest expenses, and other similar items;
- 27) Housekeeping services;
- 28) Custodial Care; companion care, day care, e.g., cooking, feeding, dressing, bathing, changing dressings;
- 29) Care by homeopathic practitioners, naturopathic practitioners (NP), acupuncturists, and medical doctors licensed in the orient (OMD);
- 30) Charges for phone consultations (e.g. reading of EKG's);
- 31) Charges for missed or broken appointments;
- 32) Charges for completion of forms;
- 33) Interest on unpaid balance(s);
- 34) Any charges paid for or payable by another group benefit, service Plan, or insurance;
- 35) Blood pressure monitors, thermometers, vaporizers;
- 36) Charges for personal comfort, beautification, or convenience items or services;
- 37) Services by a provider related to the Pensioner or Eligible Dependent by blood or marriage;
- 38) Occupational Therapy (except for the treatment of a hand Injury or disability);
- 39) Any service associated with sex transformations and/or resulting complications;
- 40) Conditions caused by an act of war, armed invasion, insurrection or aggression;
- 41) Care or treatment as a mentally abnormal or mentally disordered sex offender in any Hospital or facility of any state or political subdivision;

- 42) Care or treatment in any penal institution;
- 43) EMS (Emergency Medical Service) with no transport, except as stated under the Ambulance Benefit;
- 44) 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;
- 45) Care or treatment obtained in a federal or state facility, or a facility operated by a government agency for which the Pensioner is not required to pay except to the extent benefits are required by law to be paid by the Plan;
- 46) 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;
- 47) Weight control, such as surgical procedures, diet management, medications, exercise programs, or nutritional training regardless of any medical condition, related or otherwise;
- 48) Treatment of alcohol and drug addiction and any related Mental or Nervous conditions;
- 49) Any goal-oriented behavior modification therapy, such as smoking cessation, alcohol/drug addiction, or weight loss;
- 50) Exercise equipment, tanning booths, whirlpools, swimming pools, saunas, spas, massage therapy or gym memberships, or aquatic exercises;
- 51) Food allergy testing regardless of diagnosis;
- 52) 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;
- 53) Outpatient speech therapy;
- 54) Outpatient cardiac rehabilitation therapy;
- 55) Outpatient respiratory/pulmonary rehabilitation therapy;
- 56) Home intravenous therapy (IV therapy);
- 57) Mental health day care centers, ½-day confinements for mental and nervous conditions, residential facilities;
- 58) Treatment for Temporomandibular joint dysfunction (TMJ);
- 59) Acupuncture except as provided by a Physician;
- 60) Electric wheelchairs, electric hospital beds (allowance may be made for standard wheelchair or standard hospital bed);
- 61) Transplant and stem cell transfers (except as noted under Transplant Benefit);
- 62) Eye examinations, vision care;
- 63) Eye glasses or contact lenses;
- 64) Hospice or Hospice programs;
- 65) Charges the Patient would not be required to pay for in the absence of coverage under this Plan;
- 66) Any bodily Injury or Illness for which a Physician does not provide treatment, except as specifically provided;
- 67) Charges by a financial institution for the deposit or cashing of a previously "stop paid" or "outdated" check; and
- 68) Pain Infusion pumps for postoperative pain management.

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

## **SECTION 16**

### **COBRA CONTINUATION COVERAGE FOR SURVIVING & DIVORCED SPOUSES**

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

##### **i) Introduction**

Federal law requires that group health Plans (including this Plan) offer Eligible Dependents the opportunity to elect a temporary extension of health coverage (called "COBRA Continuation Coverage") in certain instances (called "Qualifying Events") where coverage under the Plan would otherwise end. To receive this continuation coverage, the Eligible Dependent must pay timely monthly COBRA Premiums directly to the Fund.

##### **ii) Rights of Dependent Spouse**

The Spouse of a covered Pensioner may have the right to choose COBRA Continuation Coverage if eligibility for coverage is lost under the Plan for either of the following qualifying events:

- 1) The death of the covered Pensioner; or
- 2) Divorce from the covered Pensioner.

Note that, because Surviving Spouses are generally eligible to pay a reduced rate for coverage under the Widow Self-pay Program, it only rarely makes sense for a Surviving Spouse to elect COBRA coverage. (For example, coverage under the Widow Self-pay Program ends when the Surviving Spouse remarries. So, if the Surviving Spouse expects to remarry, it might make sense in some cases to pay for more expensive COBRA coverage, even if the Surviving Spouse is initially eligible

for the Widow Self-pay Program.)

**B) How long will continuation coverage last?**

Coverage for an Eligible Dependent Spouse ends on the date of divorce or the date of the Pensioner’s death. However, the Spouse has the right to pay for COBRA Continuation Coverage. Without COBRA payments, no benefits will be paid on behalf of a former Spouse.

Qualifying Event	Qualified Beneficiary	Maximum Continuation under the Plan
Death of covered Pensioner	Spouse	36 months after the date of qualifying event
Divorce of covered Pensioner	Spouse	36 months after the date of qualifying event

**C) Termination of COBRA Coverage**

COBRA Continuation Coverage will end before the 36-month continuation coverage period expires if the Eligible Dependent Spouse: i) Fails to pay the required Premium on time; or ii) Becomes covered by another group health Plan (except a Plan that excludes or limits benefits for a pre-existing condition affecting the Eligible Dependent, and such exclusion or limitation is enforceable under Health Insurance Portability and Accountability Act (HIPAA); or iii) Becomes entitled to Medicare; or iv) COBRA Continuation Coverage is no longer available under this Plan because the Plan terminates.

**D) Duty to Notify the Fund**

In the event of the Pensioner's death, the Eligible Dependent must provide written notice with a certified copy of the death certificate within 60 days of the date of the Pensioner's death. In the event of a divorce, written notice of the divorce and a copy of the final decree must be given to the Fund Office within 60 days after the final decree is entered.

If the required notice is not provided within the time allowed, COBRA self-payment will not be permitted.

The Pensioner and/or Eligible Dependent Spouse will be required to refund any monies paid by the Fund after the date of divorce or loss of Eligible Dependent status.

**E) 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) or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

**SECTION 17  
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 be 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 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 extension of eligibility for Total Disability. Written decisions of the appeals committee on review of denials of claims these 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 Fund maintains records of determinations on appeal and Plan interpretations so that those determinations and interpretations may be referred to in future cases with similar circumstances.

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 18 FEDERAL LAWS**

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

#### **i) Creditable Coverage**

When coverage ends the Pensioner and/or covered Eligible Dependent will automatically receive a Certificate of Group Health Plan Coverage. A Certificate of Group Health Plan Coverage indicates



the period of time the Pensioner and/or Eligible Dependent was covered under the Plan (including, if applicable, any COBRA coverage period), as well as certain additional information required by law.

This Certificate is an important document for a Pensioner and/or Eligible Dependent who becomes eligible for coverage under another group health Plan, or if the Pensioner buys a health insurance policy for himself 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 Pensioner and/or any Eligible Dependent under the new group health Plan or health insurance policy.

This Certificate will be provided shortly after this Plan knows, or has reason to know, that coverage (including COBRA coverage) for the Pensioner and/or Eligible Dependent 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 Certificates of Group Health Plan Coverage to the Fund. The certificate will be sent to the Pensioner or to any Eligible Dependent by first class mail shortly after coverage under this Plan ends. If the Pensioner or any Eligible Dependent 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 HIPAA, 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 of 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, or 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 Pensioners 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  
Pensioners & Surviving Spouses Health Fund

Attention: Privacy Officer  
501 Shatto Place, 5th Floor  
Los Angeles, CA 90020  
(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**

For more information about the Fund's policies and procedures regarding privacy of PHI, contact the Fund's Privacy Officer.

#### **B) Women's Health and Cancer Rights**

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:

- i) Reconstruction of the breast on which the mastectomy was performed;
- ii) Surgery and reconstruction of the other breast to produce symmetrical appearance;
- iii) Prostheses; and
- iv) Treatment of physical complications of all stages of the mastectomy, including lymphedemas.

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

## **SECTION 19 IMPORTANT INFORMATION ABOUT THE PLAN**

#### **A) Name of Plan**

This Plan is known as the Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund.

#### **B) Plan Sponsor and Administrator**

The Plan is maintained by a collectively bargained, jointly trustee labor management trust fund. The Plan and Fund are administered by a Board of Trustees. The Board of Trustees is both the legal Plan Sponsor and the legal Plan Administrator 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  
Southern California Pipe Trades  
Pensioners & Surviving Spouses Health 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  
Pensioners & Surviving Spouses Health 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 951867598. 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  
Pensioners & Surviving Spouses Health 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,

hearing aid, and Prescription Drug benefits in the event of Illness or Injury.

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

#### **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) (also known as the "Master Labor Agreement" under the Plan);
- 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 Pensioners & Surviving Spouses Health 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 Pensioners & Surviving Spouses Health Fund.

## **L) Identity of Source of Benefits**

All of the types of benefits provided by the Plan for Pensioners & Surviving Spouses are set forth in this booklet. (There is a separate section covering benefits for Active Employees.) The source of benefits is the Southern California Trades Pensioners & Surviving Spouses Health Fund.

## **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 Pensioners & Surviving Spouses Health 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 for Eligible Dependents**

Continue health care coverage for 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 20 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.

## **Blue Shield of California (BSC)**

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. The rate is set by contractual agreement among the Fund, Blue Shield of California, 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.

## **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, Pensioners & Surviving Spouses Health 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.

## **Copayment**

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 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.

## **Eligible Dependent**

The Pensioner's lawful Spouse if timely enrolled.

## **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 19 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 Pensioners & Surviving Spouses Health 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.

### **Lifetime Maximum**

The total dollar amount payable during a Participant's, Pensioner's, or Eligible Dependent's life for benefits issued by the Fund.

### **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.

### **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 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 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 care

or treatment.

### **Pension Credit(s)**

The years of service which are accumulated and maintained for Employees.

### **Pensioner**

A retired Employee who has satisfied the rules to become eligible under the terms of 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 and who is not a family member of the Patient.

### **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.

### **Qualifying Event**

A circumstance that permits a Participant or Eligible Dependent to elect COBRA Continuation Coverage.

### **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. Cannot prescribe treatment plans.

### **Signatory/Contributing Employer**

An Employer that has signed a Collective Bargaining or Participation Agreement.

### **Spouse**

A person of the opposite sex to whom the Participant is legally married as husband or wife. 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 Participant or Eligible Dependent who satisfies the Fund's eligibility requirements for the Pensioner & Surviving Spouses Plan of the Fund.

### **Terminally Ill**

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

### **Totally Disabled**

Wholly prevented by bodily Injury or Illness from engaging in any occupation or employment and, in the case of 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.

## **SECTION 21 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