Dear Participant,

We are pleased to provide you with this set of Summary Plan Descriptions (SPDs), which describe the benefits, rules and regulations of the Southern California Pipe Trades Health & Welfare Fund, Health & Welfare Fund Vacation & Holiday Benefit, Pensioners & Surviving Spouses Health Fund, Defined Contribution Fund, Retirement Fund, and Christmas Bonus Fund.

This set of SPDs replaces and supersedes any prior SPDs and Supplements thereto that you may have received.

These SPDs summarize the comprehensive benefits program provided to you under collective bargaining agreements between Southern California Pipe Trades District Council No. 16 of the United Association and employers in the plumbing and pipefitting industry of Southern California. Your hard work in the trade pays off each time you receive a benefit from one of your plans.

It is very important that you refer to this book in order to understand how your plans work. However, we recognize that these plans are complex and encourage you to contact the Southern California Pipe Trades Administrative Corporation (the Fund Office) when you have questions.

You may contact the Fund Office by:

Mail: 501 Shatto Place, Suite 500
Los Angeles, CA 90020

Phone: (800) 595-7473 (Toll Free)
(213) 385-6161 (Outside U.S.)

Website: www.scptac.org

Email: info@scptac.org

Plan rules and benefits may change from time to time. You will receive a supplement explaining any important change. Please be sure to read all plan communications and keep them with this book.

Sincerely,

The Board of Trustees

Summary Plan Descriptions
for the Southern California Pipe Trades

HEALTH & WELFARE FUND

HEALTH & WELFARE FUND
VACATION & HOLIDAY BENEFIT

PENSIONERS & SURVIVING SPOUSES HEALTH FUND

DEFINED CONTRIBUTION FUND

RETIREMENT FUND

CHRISTMAS BONUS FUND

Life Events

Event	Action					
Fund	**Health & Welfare**	**Pensioners & Surviving Spouses Health**	**Vacation & Holiday**	**Defined Contribution**	**Retirement**	**Christmas Bonus**
Start Work	Submit Enrollment, Beneficiary, Vision Enrollment and Dental Enrollment forms			Submit Enrollment/ Change/Opt-Out form; create myplan.johnhancock .com account		
Moving	Submit a new Change of Address Form					
Birth, Adoption, or Legal Guardianship of your child	Submit a new Beneficiary Form		Submit a new Beneficiary Form			
	Submit a new Enrollment Form and a certified copy of birth certificate*, adoption, or legal guardianship documentation			Request Qualified Birth/Adoption Withdrawal if needed		
Marriage or Domestic Partnership	Submit a new Beneficiary Form		Submit a new Beneficiary Form			
	Submit a new Enrollment Form and a certified copy of the marriage or Domestic Partnership certificate*					
Loss of Eligibility	Submit COBRA Continuation Coverage application					
Disability	Apply for weekly accident & sickness benefit				Apply for total disability pension	
Financial Hardship	Take full advantage of your HRA Allowance		Apply for interim withdrawal if needed	Request Hardship Withdrawal if needed		
Divorce	Submit a new Beneficiary Form and Divorce Documents		Submit a new Beneficiary Form and Divorce Documents			
	Former Spouse may apply for COBRA Continuation Coverage			Submit Qualified Domestic Relations Order (QDRO)		
Retirement	Apply for COBRA Continuation or Pensioners Health Plan coverage			Apply for distribution if desired	Apply for pension benefits 90 days prior to retirement	Maintain Local Union membership in good standing
Death of Participant	Notify the Fund Office and submit a copy of death certificate as soon as available					
	Apply for Death Benefit					
	Surviving Eligible Dependents may apply for COBRA Continuation Coverage; surviving Spouse/Domestic Partner may apply for Pensioners Health Plan coverage				Apply for death benefit; return any benefit paid after month of death	
Death of Dependent	Notify the Fund Office and submit a copy of death certificate as soon as available					
	Submit a new Beneficiary Form		Submit a new Beneficiary Form			
	Apply for Death Benefit					

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

Summary Plan Description / Plan Rules & Regulations

of the

Southern California Pipe Trades

HEALTH & WELFARE FUND

(Active Plan)

Contents

SECTION 1. INTRODUCTION

The Southern California Pipe Trades Health & Welfare Fund ("Fund" or "Plan") was established in 1951 through the negotiating efforts of District Council No. 16 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada ("United Association") and Employers in the plumbing and pipefitting industry in Southern California. Union and Employer Trustees manage the Fund. As of September 1, 2020, the Southern California Pipe Trades Vacation & Holiday Fund was merged into the Health & Welfare Fund, but the terms of that benefit continue to be described in a separate document. You should review the Southern California Pipe Trades Health & Welfare Fund Vacation & Holiday Benefit Summary Plan Description for details regarding your paid time off benefits.

A) This Summary Plan Description

This Summary Plan Description/Plan Rules and Regulations ("SPD") is the plan document of the provisions of the Southern California Pipe Trades Health and Welfare Plan. It applies to all claims for services rendered on and after September 1, 2025. Prior written material applies only to claims for services rendered before September 1, 2025. You must read this SPD carefully to understand how the Plan works. Please keep this SPD for future reference.

Plan rules may change from time to time, in which case a written notice explaining any important change will be sent to all covered households. Please read all Plan communications and keep them with this SPD.

B) Purpose of the Plan

The Plan provides medical, dental, Prescription Drug, vision, weekly accident and sickness, death, accidental death or dismemberment, and other benefits. The Plan is funded by Employers who make contributions on behalf of their Employees on a per-hour basis under a Collective Bargaining Agreement or a Participation Agreement. The Plan pays claims only for benefits provided under the Plan. The Plan does not pay benefits for work-related Illnesses and Injuries. This Plan does not cover Pensioners, surviving Spouses, or surviving Domestic Partners, whose benefits are provided under the Southern California Pipe Trades Pensioners and Surviving Spouses Health Fund, which has a separate SPD. The Plan also provides paid time off benefits which are described in the "Southern California Pipe Trades Health & Welfare Fund Vacation & Holiday Benefit" SPD.

C) Role of the Board of Trustees

The Board of Trustees is authorized to interpret all Plan rules and documents, including the Trust Agreement and this SPD. The Board of Trustees has the discretion to decide all questions about the Plan including, but not limited to, questions about eligibility for participation in the Plan, rights to benefits, the amount of benefits, the information and proof necessary to substantiate a claim for benefits, and the definition of any Plan term. The Board of Trustees also has the authority to make any factual determinations concerning claims. No individual Trustee, Employer, or Union representative has the authority to interpret any Plan document on behalf of the Board of Trustees or to act as an agent of the Board of Trustees. The Board of Trustees may delegate its authority to a subcommittee or other subset of the Board of Trustees.

The Trustees intend to continue the Fund indefinitely. However, the Board of Trustees has the authority to amend or terminate the Plan as they deem appropriate.

D) Role of the Fund Office

The Board of Trustees has authorized the Fund Office to respond in writing to your written questions. As a courtesy, the Fund Office may also respond informally to questions by telephone, email, or in person at the Fund Office. However, such information and answers are not binding upon the Board of Trustees and cannot be relied upon in any dispute. Remember 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 your entitlement to benefits.

NOTE	If you have any questions regarding eligibility, benefits, or procedures, contact the Fund Office. Southern California Pipe Trades Administrative Corporation 501 Shatto Place, Suite 500 Los Angeles, CA 90020 Toll-Free: (800) 595-7473 / Outside U.S.: (213) 385-6161 Website: www.scptac.org / Email: info@scptac.org Contact health@scptac.org for questions relating to: • Annual Coordination of Benefits Form • Change of Address Form • HRA Form and claims • Injury and Third Party Liability Form • Specialty Medication • Therapy related Prescriptions • Weekly Disability Benefit

NOTE	Capitalized terms are defined in Section 24, page 68.

SECTION 2. SUMMARY OF PLAN BENEFITS

The Plan partners with Blue Shield of California with the goal of lowering and controlling Patient Out-of-Pocket costs while expanding the network of contracted providers. Blue Shield provides network access and some administrative services only. The Southern California Pipe Trades Health & Welfare Fund determines, administers, and pays Plan benefits. Blue Shield does not administer the Fund's dental, Prescription Drug, or vision benefits.

	Benefit	Amount
DEDUCTIBLES	Medical services	$250 per person ($750 family maximum)
	Dental benefit (applies only to the MetLife PPO option, not the DeltaCare USA DHMO option)	$50 per person ($150 family maximum)
	Prescription Drugs	$50 per person
	Hearing aids	$50 per device

SUMMARY OF PLAN BENEFITS

Benefit details are listed in alphabetical order in Section 9 beginning on page 34.

TYPE OF SERVICE	BLUE SHIELD OF CALIFORNIA (BSC) PPO NETWORK PROVIDER Plan Pays:	OUT-OF-NETWORK PROVIDER Plan Pays:
ACUPUNCTURE Not to exceed 20 visits per Calendar Year.	100% of the BSC PPO Network Rate	100% of the Allowable Charge

SUMMARY OF PLAN BENEFITS

Benefit details are listed in alphabetical order in Section 9 beginning on page 34.

TYPE OF SERVICE		BLUE SHIELD OF CALIFORNIA (BSC) PPO NETWORK PROVIDER Plan Pays:	OUT-OF-NETWORK PROVIDER Plan Pays:
ALLERGY TESTING		100% of the BSC PPO Network Rate	100% of the Allowable Charge
ALLERGY TREATMENT The Plan will pay for up to a three-month supply, not to exceed four times in any 12-month period.		95% of the BSC PPO Network Rate	95% of the Allowable Charge up to $75 per vial
AMBULANCE		80% of the BSC PPO Network Rate	80% of the Allowable Charge
ANESTHESIA For Pain Management injections, see the Pain Management benefit.		100% of the BSC PPO Network Rate	100% of the Allowable Charge
BARIATRIC SURGERY Prior authorization is required.	**Surgeon**	100% of the BSC PPO Network Rate	
	Hospital or Facility	95% of the BSC PPO Network Rate	
CARDIAC REHABILITATION	**Performed in a Physician's Office**	100% of the BSC PPO Network Rate	100% of the Allowable Charge up to $25 per visit
	Outpatient Hospital or Facility	95% of the BSC PPO Network Rate	90% of the Allowable Charge up to $25 per visit
	Inpatient Hospital or Facility	95% of the BSC PPO Network Rate	90% of the Allowable Charge up to $1,215 per day for all Hospital or facility charges
CHEMOTHERAPY		95% of the BSC PPO Network Rate	95% of the Allowable Charge
CHIROPRACTIC Maximum of three visits per week, not to exceed 35 visits per Calendar Year. Children under seven require a referral from their attending Physician.		100% of the BSC PPO Network Rate	100% of the Allowable Charge up to $54 per visit
COLONOSCOPY / SIGMOIDOSCOPY SCREENING Covered once every five years for Patients age 45 and older.		100% of the BSC PPO Network Rate	100% of the Allowable Charge
CONVALESCENT CARE FACILITY / EXTENDED CARE FACILITY / ADULT DAY HEALTH CARE		95% of the BSC PPO Network Rate up to $27 per day	90% of the Allowable Charge up to $27 per day

SUMMARY OF PLAN BENEFITS

Benefit details are listed in alphabetical order in Section 9 beginning on page 34.

TYPE OF SERVICE		BLUE SHIELD OF CALIFORNIA (BSC) PPO NETWORK PROVIDER Plan Pays:	OUT-OF-NETWORK PROVIDER Plan Pays:
DENTAL		Benefits are insured by DeltaCare USA (HMO) and by MetLife (PPO). • HMO: Covered benefits are payable at 100%. • PPO: Preventive, basic restorative, and orthodontia services are covered at 100%. Major restorative services are covered at 90%. A $1,800 per patient benefit maximum applies each calendar year. Orthodontia has a lifetime benefit maximum of $1,800 per patient.	
DIALYSIS (Renal)	**Performed in a Physician's Office**	95% of the BSC PPO Network Rate	95% of the Allowable Charge
	Performed in a Hospital or Facility	95% of the BSC PPO Network Rate	90% of Allowable Charge up to $200 per visit for all Hospital or facility charges
DURABLE MEDICAL EQUIPMENT Replacement or repair is allowed once every 36-months, except for orthotics which are allowed once per condition.		Benefits are paid on a rental-to-purchase basis based on the Patient's monthly eligibility.	
		95% of the BSC PPO Network Rate	95% of the Allowable Charge
GENETIC TESTING		100% of the BSC PPO Network Rate	100% of the Allowable Charge
HEARING AID Replacement or repair is allowed once every 36 months, with a separate $50 deductible per device.		100% of the BSC PPO Network Rate up to $1,000 per device	100% of the Allowable Charge up to $1,000 per device
HOME HEALTH NURSING Not to exceed 120 visits per Calendar Year (combined with Skilled Nursing Facility days).		95% of the BSC PPO Network Rate	95% of the Allowable Charge up to $94.05 per visit
HOME INTRAVENOUS (IV) THERAPY		95% of the BSC PPO Network Rate	95% of the Allowable Charge
HOSPICE CARE PROGRAM In a Hospice facility or at home		95% of the BSC PPO Network Rate	95% of the Allowable Charge

SUMMARY OF PLAN BENEFITS

Benefit details are listed in alphabetical order in Section 9 beginning on page 34.

TYPE OF SERVICE		BLUE SHIELD OF CALIFORNIA (BSC) PPO NETWORK PROVIDER Plan Pays:	OUT-OF-NETWORK PROVIDER Plan Pays:
HOSPITAL	**Hospital Inpatient or Hospital Outpatient**	95% of the BSC PPO Network Rate	90% of the Allowable Charge up to $1,215 per day
	Emergency Services		95% of the BSC Qualifying Payment Amount
IMMUNIZATIONS		100% of the BSC PPO Network Rate	100% of the Allowable Charge
LABORATORY	**Performed in an Outpatient Laboratory Facility or Physician's Office**	100% of the BSC PPO Network Rate	100% of the Allowable Charge
	Performed in a Hospital or Facility	95% of the BSC PPO Network Rate	90% of the Allowable Charge up to $1,215 per day for all Hospital or facility charges
MEDICAL SUPPLIES		95% of the BSC PPO Network Rate	95% of the Allowable Charge
MENTAL HEALTH	**Adult Day Health Care Center (ADHC)**	95% of the BSC PPO Network Rate up to $27 per day	90% of the Allowable Charge up to $27 per day
	Hospital, Partial Hospitalization, or Residential Treatment Facility	95% of the BSC PPO Network Rate	90% of the Allowable Charge up to $1,215 per day
	Office	100% of the BSC PPO Network Rate	100% of the Allowable Charge
MIDWIFE SERVICES Delivery services must be performed in a Hospital or state-licensed birthing center.		100% of the BSC PPO Network Rate	100% of the Allowable Charge
NON-PRESCRIPTION AND OVER-THE-COUNTER DRUGS		NOT COVERED (but may be reimbursable through your Health Reimbursement Arrangement Allowance).	

SUMMARY OF PLAN BENEFITS

Benefit details are listed in alphabetical order in Section 9 beginning on page 34.

TYPE OF SERVICE		BLUE SHIELD OF CALIFORNIA (BSC) PPO NETWORK PROVIDER Plan Pays:	OUT-OF-NETWORK PROVIDER Plan Pays:
NUTRITIONAL COUNSELING Not to exceed eight visits per Calendar Year.		100% of the BSC PPO Network Rate	100% of the Allowable Charge
OCCUPATIONAL THERAPY Prescription required.	**Performed in an Occupational Therapist's Office**	100% of the BSC PPO Network Rate	100% of the Allowable Charge up to $70 per visit
	Outpatient Hospital or Facility	95% of the BSC PPO Network Rate	90% of the Allowable Charge up to $70 per visit
	Inpatient Hospital or Facility	95% of the BSC PPO Network Rate	90% of the Allowable Charge up to $1,215 per day for all Hospital or facility charges
OPIOID DRUG TESTING Not to exceed once every three months.		100% of the BSC PPO Network Rate	100% of the Allowable Charge
PAIN MANAGEMENT Maximum of three injections per day.		100% of the BSC PPO Network Rate	100% of the Allowable Charge, not to exceed $1,215 for surgery center or Hospital fees
PHYSICAL EXAMINATION Once per Calendar Year (for children, see the well-child benefit).		100% of the BSC PPO Network Rate	100% of the Allowable Charge
PHYSICAL THERAPY Prescription required.	**Performed in a Physical Therapist's Office**	100% of the BSC PPO Network Rate	100% of the Allowable Charge up to $70 per visit
	Outpatient Hospital or Facility	95% of the BSC PPO Network Rate	90% of the Allowable Charge up to $70 per visit
	Inpatient Hospital or Facility	95% of the BSC PPO Network Rate	90% of the Allowable Charge up to $1,215 per day for all Hospital or facility charges
PHYSICIAN		100% of the BSC PPO Network Rate	100% of the Allowable Charge
PRESCRIPTION DRUGS Benefits per Calendar Year.		• $50 Prescription Drug Deductible per person • Prescription Drugs are reimbursable at 100% for the first $1,800, 50% of the next $4,200, and 65% of incurred expenses exceeding $6,000 in a Calendar Year per person • See also Specialty Medications below.	

SUMMARY OF PLAN BENEFITS

Benefit details are listed in alphabetical order in Section 9 beginning on page 34.

TYPE OF SERVICE		BLUE SHIELD OF CALIFORNIA (BSC) PPO NETWORK PROVIDER Plan Pays:	OUT-OF-NETWORK PROVIDER Plan Pays:
RADIATION THERAPY	**Performed in a Physician's Office**	100% of the BSC PPO Network Rate	100% of the Allowable Charge
	Performed in a Hospital or Facility	95% of the BSC PPO Network Rate	90% of the Allowable Charge up to $1,215 per day for all Hospital or facility charges
RADIOLOGY X-rays, CAT/PET/MRI scans, etc.	**Performed in an Outpatient Radiology Facility or Physician's Office**	100% of the BSC PPO Network Rate	100% of the Allowable Charge
	Performed in a Hospital	95% of the BSC PPO Network Rate	90% of the Allowable Charge up to $1,215 per day for all Hospital or facility charges
SKILLED NURSING FACILITY Not to exceed 120 days per Calendar Year (combined with Home Health Nursing visits).		95% of the BSC PPO Network Rate	90% of the Allowable Charge up to $1,215 per day
SLEEP STUDY	**Physician**	100% of the BSC PPO Network Rate	100% of the Allowable Charge
	Hospital	95% of the BSC PPO Network Rate	90% of maximum Allowable Charge up to $1,215 per day
SPECIALTY MEDICATION Specialty Medications are Prescription Drugs that: • Require special handling • Require special administration/monitoring • Treat complex conditions • Cost $1,000 (average wholesale price) or more for a 30-day supply.		95% of the BSC PPO Network Rate	95% of the Allowable Charge, or 95% of the cost of the medication, whichever is less (The Allowable Charge is based on the average wholesale price)
SPEECH THERAPY Prescription required.	**Performed in a Speech Therapist's Office**	100% of the BSC PPO Network Rate	100% of the Allowable Charge up to $22.50 per visit
	Outpatient Hospital or Facility	95% of the BSC PPO Network Rate	90% of the Allowable Charge up to $22.50 per visit
	Inpatient Hospital of Facility	95% of the BSC PPO Network Rate	90% of the Allowable Charge up to $1,215 per day for all Hospital or facility charges

SUMMARY OF PLAN BENEFITS

Benefit details are listed in alphabetical order in Section 9 beginning on page 34.

TYPE OF SERVICE		BLUE SHIELD OF CALIFORNIA (BSC) PPO NETWORK PROVIDER Plan Pays:	OUT-OF-NETWORK PROVIDER Plan Pays:
SUBSTANCE USE DISORDER	**Hospital, Partial Hospitalization, or Residential Treatment Facility**	95% of the BSC PPO Network Rate	90% of the Allowable Charge up to $1,215 per day
	Office	100% of the BSC PPO Network Rate	100% of the Allowable Charge
SURGERY	**Physician**	100% of the BSC PPO Network Rate	100% of the Allowable Charge
	Anesthesiologist	100% of the BSC PPO Network Rate	100% of the Allowable Charge
	Hospital	95% of the BSC PPO Network Rate	90% of the Allowable Charge up to $1,215 per day
TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)		100% of the BSC PPO Network Rate	100% of the Allowable Charge
TRANSPLANTS	**First $100,000**		
	Professional	100% of the BSC PPO Network Rate	100% of the Allowable Charge
	Hospital or Facility	95% of the BSC PPO Network Rate	90% of the Allowable Charge up to $1,215 per day
	Amounts above $100,000		
	Professional	60% of the BSC PPO Network Rate	NOT COVERED (but may be reimbursable from your Health Reimbursement Arrangement).
	Hospital or Facility	57% of the BSC PPO Network Rate	
VISION A deductible does not apply to this benefit.		VSP insures benefits. Frames are covered once every 24 months for adults and once every 12 months for children under 18. Lenses are covered every 12 months. Exams are covered every 12 months for a $20 Copayment.	
WELL-CHILD SERVICES Through age 17		100% of the BSC PPO Network Rate	100% of the Allowable Charge

SECTION 3. ENROLLMENT

A) Enrolling an Eligible Dependent

To enroll Eligible Dependents, you must complete an Enrollment Form and provide required documents.

Processing of benefit claims will be delayed until the Fund Office receives a completed Enrollment Form signed by you and required documents.

You may obtain an Enrollment Form from any local Union office, the Fund Office, or the Fund Office website at www.scptac.org.

B) Dis-enrolling a Dependent

You must complete a Disenrollment Form, including all required signatures, and provide any required document, to dis-enroll a dependent. Forms received by the 15th of the month will be effective the first of the following month.

Once dis-enrolled, you may re-enroll your Eligible Dependent at a later date if you remain enrolled in the Plan.

You may obtain a Disenrollment Form from any local Union office, the Fund Office, or the Fund Office website at www.scptac.org.

C) Designating a Beneficiary

To designate a Beneficiary(ies), you must complete a Beneficiary Form.

You must submit an updated Beneficiary Form to the Fund Office upon request or if you want to change a Beneficiary for death benefits.

You may obtain a Beneficiary Form from any local Union office, the Fund Office, or the Fund Office website at www.scptac.org.

D) Required Documents

To add or remove an Eligible Dependent, you must provide the Fund Office with appropriate documentation, such as:

i) A certified copy of the marriage certificate; or
ii) An original, filed, domestic partnership registration with the state of California or another state with rules similar to California's (a form W-4 is required because Domestic Partner benefits result in taxable income to the Participant); or
iii) A certified copy of the birth certificate (or paternity test results if applicable); or
iv) A copy of the document placing the child for adoption or finalizing the adoption; or
v) A copy of the guardianship papers; or
vi) A copy of the death certificate; or
vii) A copy of the final divorce decree; or
viii) A copy of the dissolution of domestic partnership.

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

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

i) Marriage or Domestic Partnership Documents

You must submit a new Enrollment Form with the required documents listed above within 90 days of the date of marriage or domestic partnership registration. If the Enrollment Form and required documents are not received within 90 days of the date of marriage or domestic partnership, the eligibility date of your Spouse/Domestic Partner will be the date of receipt of the required documents, not the date of marriage or date of registration. You must notify the Fund Office immediately if there is a delay in obtaining a copy of the certified marriage certificate or the domestic partnership registration.

ii) Birth, Adoption, or Guardianship Documents

You must submit a new Enrollment Form with the required documents as listed above. Failure to provide documents timely may result in the denial of claims.

iii) Death Certificates

A copy of the death certificate must be submitted no later than 12 months after the date of death for death benefits to be paid. However, the Fund Office should be notified within 60 days of the death of any person covered by the Plan. If the Fund Office is not notified, COBRA, Pensioners Health Fund coverage, and other benefits, if applicable, may not be provided.

iv) Divorce or Dissolution Documents

You must submit a copy of any final divorce decree or dissolution of domestic partnership to the Fund Office as soon as it is available. You and/or your former Spouse or former Domestic Partner will be required to repay to the Fund any benefits paid on their behalf after the date of divorce or dissolution of the partnership.

F) Change of Address

If you want to change your address, you may obtain a Change of Address Form from any local Union office, the Fund Office, or the Fund Office website at www.scptac.org. The form must be filled out completely and returned to the Fund Office.

Your dependents may also elect an address different from your own by completing a Patient Change of Address Form, which may be obtained from the Fund Office or the Fund Office website.

IMPORTANT	**If there is a change in status of an Eligible Dependent (such as birth, adoption, domestic partnership, marriage, divorce, dissolution of domestic partnership, or death), a change in status of your Beneficiary (adding, removing or changing Beneficiary) or a change of address, please notify the Fund Office as soon as possible, but no later than 90 days after the change.**

SECTION 4. ELIGIBILITY

A) Establishing and Re-establishing Eligibility

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

Your Employer's contributions and any reciprocal contributions received on your behalf will be allocated (1) as a Base Contribution for eligibility purposes, (2) to your HRA Allowance, (3) as a general contribution to the Fund, and (4) to the Pensioners Health Fund. The allocation of your Employer's contribution is determined by the applicable Collective Bargaining Agreement. See Section 4(E), page 13, for information regarding the allocation of reciprocal contributions.

At the time of publication, the Base Contribution rate (the portion of an Employer's contribution that counted for eligibility purposes) was $7.66.

You and your Eligible Dependents become eligible for benefits when $1,992 in Base Contributions has been credited to your Eligibility Bank within 24 consecutive months. If you lose eligibility, it will be reinstated when $1,992 in Base Contributions has been credited to your Eligibility Bank within 24 consecutive months.

Notwithstanding the above, if your loss of eligibility is due to insufficient contributions and is for a period of fewer than 12 months, your eligibility will be reinstated when $919.20 in Base Contributions is credited to your Eligibility Bank.

The $1,992 and $919.20 amounts will be adjusted proportionally whenever the health and welfare Base Contribution rate under the Collective Bargaining Agreement changes and will be effective the first day of the second month following the change.

You and your Eligible Dependents will be covered under the Plan beginning the first day of the second month following the month in which your Eligibility Bank is first credited with $1,992 or $919.20 (as adjusted above) in Base Contributions.

Contributions are applied to the month worked, not the month the contribution is received by the Fund Office. Your coverage may be delayed or applied retroactively if the contributions are not received when due.

EXAMPLE	**You run out your Eligibility Bank, and your eligibility ends on December 31, 2025. You return to work, and contributions for 120 hours totaling $919.20 are made by your Employer on your behalf for the work month of March 2026. March contributions apply for May eligibility, so your eligibility will be reestablished effective May 1, 2026.**

EXAMPLE	**You run out your Eligibility Bank, and your eligibility ends on December 31, 2024. You return to work, and contributions for 120 hours totaling $919.20 are made by your Employer on your behalf for the work month of November 2025. November contributions apply for January eligibility, so you will have more than a 12-month gap in eligibility. Therefore, your eligibility will not be reestablished effective January 1, 2026. Contributions $1,992 must be received to reestablish eligibility.**

B) Maintaining Eligibility

Base Contributions paid on your behalf by a Contributing Employer or via reciprocity will be credited to your Eligibility Bank. The maximum amount that may be credited to your Eligibility Bank is the amount that will provide six months of eligibility. (If you had an Eligibility Bank balance before September 1, 2002, you could accumulate an Eligibility Bank of up to 12 months, but if any part of your Eligibility Bank exceeding six months is used after that date, it will not be restored by subsequent contributions.)

A charge will be deducted from your Eligibility Bank for each month of eligibility. This charge, called the Monthly Deduction Amount, was $766 at the time of publication. The Monthly Deduction Amount will be adjusted proportionally whenever the health and welfare Base Contribution rate changes and will be effective the first day of the second month following the change.

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

Your Eligibility Bank may also contain contributions credited under the weekly accident and sickness benefit. (See Section 13, page 47.)

EXAMPLE

Month Hours Worked	January	February	March
	↓	↓	↓
Month Contributions Received	**February**	**March**	**April**
Hours Worked	100	100	100
Base Contribution Rate	$7.66	$7.66	$7.66
Base Contribution Total	$766	$766	$766
Base Contribution Accumulated	$766	$1,532	$2,298
Base Contribution Required	$1,992	$1,992	$1,992
Month Eligibility Begins	**Not Yet Eligible**	**Not Yet Eligible**	**May**

C) Suspension & Termination of Eligibility

i) When Coverage is Suspended

Coverage will be suspended if you work for an employer that is a signatory to a Collective Bargaining Agreement with District Council No. 16 but has stopped contributing to this Fund and is providing alternate coverage under the terms of its Collective Bargaining Agreement. The suspension will result in the following:

a) No additional employer contributions being credited to your Eligibility Bank; and
b) Continuation of the Monthly Deduction Amount during the period of suspended coverage; and

c) The discontinuation of payment for any claims incurred during the time the employer is no longer making contributions to this Fund and is instead providing you alternate coverage.

Your coverage will be suspended for as long as you work for this kind of noncontributing employer.

ii) When Coverage is Terminated

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

1) The last day of the month in which your Eligibility Bank falls below the Monthly Deduction Amount in effect at the time (see Section 4(B), page 11); or
2) The last day of the month in which the maximum months permitted for self-payment and/or COBRA coverage have been reached; or
3) The date a self-payment or COBRA payment is not timely or not made in the amount required; or
4) The date of your death; or
5) The date you start performing work in the plumbing, heating, and piping industry that is not pursuant to a United Association Collective Bargaining Agreement (the balance of your Eligibility Bank will be forfeited and will not be reinstated; however, you may be entitled to purchase COBRA coverage); or
6) The date you enter Uniformed Service, and, if such service is Qualified Uniformed Service, you do not elect coverage under the Plan (see Section 4(G), page 15); or
7) The date the Plan terminates.

b) Special Rules for Owners and Bargaining Unit Alumni

Under the terms of the Collective Bargaining Agreement:

1) Owners are (1) sole proprietors or (2) corporate shareholders or corporate officers of a Contributing Employer.
2) Alumni are individuals who previously participated in the Fund based on hours worked in Covered Employment, who may still participate in the Fund but who no longer do bargaining unit work.

In addition to the circumstances listed above in Section 4(C), page 11, if you are an owner performing bargaining unit work, you will lose your coverage and forfeit your Eligibility Bank when you are no longer performing bargaining unit work, or your Employer's contributions to the Fund become more than 45 days delinquent unless as an Employer you go out of business and you become unemployed but available for Covered Employment by signing the local Union's out-of-work list.

In addition to the circumstances listed above, if you are an owner engaged in the administration of bargaining unit work or an alumnus, you lose your coverage and forfeit your Eligibility Bank if the Employer elects not to continue participation in the Plan or the Employer's contributions to the Fund become more than 45 days delinquent, unless the Employer goes out of business, you become unemployed and make yourself available for Covered Employment by signing the local Union's out-of-work list.

D) Dependent Eligibility

i) Who are Eligible Dependents?

Your Eligible Dependents may be:

a) Your Spouse;
b) Your Domestic Partner; or
c) Your child.

The Plan will cover your children through age 25, ending at 12:01 a.m. on the day of the child's 26th birthday. Your children will be covered regardless of whether or not they are (1) married; (2) full-time students; (3) in the custody of or living with either parent; and (4) dependent on any support of either parent.

Legally adopted children along with children placed under your guardianship will also be covered under the Plan as of the date of adoption/guardianship or date of placement for adoption/guardianship.

None of the following are covered under the Plan: stepchildren (your current or former Spouse's or Domestic Partner's children), grandchildren, your other relatives, adults placed under your guardianship, or a dependent of a child covered under the Plan.

You must submit to the Fund Office documentation to establish a child's eligibility.

ii) Dual Coverage

If a person has dual coverage under the Plan (a) both as a Participant and as an Eligible Dependent or (b) as an Eligible Dependent of two Participants, then the Plan will apply coordination of benefit rules. (See Section 18, page 55.)

iii) When Eligible Dependent Coverage Starts

Your Eligible Dependent coverage starts on the later of the following dates:

a) The date you become eligible;
b) The date your child is born, or the earlier of the date a child is placed with you for adoption or the adoption is finalized; or
c) Your date of marriage or domestic partnership registration, unless more than 90 days have passed since the date of marriage or registration, in which case the date the Fund Office receives your marriage certificate or domestic partnership registration.

iv) When Dependent Coverage Terminates

Your Eligible Dependent coverage terminates on the later of the following dates:

a) The date your eligibility terminates; or
b) The date the dependent no longer qualifies as an Eligible Dependent due to your divorce or dissolution of domestic partnership or because a child turns age 26; or
c) The date the dependent is dis-enrolled upon application by you); or
d) The date your child is adopted by another person; or
e) The date the guardianship terminates for a minor child who previously qualified as an Eligible Dependent;
f) The date of death of the dependent; or
g) The date the Plan terminates.

There are no other circumstances where an Eligible Dependent will be removed from the Plan.

Eligibility may be extended under COBRA Continuation Coverage. (See Section 5, page 18.)

v) Surviving Eligible Dependents of Deceased Participants

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

a) Surviving Spouses or Domestic Partners

In the case of a Survivor of an active Participant, if the Eligibility Bank provides fewer than three months of coverage, the Survivor may use the Eligibility Bank and be eligible for free coverage under the Pensioners Health Plan for three months, less the number of months provided by the Eligibility Bank.

When the Eligibility Bank is depleted, the eligible surviving Spouse can continue coverage under COBRA or the Pensioners Health Plan. Surviving Spouses who initially elect COBRA coverage under this (active) Plan forfeit their right to coverage under the Pensioners Health Plan and may not subsequently elect or receive coverage under the Pensioners Health Plan. Domestic Partners are not eligible for COBRA coverage but are eligible to continue coverage in the Pensioners Health Plan. (See Section 5(C), page 23.)

b) Children

When your Eligibility Bank is depleted, eligible children may continue coverage only under COBRA. (See Section 5, page 18.)

vi) Qualified Medical Child Support Order (QMCSO)

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

A QMCSO is a court order or administrative notice that meets certain legal requirements. If you have obtained or received a QMCSO that requires the Plan to cover a child, you should immediately provide the Fund Office with a copy. The Plan has procedures to determine whether the order or other document is a QMCSO. A copy of the Plan's QMCSO procedure is available upon request.

E) Reciprocal Contributions

This Plan is signatory to the United Association Health & Welfare Fund Reciprocal Agreement, which provides for money-follows-the-member reciprocity with all funds that have also signed the agreement. Under this agreement, contributions are automatically transferred to your home local health fund(s). This Fund may also enter into other similar reciprocity agreements.

i) Incoming Reciprocity

If your home local is a District Council No. 16 local and you work outside of the jurisdiction of District Council No. 16, contributions made to another health fund that has signed an applicable reciprocal agreement will be transferred to this Fund according to the terms of the reciprocal agreement.

ii) Outgoing Reciprocity

If your home local is not a District Council No. 16 local and you work within the jurisdiction of District Council No. 16, contributions to this Fund will be transferred to your home local health fund(s) if your home local fund has signed an applicable reciprocal agreement, according to the terms of the reciprocal agreement.

Contributions are reciprocated based on your home local as reflected in the United Association's records.

The amount of contributions varies regionally, and this may affect eligibility. For instance, if the contribution rate is higher where you are working than in District Council No. 16, you may gain eligibility faster, and your Eligibility Bank may grow faster, up to the maximum Eligibility Bank permitted by the Plan. Conversely, if the contribution rate is lower where you are working than in District Council No. 16, you may gain eligibility more slowly, and your coverage may be interrupted. If the contribution rate in your outside work local is the same or higher than the Fund's standard rates, your reciprocal contributions will be allocated pro-rata based on the Fund's standard rates. If the contribution rate in your work local is lower than the Fund's standard rates, your reciprocal contributions will first be allocated pro-rata between this Fund and the Pensioners & Surviving Spouses Health Fund; then the portion allocated to this Fund will be credited, based on the Fund's standard rates, first to a Base Contribution for eligibility purposes, then to your HRA Allowance, and finally as a general contribution to the Fund.

Generally, it takes at least 30 days before the Plan receives reciprocal contributions from other health plans. Contributions are applied to the month worked, not the month the contribution is made or received by the Fund Office. This may result in an interruption in coverage and the issuance of a COBRA notice depending on the amount in your Eligibility Bank. (See COBRA Continuation Coverage in Section 5, page 18.)

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

F) Health Coverage for Pensioners Returning to Work for a Contributing Employer

If you are a Pensioner returning to work, you may be eligible to participate in the Plan depending on your status and the type of work you perform.

i) Return to Work Under the Temporary Waiver Program

If you are a Pensioner who returns to work under the temporary waiver program, you will lose coverage under the Pensioners Health Plan, but you may continue coverage under this Plan by paying the same premium amount you would be required to pay under the Pensioners Health Plan.

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

If you are a Pensioner who returns to work as an instructor for the Southern California Pipe Trades Apprentice and Journeyman Training Trust Fund, you will lose coverage under the Pensioners Health Plan, but you may continue coverage under this Plan by paying the same premium amount you would be required to pay under the Pensioners Health Plan.

iii) Return to Work Resulting in Suspension of Pension Benefit

If you are a Pensioner who returns to Covered Employment or employment under a Participation Agreement, causing your benefit from the Southern California Pipe Trades Retirement Fund to be suspended, you will also lose coverage under the Pensioners Health Plan. However, you may continue coverage under this Plan by paying the full COBRA rate until you become eligible under this Plan based on Employer contributions made for your hours worked.

iv) Return to Work at Age 65 for 39 or Fewer Hours Per Month

If you are a Pensioner aged 65 to age 70½ who returns to Covered Employment or employment under a Participation Agreement, you will lose coverage under the Pensioners Health Plan, but you may continue coverage under this Plan by paying the same premium amount you would be required to pay under the Pensioners Health Plan for the entire period of your employment.

v) Return to Work at Age 70½

If you are a Pensioner aged 70½ or older who returns to Covered Employment or employment under a Participation Agreement, you will lose coverage under the Pensioners Health Plan, but you may continue coverage under this Plan by paying the same premium amount you would be required to pay under the Pensioners Health Plan until you become eligible under this Plan based on Employer contributions made for your hours worked.

vi) Return to Work in a Non-Bargaining Unit Position

If you return to work in non-Covered Employment (a position not in a bargaining unit covered under a Collective Bargaining Agreement, e.g., estimator, detailer, management, or corporate officer), you will lose coverage under this Plan for the length of your non-Covered Employment.

vii) Reinstatement upon Return to Covered Employment

If you were retired and were previously eligible for, and timely enrolled in, the Pensioners Health Plan before returning to work for a Contributing Employer, when you cease working in Covered Employment or in non-Covered Employment, and upon the exhaustion of any Eligibility Bank in this Plan, you will be eligible to resume coverage in the Pensioners Health Plan. Please contact the Fund Office immediately when your Covered or non-Covered Employment ceases. If you elect not to re-enroll in the Pensioners Plan and pay the applicable premium, you will be barred from re-establishing eligibility later. See the Pensioners Health Plan SPD for complete details.

G) Eligibility Under USERRA

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), if you are ordered to serve in Uniformed Service while covered under the Plan, and you meet the other requirements of that Act, you are entitled to elect continuation coverage for you and your Eligible Dependents. You may elect core or full coverage, as with COBRA. (See Section 5, page 18.)

i) USERRA Continuation Coverage

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

ii) Cost of Coverage

If you are absent from work to perform Qualified Uniformed Service for 30 days or fewer, the continuation coverage is provided at no cost. If your Qualified Uniformed Service is for 31 or more days, the Fund may charge you up to 102% of the full cost of coverage, as with COBRA.

iii) You have four options under USERRA in case of Qualified Uniformed Service

a) Exhaust Eligibility Bank, Elect USERRA Upon Return

If you have a balance in your Eligibility Bank, you may elect to use up the balance of your Eligibility Bank to continue your eligibility for health coverage. Upon your return from Qualified Uniformed Service to work for a Contributing Employer, you may continue your eligibility in the Fund under USERRA continuation coverage until sufficient contributions from hours worked are received from your Employer to make you eligible under the Plan's normal eligibility rules.

b) Exhaust Eligibility Bank, Elect USERRA Immediately After

If you have a balance in your Eligibility Bank, you may elect to exhaust the balance in your Eligibility Bank to continue your eligibility for health coverage. If the balance in your Eligibility Bank drops below the Monthly Deduction Amount, you may elect USERRA continuation coverage immediately.

c) Freeze Eligibility Bank, Elect USERRA

Whether or not you have money in your Eligibility Bank, you may choose to pay for the USERRA continuation coverage yourself. In this case, the money in your Eligibility Bank will be frozen until you return from Qualified Uniformed Service to work for a Contributing Employer and may be used at that time to establish your continuing eligibility for coverage at no cost to you.

d) Freeze Eligibility Bank, Waive USERRA

You may choose NOT to pay for USERRA continuation coverage and freeze your Eligibility Bank until you return from Qualified Uniformed Service to work for a Contributing Employer and then use your Eligibility Bank balance at that time to establish your continuing eligibility for coverage at no cost to you.

iv) Notice Requirements

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

If you do not give advance notice of your leave for Uniformed Service to the Fund Office, your coverage will be terminated as of the date you leave employment for Uniformed Service. If your failure to give advance notice of your Uniformed Service is excused because it was impossible or unreasonable to do so or because doing so was precluded by military necessity, the Fund Office will reinstate your health coverage retroactive to the date of departure from employment if (1) you contact the Fund Office to request continuation coverage within 30 days of your departure and (2) you return the USERRA continuation coverage election form to the Fund Office with your initial payment within 30 days of receiving that form from the Fund Office.

H) Health Coverage for Employees Transitioning from other Employer-Sponsored Health Coverage

The Transitioning Employee Program ("Program") provides Employees transitioning from positions eligible for coverage under an employer-sponsored health plan the ability to participate in the Plan with accelerated eligibility to avoid a gap in coverage.

The Transitioning Employee program gives Employers (1) who have provided health coverage to their first-year apprentice Employees or (2) who employ newly organized Employees a lower-cost method of providing such Employees immediate coverage from the Fund.

i) Definition of Transitioning Employee

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

a) Category I: Current Employees of a newly organized company that signs a District Council No. 16 Collective Bargaining Agreement;
b) Category II: An existing Employee who is an apprentice and whose Employer provides health coverage to apprentices who are not entitled to coverage under the Fund and who advances to a job class under which contributions to the Fund are required.

These special eligibility rules are not available to:

a) Current Employees represented by a District Council No. 16 local Union (except for Category II apprentices); or
b) Travelers from outside District Council No. 16; or
c) Newly indentured first-year apprentices; or
d) Other regular applicants for representation by a District Council No. 16 local Union; or
e) New Employees who do not currently have employer-provided group health coverage; or
f) Anyone who has previously attained eligibility for benefits from the Fund under a special program for Transitioning Employees.

ii) Methods by which Transitioning Employees May Become Eligible

You must provide proof of your health coverage up to the date that contributions to the Fund commence. Your Employer must certify that you are employed on the date coverage from the Fund is to begin. Your Employer may choose either to register (1) all of its Transitioning Employees or (2) none of its Transitioning Employees. It may not choose to register only some of its Transitioning Employees.

There are two methods by which you may become eligible to participate in the Plan as a Transitioning Employee:

a) Employer Lump Sum

An Employer may agree to make a single lump sum payment on your behalf. This payment is in addition to regular hourly contributions. At the time of publication, the lump sum payment was $995.80 per Employee. When the health and welfare Base Contribution rate under the Collective Bargaining Agreement changes, the required lump sum payment will automatically change proportionally on the effective date of the contribution rate change. (The Base Contribution is that part of the total Employer contribution used to calculate eligibility.) You will start with a zero balance in your Eligibility Bank.

1) Category I

The Employer lump sum payment must be made upon signing a Collective Bargaining Agreement with District Council No. 16 or upon your employment. You will then be covered on the first day of the month following the month

in which you begin working under a District Council No. 16 agreement, provided that you have contributions made on your behalf for the minimum number of hours set forth below.

2) Category II

The lump sum payment must be made before eligibility from the Fund is to begin. You will then be covered on the first day of the month in which you advanced to an apprentice job class that requires contributions to the Fund, provided that you have contributions made on your behalf for the minimum number of hours set forth below.

b) Negative Bank

If an Employer does not make the single lump sum payment on your behalf, you will start with a negative amount in your Eligibility Bank equal to the amount of Base Contributions required to establish initial eligibility (which at the time of publication was $1,992). (The Base Contribution is that part of the total Employer contribution used to calculate eligibility.)

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

1) Category I Employees

If you fall into Category I, as referenced in Section 4(H)(i), page 16, you will be covered on the first day of the month following the month in which you first worked under a District Council No. 16 Collective Bargaining Agreement requiring contributions to this Fund provided that you have contributions made on your behalf for the minimum number of hours set forth below.

2) Category II Apprentices

If you fall into Category II, as referenced in Section 4(H)(i), page 16, you will be covered on the first day of the month in which you advanced to an apprentice job class that requires contributions to the Fund, provided contributions were made on your behalf for the minimum number of hours set forth below.

iii) Hours Requirement for Transitioning Employees

Each month, your Eligibility Bank will be credited with any Base Contributions over the Monthly Deduction Amount in effect at the time. The Monthly Deduction Amount was $766 at the time of publication. The Monthly Deduction Amount will change proportionally whenever the health and welfare Base Contribution rate under the Collective Bargaining Agreement changes, on the effective date of the contribution rate change.

During the first two months of participation, you will be eligible. Until your Eligibility Bank equals or exceeds the Monthly Deduction Amount, you will lose eligibility two months after any work month you are employed for fewer than 100 hours. If you lose eligibility, you may regain eligibility by having sufficient contributions made on your behalf as required under the Plan's regular eligibility rules.

iv) Employer's Minimum Contribution Requirement

Your Employer is required to make contributions based on hours worked. If you work fewer than 120 hours during either of your first two months, the Fund will bill your Employer, and your Employer will be required to pay, supplemental contributions in the amount of the difference between hours worked and 120 hours, times the total health contribution rate under the primary Collective Bargaining Agreement in effect at the time, less the portion of the total health contribution due to the Health Reimbursement Arrangement (HRA) and the Pensioners Health Fund. No portion of these supplemental contributions will be credited to your Eligibility Bank or HRA Allowance.

v) Subsidized Self-Pay and COBRA for Transitioning Employees

If you lose coverage, you have the same rights to make continuation coverage payments under COBRA as any other Participant. However, if the loss of coverage occurs within the first 12 months of eligibility or before any negative Eligibility Bank balance is restored, you will not be entitled to the Subsidized Self-pay Program, and you must pay the full COBRA amount. Otherwise, COBRA coverage is subject to the Fund's regular rules for such coverage.

vi) Dependents, Including Spouses and Domestic Partners, of Transitioning Employees

Your dependents become Eligible Dependents under this special program only if coverage for the dependents was provided under your prior group health plan. Otherwise, dependents will be Eligible Dependents only after you would have otherwise attained eligibility under the Plan's regular rules.

vii) Special Benefit Provisions for Transitioning Employees

Transitioning Employees are neither eligible for the Plan's weekly accident and sickness benefit nor for extended coverage for total disability during the first 12 months of eligibility.

Except as otherwise specifically stated in this SPD, all of the Plan's regular rules continue to apply to all Transitioning Employees and their Eligible Dependents.

SECTION 5. EXTENDING ELIGIBILITY

You may be able to extend eligibility as follows:

- You may be eligible to pay for COBRA continuation coverage if you experience a Qualifying Event.
- You may be eligible to pay for coverage at a lower subsidized rate in the Subsidized Self-pay Program for up to six months after your Eligibility Bank runs out if you experience a Qualifying Event and meet certain conditions.
- If you are deceased, your Survivor may enroll in the Survivor Premium Program in the Pensioners Health Plan.
- If you are Totally Disabled, medical expenses for that disability may be covered for the first three months after your loss of coverage.

The conditions you must satisfy to qualify for these options are described below. The applications and election forms for these options will be sent to you if the Fund Office knows you are eligible for any of these options.

A) COBRA Continuation Coverage

i) What is COBRA Continuation Coverage?

a) Introduction

Federal law (the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA) requires that most group health plans (including this Plan) allow Employees and their families to continue their health care coverage when there is a "Qualifying Event" that would result in a loss of coverage under the Plan. Depending on the type of Qualifying Event, "Qualified Beneficiaries" can include the Employee covered under the group health plan, a covered Employee's eligible Spouse, and the eligible child(ren) of the covered Employee. A Domestic Partner is not a Qualified Beneficiary under COBRA but may be covered if the Participant is a Qualified Beneficiary.

Before purchasing COBRA, review the costs and benefits available through the Covered California marketplace, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or other group health coverage options (such as through a Spouse's or Domestic Partner's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

You, your eligible Spouse, and your eligible child may choose one of the following COBRA Plans:

1) Core coverage – Provides medical coverage only.
2) Full coverage – Provides medical, dental, and vision coverage.

NOTE	**Once full or core coverage has been elected, the election cannot be changed.**

Death, accidental death or dismemberment, weekly accident and sickness, and extended coverage for total disability benefits are not provided under COBRA. Each Qualified Beneficiary who elects continuation coverage will have the same rights as any other individual covered under the Plan, including special enrollment rights.

b) Rights of Covered Participant

You may have a right to choose this continuation coverage if you lose group health coverage because of a Qualifying Event.

A Qualifying Event includes:

1) A reduction in your Eligibility Bank to a level below the Monthly Deduction Amount due to layoff (see Section 4(B), page 11);
2) Reduced hours;
3) Voluntary termination;
4) Disability;
5) Retirement; or
6) Any other reason except gross misconduct.

If you do not elect COBRA coverage, your eligible Spouse and eligible child each have a separate right to elect COBRA.

c) Rights of Eligible Spouse

Your Spouse may have the right to choose continuation coverage if you lose group health coverage under the Plan because of a Qualifying Event such as:

1) A reduction in your Eligibility Bank to a level below the Monthly Deduction Amount (see Section 4(B), page 11) due to layoff, reduced hours, voluntary termination, disability, retirement, or any other reason except gross misconduct.
2) Your death; or
3) Your divorce.

Note that a Domestic Partner is not a Qualified Beneficiary under COBRA but may be covered if the Participant is a Qualified Beneficiary.

d) Rights of Eligible Child

Your eligible child may have the right to continuation coverage if coverage is lost because of a Qualifying Event such as:

1) A reduction in your Eligibility Bank to a level below the Monthly Deduction Amount (see Section 4(B), page 11) due to layoff, reduced hours, voluntary termination, disability, retirement, or any other reason except gross misconduct.
2) Your death; or
3) Your child ceasing to be an Eligible Dependent as defined under this Plan.

ii) How Long will Continuation Coverage Last?

Generally, in the case of a loss of coverage due to the end of employment or a reduction in hours of employment, coverage may be continued for up to 18 months under COBRA. However, under this Plan, coverage may be extended for up to 24 months. If coverage is lost due to (1) your death, (2) your divorce, or (3) your child ceasing to be an Eligible Dependent under the terms of the Plan, coverage may be continued for up to 36 months. When the Qualifying Event is the end of your employment or the reduction of your hours of employment, and you became entitled to Medicare benefits fewer than 18 months before the Qualifying Event, COBRA coverage for Qualified Beneficiaries other than you lasts until 36 months from the date of Medicare entitlement.

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

a) Any required premium is not paid on time;
b) A Qualified Beneficiary becomes covered under another group health plan;
c) A Qualified Beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage; or
d) The Plan ceases providing coverage to all Participants.

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

iii) Can I Enroll in Medicare Instead of COBRA Continuation Coverage after my Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

a) The month after your employment ends; or
b) The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

IMPORTANT	No benefits are payable after the loss of Eligible Dependent status. You will be required to refund any benefit payments issued in error for expenses incurred after the date coverage should have been terminated due to loss of eligibility.

Under the terms of this Plan, the initial 18-month COBRA coverage period is extended by six months to 24 months.

A further extension of this period may be available if a Qualified Beneficiary is disabled or a second Qualifying Event occurs. The Fund Office must be notified of a disability or a second Qualifying Event to extend this period of continuation coverage. Failure to provide notice of a disability or second Qualifying Event may affect the right to extend the period of continuation coverage. If a Qualified Beneficiary is already receiving COBRA coverage for the maximum 36-month period, coverage may not be extended due to the occurrence of either of these events.

Maximum Periods of COBRA Continuation Coverage

Qualifying Event	Qualified Beneficiary	The Maximum Continuation Period Under the Plan
1. Reduction in covered Participant's hours	Participant, Spouse, and eligible children	24 months after the date of the Qualifying Event*
2. Termination of covered Participant's employment	Participant, Spouse, and eligible children	24 months after the date of the Qualifying Event*
3. Death of covered Participant	Spouse and eligible children	36 months after the date of the Qualifying Event
4. Divorce of covered Participant	Spouse	36 months after the date of the Qualifying Event
5. Eligible child's loss of that status	Affected eligible child	36 months after the date of the Qualifying Event
6. Covered Participant's entitlement to Medicare after signing up for COBRA	Spouse and eligible children	36 months after the initial Qualifying Event
7. Covered Participant's entitlement to Medicare before signing up for COBRA	Spouse and eligible children	The later of 24 months from the Qualifying Event or 36 months from the date of the Participant's Medicare entitlement

*Maximum continuation periods on lines 1 and 2 include six months of coverage under the Subsidized Self-pay Program plus 18 months of regular COBRA coverage. Continuation periods on lines 1, 2, and 3 begin after the Eligibility Bank, if any, is exhausted. Even if the Participant is not eligible for the six months of Subsidized Self-pay Program coverage, the Participant (or Spouse or eligible children) may pay for a maximum of 24 months of regular COBRA coverage.

iv) Disability

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

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

v) Duty to Notify the Fund

a) Divorce or Dissolution of Domestic Partnership

Coverage for a Spouse or Domestic Partner ends on the date of divorce or dissolution of the domestic partnership. You must provide written notice of the divorce or dissolution and a copy of the final divorce/dissolution documents to the Fund Office as soon as possible but no later than 60 days after the divorce/dissolution is final.

If the Fund Office is not notified of the divorce or dissolution, and benefits are paid, the Participant will be responsible and required to reimburse the Fund. Moreover, COBRA coverage will not be offered to the former Spouse.

b) Ineligible Dependent

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

If the Fund Office is not notified of the dependent's loss of Eligible Dependent status, and benefits are paid, the Participant will be responsible and required to reimburse the Fund. Moreover, COBRA coverage will not be offered to the ineligible child.

c) Death

The Fund Office should be notified within 60 days of the death of any person covered by the Plan. If the Fund Office is not notified, COBRA, Pensioners Health Fund coverage, and other benefits, if applicable, may not be offered.

vi) How Is Continuation Coverage Elected?

To elect continuation coverage, you must complete the election form and return it according to the directions on the form. Each Qualified Beneficiary has a separate right to elect continuation coverage.

vii) How Much Does Continuation Coverage Cost?

Generally, you are required to pay the entire cost of continuation coverage. However, this Plan's Subsidized Self-pay Program covers a portion of the cost of continuation coverage for the first six months of coverage if you meet the conditions to qualify for the Subsidized Self-pay Program described below. If you qualify for the subsidy, coverage for the first six months will be at the lower subsidized premium and will then increase to the applicable COBRA premium amount. The amount you may be required to pay may not exceed 102% of the cost to the group health plan for coverage of a similarly situated person who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150%). The required payment for continuation coverage is described in the notices you will receive when you qualify for COBRA coverage.

viii) When and How Payment Must be Made for Continuation Coverage?

a) Your First Payment

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

However, you must make your first payment for continuation coverage no later than 60 days from the date of your timely election. To avoid delays in confirming eligibility and paying claims, the Fund Office should receive your first payment no later than the 20th day of the month before the month of coverage. Your first payment must cover the months from the date coverage would otherwise have terminated through the month in which you make your first payment. There can be no gap between your regular eligibility and your COBRA eligibility. If you do not make your payment for continuation coverage in full within 60 days after the date of your timely election, you will lose all continuation coverage rights under the Plan.

You are responsible for making sure the amount of your first payment is enough to cover this entire period. Coverage will not be confirmed until payment is received.

EXAMPLE	Your First COBRA Payment
	If you lose regular coverage on January 1, and elect COBRA coverage on March 1, your first payment is due no later than April 30. If you then make your first payment in March, it must include premiums for January – March. If you make your first payment in April, it must include premiums for January – April.

b) Periodic Payments for Continuation Coverage

After making your first payment for continuation coverage, you must pay for continuation coverage for each subsequent month. Under the Plan, these periodic payments are due by the 20th day of the month preceding each month of coverage.

The Plan may send periodic notices of payments due for those coverage periods, but you are responsible for making the payments timely whether or not you receive the notices.

c) Grace Period for Periodic Payments

Although periodic payments are due on the dates shown above, you will be given a grace period until the end of the coverage month or 30 days, whichever is greater, to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period

for that payment. Coverage will not be confirmed until payment is received. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

EXAMPLE	Your Periodic COBRA Payments
	Your payment for July coverage is due no later than June 20th. Your coverage will be terminated if payment is not received by July 30th.

d) Form of Payment

All payments must be made by check, cashier's check, money order, electronic debit (ACH), or deduction from your Health Reimbursement Allowance. Cash is not accepted for COBRA payments.

e) Payments

Payments for continuation coverage should be sent to:

Southern California Pipe Trades Administrative Corporation
Attention: Eligibility Department
501 Shatto Place, Suite 500
Los Angeles, CA 90020

ix) For More Information

If you have any questions about COBRA coverage, please contact the Fund Office.

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

B) Subsidized Self-Pay Program

Under the Subsidized Self-pay Program, eligible Participants whose coverage under the Plan terminates due to a Qualifying Event and meets the conditions below may continue such coverage for up to six consecutive months by paying a monthly premium. (After this period, Participants may be eligible to continue coverage under regular COBRA.) The Subsidized Self-pay Program does not include death, accidental death or dismemberment, weekly accident and sickness, or extended coverage for total disability benefits. Under the Subsidized Self-pay Program, eligible Participants pay only a portion of the actual cost of the coverage; the Plan subsidizes the remainder of the cost.

The monthly Subsidized Self-pay premium at publication was 50% of the full COBRA premium. As the COBRA rate is adjusted in the future, the Subsidized Self-pay premium will be adjusted to equal 50% of the monthly full COBRA premium. This means that eligible Participants will continue to pay only a portion of the actual cost for coverage. The premium may be changed from time to time by the Trustees.

You can receive a subsidy from the Fund for the first six months of continuation coverage if you meet all of the following conditions. You:

i) Must be available for Covered Employment (i.e., unemployed) at some point between 60 days before the date coverage is terminated and the date you apply for this benefit; and
ii) Must maintain membership in good standing with a local Union affiliated with District Council No. 16; and
iii) Must reside within the geographical jurisdiction of District Council No. 16 unless you are:
    a) Placed on special assignment by the United Association, or you are employed by a Building and Construction Trades Labor Council in California; or
    b) Seeking work outside the jurisdiction of District Council No. 16 and a travel card is taken for this purpose; and
iv) Must make timely and continuous contributions in the amount established for such coverage; and
v) Must not be receiving disability benefits; and
vi) Must not be in the process of retiring; and
vii) Must not be a Contributing Employer, a partner of a Contributing Employer, a corporate officer, or an Employee covered under a Participation Agreement.

You are not eligible for the Subsidized Self-pay Program if you:

i) Have submitted a pension application to the Fund because you are retiring; or
ii) Are Totally Disabled and unable to work; or
iii) Are employed.

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

C) Survivor Premium Program Coverage

At the time of your death, your eligible Spouse or eligible Domestic Partner may elect to participate in the Pensioners Health Plan's Survivor Premium Program. This coverage starts after the Special Extension Period, if any, is for your Survivor only and does not include coverage for any children. The Special Extension Period includes health coverage. Dental and Vision are available at an additional cost.

Benefits under the Pensioners Health Plan are different from those provided under this Plan. For instance, the medical, hospital, and Prescription Drug benefits are more limited than those available under this Plan, and dental and vision coverage is available at an additional cost. The premium for the Survivor Premium Program is significantly lower than this Plan's COBRA rates. Survivor Premium Program coverage must be elected within 60 days of the notice that will be sent if the Fund is properly notified of the death. The initial payment for Survivor Premium Program coverage is due no later than 60 days from the loss of eligibility (including the Special Extension Period, if any).

Survivor Premium Program coverage will end on the earliest of the following dates:

i) The date on which the Survivor fails to make a timely premium payment; or
ii) The date the Survivor remarries; or
iii) The date Survivor enters into a domestic partnership; or
iv) The date on which the Fund ceases to provide health care coverage.

Your surviving Spouse may choose coverage either under this Plan's COBRA benefit OR under the Survivor Premium Program in the Pensioners Health Plan, but not both. In other words, your surviving Spouse cannot choose this Plan's COBRA coverage and later get coverage under the Pensioners Health Plan, or vice versa.

Domestic Partners are not eligible for COBRA but may choose coverage under the Survivor Premium Program in the Pensioners Health Plan.

If your Survivor elects to participate in the Survivor Premium Program in the Pensioners Health Plan, your eligible children will be entitled to continue coverage under this Plan's COBRA benefit.

D) Extended Coverage in Case of Total Disability

If your eligibility, or your Eligible Dependent's eligibility, terminates while you or they are Totally Disabled, medical expense benefits will be available for that disabling condition only for three months after the loss of eligibility. This extension is for the disabled individual only. The extension must be requested in writing, and a statement from the attending Physician is required.

EXAMPLE	**You are Totally Disabled due to a stroke, eligibility terminates, and you receive treatment for a broken leg. No benefit is payable for your broken leg because it is not related to the disabling condition of the stroke.**

This benefit is not available under the Subsidized Self-pay Program or COBRA coverage and is not offered to Transitioning Employees.

Claims for extensions of eligibility for total disability are handled following the same procedures and limitations as claims for weekly accident and sickness benefits or dismemberment benefits.

SECTION 6. HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

If required under the terms of a Collective Bargaining Agreement or a Participation Agreement, an Employer may make pre-tax contributions on your behalf to this Plan to fund a Health Reimbursement Arrangement (HRA). Amounts contributed to an HRA Allowance (defined below), if any, may be used to reimburse you tax-free for eligible medical expenses recognized under the Internal Revenue Code Section 213 as tax-deductible and which are not covered by this Plan or any other source. If your Spouse or children are eligible under the terms of the Plan, their reimbursable medical expenses also qualify for tax-free treatment from the HRA Allowance. Your Domestic Partner's expenses are reimbursable only if they are your dependent for federal tax purposes.

All HRA contributions are Fund assets. You are not vested in any contributions made on your behalf, and an HRA Allowance may only be used per the terms of the Plan. Although the Board of Trustees has no intention to do so, it may decide to reduce your HRA Allowance to zero at any time.

A) Active Participant Eligibility

If an Employer makes an HRA contribution to the Fund on your behalf, you are entitled to these contributions, subject to the terms of the Plan, once you become eligible to participate in the Plan. Your HRA benefit is called an "HRA Allowance". Your HRA Allowance may be used to reimburse eligible medical expenses incurred by you, your eligible Spouse or Domestic Partner (if they are your dependent for federal tax purposes), and your eligible children.

When you begin working to establish or re-establish eligibility, HRA contributions are not credited to your HRA Allowance. These are called "ineligible contributions", and the Fund retains them to pay for normal Plan expenses. Once you are eligible, you can access any HRA contributions made for work months in which you are eligible.

This rule is necessary to comply with the Patient Protection and Affordable Care Act, which does not permit an HRA Allowance to accrue during any period when an employee is ineligible for benefits under a health plan.

You can still access any balance remaining in your HRA Allowance when you are not eligible.

B) Loss of Eligibility

If you have a balance remaining in your HRA Allowance and you cease to be eligible for benefits under the Plan—due to circumstances such as termination of employment, reduction in hours of employment, or retirement—you may continue to submit claims for reimbursement from your HRA Allowance. Any dependent covered before you ceased to be eligible for benefits continues to be covered. However, once an eligible child turns age 26, or your divorce is finalized, or your domestic partnership dissolution is finalized, your child, former Spouse, or former Domestic Partner is no longer eligible under the terms of the Plan, and expenses incurred after the loss of eligibility are no longer reimbursable from the HRA. Your child or former Spouse may retain access to your HRA Allowance if they elect and pay for COBRA coverage (discussed further below).

EXAMPLE	**You lose eligibility at a time when your 25-year-old child was covered by the Plan. You may claim reimbursement for the child's eligible expenses, whether incurred before or after your loss of eligibility, but not for expenses incurred after that child turns 26.**

EXAMPLE	**You lose eligibility at a time when your Spouse was covered by the Plan. You may claim reimbursement for your Spouse's eligible expenses, whether incurred before or after the loss of eligibility, but not for expenses incurred after you and your Spouse later divorce.**

EXAMPLE	**You lose eligibility because your employment ends and your Eligibility Bank runs out. You do not elect COBRA coverage because you can obtain coverage through your eligible Spouse's employer. You may nonetheless continue to claim reimbursement from your HRA Allowance for eligible expenses, including any after-tax premiums your Spouse pays for their medical coverage, as well as the eligible expenses of your Spouse or other Eligible Dependent.**

C) Benefit Amount

The amount of your HRA benefit in any Calendar Year is determined by the number of hours you work for a Contributing Employer, multiplied by the HRA contribution rate set forth in the Collective Bargaining Agreement or other agreement. If your HRA Allowance is not used in any Calendar Year, it may be carried over year-to-year until it is depleted. This benefit is expected to be provided as long as the Collective Bargaining Agreement or other agreement provides for a contribution for such a benefit.

In addition, once an HRA Allowance is established, it will remain available to you indefinitely, except that:

i) The Trustees have the right to change the HRA rules, including taking away any HRA Allowance you may have, at any time;
ii) Your Allowance may be forfeited according to the rules outlined below; and
iii) You may opt out according to the rules outlined below.

D) Forfeitures

If no contributions have been received and no claims have been filed for 24 months, and if you do not respond to a letter sent to your last known address by the Fund Office, your HRA Allowance will be forfeited to the Fund.

E) HRA Opt-Out Feature

If you lose coverage under the Health & Welfare Fund, you may want to opt out of the HRA to qualify for other coverage, such as the federal government health insurance premium and cost-sharing assistance through the health marketplace exchanges (e.g., Covered California) established by the Patient Protection and Affordable Care Act.

If you have an HRA Allowance, you may opt out of the HRA and waive reimbursement from the HRA. This opt-out feature is permanent for any money in your HRA Allowance at the time you opt out – once elected, you forever waive your right to access the money in your HRA Allowance, and any money remaining in your HRA Allowance is forfeited. It is possible, however, to establish a new HRA Allowance later; for example, if you are re-employed under a Collective Bargaining Agreement and new contributions are made toward a new HRA Allowance.

You will be eligible to opt out of the HRA in December of each year or upon loss of coverage under this Plan due to termination of employment.

F) Reimbursable Expenses

Your HRA Allowance may be used to reimburse eligible health care expenses incurred by you, your Spouse, your Domestic Partner (if they are your dependent for federal tax purposes), or eligible children which would otherwise be only partially covered or excluded from coverage by the Plan and any other health plan. Reimbursable expenses are those that constitute "medical care" under Section 213 of the Internal Revenue Code.

NOTE	**Generally, reimbursement from an HRA Allowance for eligible expenses will not be taxable. However, it is your responsibility to determine your own individual tax obligation.**

i) Examples of eligible expenses are as follows:

- Acupuncture services
- Chiropractic visits
- COBRA premiums
- Coinsurance and Deductibles
- Crutches
- Dental expenses
- Expenses that exceed medical, hospital, dental, or vision plan limits
- Eye exams, glasses, and contact lenses
- Hearing aids
- Laser eye surgery
- Long-term care insurance premiums
- Medicare premiums
- Medicare supplemental coverage
- Orthodontia
- Orthopedic shoes
- Other post-tax medical plan coverage
- Physical exams
- Physical therapy
- Pregnancy services for an eligible child
- Prescription Drugs and nonprescription drugs prescribed by a Physician
- Psychotherapy
- Subsidized Self-pay Program premiums
- Transportation expenses related to medical care
- Well-baby and well-child care
- Wheelchairs

ii) Examples of ineligible expenses are as follows:

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

G) Claims Procedures

There are several ways to access your HRA account, this includes filing claims for reimbursement through mail and email, filing claims through the online portal at https://scptac.lh1ondemand.com, or filing claims through the app in the Google Play or the Apple App Store.

To file a claim for reimbursement, you must submit a completed HRA Reimbursement Form. This form, available from the Fund Office or at the Fund Office website at www.scptac.org, requires your certification that the expenses were not reimbursed, and are not reimbursable, by this Plan or from any other source.

Along with the HRA Reimbursement Form, you must submit supporting documentation with a description of the expenses and proof of payment. Supporting documentation may include, but is not limited to, the following, as applicable:

- An itemized bill describing the services provided, the person to whom the services were provided, the name of the provider, the date of service, and the charged amount
- An Explanation of Benefits (EOB)
- A receipt or canceled check indicating proof of payment
- Proof that your Domestic Partner is your dependent for federal tax purposes

If you file an HRA claim, but there are insufficient funds in your HRA Allowance to pay the entire claim, the Fund will pay only the amount in your HRA Allowance. Once additional contributions have been credited to your HRA Allowance, additional payments will be released to you automatically. Claims for services for which you are making installment payments can be re-filed indefinitely as you make additional payments to the provider, so long as the initial claim for reimbursement was timely filed.

The claim must be filed within 60 months after the date of service to be eligible for reimbursement. Claims submitted more than 60 months after the date of service will be denied. Claims initially filed by the 60-month deadline but which still had a reimbursable amount remaining after your HRA Allowance was exhausted may be re-filed indefinitely as new contributions to your HRA Allowance are received.

H) COBRA Continuation Coverage and Your HRA

If you or an Eligible Dependent have a Qualifying Event and are eligible for COBRA coverage, you can pay for COBRA coverage. Before enrolling in COBRA, you should check the Covered California marketplace to compare the marketplace plans with your COBRA plans and costs; you may qualify for government-subsidized premium coverage.

i) COBRA Coverage for Participants

A Participant is not required to elect COBRA coverage or to pay COBRA premiums to retain access to the HRA Allowance.

If you do elect COBRA coverage, you may elect HRA COBRA by paying an additional HRA COBRA premium which will add additional contributions to your HRA Allowance. These additions to your HRA Allowance will, however, be after-tax amounts.

ii) COBRA Coverage for Eligible Spouses and Children

Eligible Spouses and eligible children who qualify as COBRA Beneficiaries fall into two categories:

a) If the eligible Spouse's or child's loss of eligibility is due to your termination of employment, reduction in hours, or death:

As noted above, an eligible Spouse, eligible Domestic Partner (if they are your dependent for federal tax purposes), or eligible child continues to be eligible to have qualified expenses reimbursed from your HRA Allowance upon their loss of eligibility in the Plan due to your termination of employment, reduction in hours or death. The Eligible Dependent's expenses will continue to be reimbursed in the same manner as they were reimbursed before the loss of eligibility. In these cases, an eligible Spouse or child is not required to elect COBRA to have qualified expenses reimbursed from your HRA Allowance. (Domestic Partners are not eligible for COBRA.) However, if your Spouse or child elects COBRA coverage, they can also elect HRA COBRA by paying an additional HRA COBRA premium. Paying the additional premium will add additional contributions to the HRA Allowance.

b) If the Eligible Dependent's loss of eligibility is due to divorce or because an Eligible Dependent no longer meets the definition of Eligible Dependent under the Plan:

An eligible Spouse or child who loses eligibility under the Plan because they no longer meet the definition of an Eligible Dependent under the Plan (for example, because of divorce in the case of a Spouse or turning age 26 in the case of a child) no longer has access to your HRA Allowance upon the loss of eligibility unless they elect both COBRA coverage and HRA COBRA. (Domestic Partners are not eligible for COBRA.) The additional HRA premium gives the eligible Spouse or child access to the HRA Allowance and adds additional contributions to the HRA Allowance on an after-tax basis.

An eligible Spouse or child who pays a COBRA premium may obtain reimbursement only for their own eligible expenses incurred after the start of COBRA coverage and only to the extent that there is a balance in the HRA Allowance. Eligible expenses incurred before the start of COBRA coverage will still be reimbursable to you.

EXAMPLE	COBRA without HRA COBRA
	Your eligible child turns age 26 and therefore loses coverage under the Plan. The child chooses to pay for COBRA coverage but not for HRA COBRA coverage. The child then suffers an Injury, the treatment for which is not entirely covered by the Plan or any other source. The child may not claim reimbursement from the HRA Allowance because the child did not pay for HRA COBRA coverage.

EXAMPLE	COBRA with HRA COBRA
	You and your eligible Spouse divorce, so your former Spouse loses coverage under the Plan. She elects to pay for COBRA coverage, including HRA COBRA coverage. She then suffers an Injury, the treatment for which is not entirely covered by the Plan or any other source. Your former Spouse may claim reimbursement from the HRA Allowance because she paid for COBRA coverage, including HRA COBRA coverage.

I) HRA COBRA Premiums

The amount of the HRA COBRA premium will be determined by the Fund and its Trustees, who may change the amount as they determine appropriate. The paid premium will be added to your existing HRA Allowance as an additional contribution, except for a small portion that will defray administrative expenses. As previously noted, you may not elect HRA COBRA unless you have elected regular COBRA coverage (Core or Full).

If you or your eligible Spouse or children add to the HRA Allowance by paying an HRA COBRA premium, these amounts are subject to all regular HRA rules and restrictions and may be forfeited per those rules. The amounts added by paying an HRA COBRA premium become part of the HRA Allowance. Any eligible individual may use them for reimbursement from the HRA Allowance, not just the party paying the COBRA premium.

J) Election of Additional Contributions from Eligibility Bank

You may elect to forfeit your Eligibility Bank balance and, in exchange, have the Fund transfer 50% of your Eligibility Bank balance (as of the end of the second month before your retirement effective date and as further explained below) to your HRA Allowance. If you elect this forfeiture and transfer option, your Eligibility Bank will be reduced to $0.00, and it will not be available to extend coverage in the Plan after your retirement effective date to you or any Eligible Dependents. The transferred amount will be available to you and your Eligible Dependents in your HRA Allowance to reimburse you for eligible healthcare expenses pursuant to all the normal HRA rules.

There are strict rules, required primarily by law and government regulation, on when and how this election can be made. ALL of the following conditions must be satisfied:

i) The election may only be made when you apply to retire and actually retire under the terms of the Southern California Pipe Trades Retirement Fund or the Southern California Pipe Trades Defined Contribution Fund or on a Retirement Declaration form.
ii) The election may only be made when you are an employee of a Contributing Employer. Therefore, you must plan ahead if you want to make this election. If you have not worked for a Contributing Employer during the month before your retirement, you are not eligible to elect the transfer to your HRA Allowance. Time spent on a local Union's "out-of-work" list or periods of disability do NOT count as work for a Contributing Employer.
iii) The election can only be made while you are eligible for medical benefits in this Plan.
iv) The election must be made on an application form provided by the Fund Office.
v) If you are eligible to enroll in the Pensioners Health Plan, you must enroll as of your retirement effective date.

For this program, your Eligibility Bank balance is the amount in your Eligibility Bank at the end of the second month before your retirement effective date. For example, if your retirement effective date is April 1, your Eligibility Bank balance for this purpose is the balance as of February 28, which normally includes hours worked in January if your Employer is not delinquent.

Any contributions received after your Eligibility Bank balance is determined (e.g., for your final or next to last work month or delinquent contributions paid to the Fund late) will remain in the Fund and will neither provide additional months of eligibility nor be included in your HRA.

The current monthly charge-off for coverage is $766, so the maximum six-month Eligibility Bank balance is $4,596, and the maximum HRA contribution under this program is $2,298. (Some Participants who were eligible in the Plan before September 1, 2002, may accumulate an Eligibility Bank that provides up to 12 months of coverage, in which case the HRA contribution under this program will exceed $2,298 accordingly.)

If you return to work for a Contributing Employer and establish a new Eligibility Bank, you are entitled to a new 50% election when you re-retire, subject to the above rules.

K) Death of Participant

If you have an HRA Allowance and you die before submitting a claim to the Fund Office for eligible health care expenses, the expenses may nonetheless constitute eligible expenses, and payment may be made to your estate. Payment can generally not be made to the Beneficiary of other Fund benefits but only to your estate. In such cases, the claim for reimbursement must be completed and submitted to the Fund Office either by your surviving Eligible Dependents or by a representative of your estate.

Your eligible Spouse, eligible Domestic Partner (if they are your dependent for federal tax purposes), and/or eligible children will retain access to any balance in your HRA Allowance to pay for their qualified medical expenses so long as they would have been eligible had you survived and continued to participate in the Plan. Upon your death and the death of any surviving eligible Spouse and any surviving eligible Domestic Partner and upon the loss of eligibility of any eligible children (such as when an eligible child reaches age 26), any remaining balance in the HRA Allowance will be forfeited to the Fund. See Section 6(D), page 25, for additional forfeiture rules.

L) Family and Medical Leave Act (FMLA)

During your FMLA leave, your HRA Allowance will be maintained. If you properly notify your Employer of your leave, your Employer may be required to continue to make an HRA contribution to the Fund on your behalf. Any questions about whether or not you are entitled to continued contributions to your HRA Allowance must be resolved with your Employer. (See Section 23(B), page 67.)

M) Uniformed Service Leave

If you serve in Qualified Uniformed Service for fewer than 31 days, you are entitled under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) to have contributions made to your HRA Allowance by your Employer during this period of service. Any questions about whether or not your Uniformed Service is Qualified Uniformed Service entitling you to continued contributions to your HRA Allowance must be resolved with your Employer. No additional contributions must be made to your HRA Allowance if you serve longer periods in Uniformed Service. However, if you notify the Fund Office that you are serving in Qualified Uniformed Service, time spent in Uniformed Service will not be counted in determining whether there has been sufficient inactivity in your HRA Allowance to cause forfeiture. (See Section 6(D), page 25.)

SECTION 7. PLAN BASICS

A) Calendar Year Deductible

You and/or your Eligible Dependent(s) are responsible for the first $250 in amounts otherwise payable by the Plan in a Calendar Year. This is called the Calendar Year Deductible. The Calendar Year Deductible applies separately to you and each Eligible Dependent up to a maximum of $750 per Calendar Year per family.

Effective January 1, 2026, if you transition between this Plan and the Pensioners & Surviving Spouses Health Fund within the same year you will only need to meet one Deductible per covered individual.

The Calendar Year Deductible does not apply to the following:

i) Hearing aid benefit – There is a separate $50 per device Deductible.
ii) Prescription Drug benefit – There is a separate $50 Calendar Year Deductible for Prescription Drugs.
iii) Dental benefit – The MetLife PPO option has a separate $50 Deductible; the DeltaCare USA option has no Deductible.
iv) Vision benefit – There is no Deductible for vision services.

Non-covered charges do not count toward the Deductibles. Charges payable by the Plan, non-covered charges, or the portion of covered charges that the Patient must pay above the Blue Shield of California PPO Network Rate or the Allowable Charge cannot be used to satisfy the Deductible.

B) Out-of-Pocket Maximum

You and/or your Eligible Dependent(s) are responsible for Out-of-Pocket costs under the Plan, such as your Calendar Year Deductible and Coinsurance for Covered Services, up to an Out-of-Pocket Maximum. The Out-of-Pocket Maximum does not apply to amounts over the Allowable Charge.

The individual and family Out-of-Pocket Maximums will change annually. The family Out-of-Pocket Maximum is two times the individual amount.

The in-network Out-of-Pocket Maximum will be based on the Out-of-Pocket limits determined by the Department of Health and Human Services for the Affordable Care Act. The out-of-network Out-of-Pocket Maximum is two times the in-network amount.

For claims incurred during the 2025 Calendar Year, the in-network Out-of-Pocket Maximum is $9,200, for individuals ($18,400 for families), and the out-of-network Out-of-Pocket Maximum is $18,400 for individuals ($36,800 for families).

For claims incurred during the 2026 Calendar Year, the in-network individual Out-of-Pocket Maximum is $10,600, and the out-of-network individual Out-of-Pocket Maximum is $21,200.

EXAMPLE	**You have surgery on July 1, 2025, in an in-network Hospital; the billed amount is $5,000, the Blue Shield of California PPO Network Rate is $4,000, and you are responsible for the 5% Coinsurance amount of $200.** • **The $200 Coinsurance that you pay applies toward your individual and family in-network Out-of-Pocket Maximum for 2025.**

EXAMPLE	**You have surgery on November 4, 2025, in an out-of-network surgery center; the billed amount is $5,000, the Allowable Charge is $1,350, and you are responsible for the 10% Coinsurance amount of $135 plus the amount over the Allowable Charge of $3,650 ($5,000 - $1,350).** • **The $135 Coinsurance that you pay applies toward your individual and family out-of-network Out-of-Pocket Maximum for 2025.** • **The $3,650 does not apply toward your Out-of-Pocket Maximum.**

EXAMPLE	**You buy a hearing aid from an in-network Durable Medical Equipment supplier on December 28, 2025; the billed amount is $1,700, the Blue Shield of California PPO Network Rate is $1,500, the Allowable Charge is $1,000, and there is a $50 Deductible. Because the Allowable Charge is less than the Blue Shield of California PPO Network Rate, you are responsible for the remaining $500 ($1,500 - $1,000) and the Deductible.** • **The $50 Deductible you pay applies to your individual and family in-network Out-of-Pocket Maximum for 2025.** • **Because the Fund Allowable Charge is $1,000 per hearing aid, the $500 does not apply to your Out-of-Pocket Maximum.**

C) Preferred Provider Organization (PPO) Network

The best value and lowest costs to you will generally be realized when you go to an in-network provider.

Blue Shield of California (BSC) is a non-profit organization that provides you 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.

The Blue Shield of California PPO network is a voluntary program. You may continue to choose any healthcare provider you wish. However, there is a financial advantage to you and the Plan if you choose healthcare providers from the Blue Shield of California PPO network.

When you seek medical care, select a provider from the Blue Shield of California PPO network to receive the maximum benefit under this Plan at the lowest cost to you. A list of Blue Shield of California PPO network providers can be found at www.blueshieldca.com, or contact the Fund Office at (213) 385-6161 or (800) 595-7473.

BSC updates its provider directories at least once every ninety (90) days and will respond to your inquiry about the network status of a provider or facility within one business day. If you receive inaccurate information from BSC or the Fund Office about a provider or facility's network status, you will be liable only for in-network cost-sharing for the services underlying your inquiry. However, it is your responsibility to confirm that the provider or facility that you have selected is in-network at the time you receive services.

Blue Shield of California, an independent member of the Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Obtaining services from a Blue Shield of California PPO network provider does not guarantee that the services will be covered. Services not covered by the Plan are excluded, regardless of where or by whom the services are provided.

IMPORTANT	**To verify that your healthcare provider is in the Blue Shield of California PPO network, go to www.blueshieldca.com or call the Fund Office at (213) 385-6161 or (800) 595-7473. When you make your appointment, and at the time of your appointment, confirm that your provider is participating in this network.**

IMPORTANT	**When seeking medical care, notify the provider's staff that benefits are provided through the Blue Shield of California PPO network. If you are referred to a specialist or a Hospital, or if laboratory work is needed, remind the doctor that Blue Shield of California PPO network providers, laboratories, and Hospitals are to be used. If you use Blue Shield of California PPO network providers, your Out-of-Pocket cost will be less than if an out-of-network provider is used. Using Blue Shield of California PPO network providers saves you and the Fund money.**

D) When Claims are Paid

Every effort will be made to pay a claim within a reasonable time after it has been submitted with all necessary information. The Plan rules described or referred to in this document control whether a claim will be paid, in whole or in part, or whether it will be denied. In addition, claims submitted more than 12 months after the date of service will be automatically denied except that when the Plan is not the primary payer, the deadline for filing a claim is 12 months after the primary insurance has adjudicated the claim.

Because it becomes increasingly difficult over time to determine if a benefit payment has been cashed or negotiated, and in order to establish certainty as to the benefits owed by the Fund, it is the Fund's policy not to:

i) Allow a check to be deposited or cashed more than 180 days after it was issued; or
ii) Reissue any benefit payment more than two years after it was first issued.

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

E) What the Plan will Pay

After your Calendar Year Deductible is satisfied, the Plan will pay for any further Medically Necessary Covered Services based on the Blue Shield of California PPO Network Rate or based on the Allowable Charge, whichever is applicable.

i) Blue Shield of California PPO Network Providers

If you use a Blue Shield of California PPO network provider, in most circumstances, the Plan will pay a percentage of the Blue Shield of California PPO Network Rate, so long as the services are determined by the treating Physician or other recognized provider and by the Plan to be Medically Necessary for the care and treatment of an Injury or Illness. However, even if a service is considered Medically Necessary, it may not be covered by the Plan. If you or your doctor have a question about coverage for a service, you can contact the Fund Office.

The Blue Shield of California PPO Network Rate is the amount a participating provider has agreed to accept in payment for specific services. The participating provider cannot charge above the Blue Shield of California PPO Network Rate. In most cases, but not all, the Plan pays 100% of the Blue Shield of California PPO Network Rate.

In some cases, such as orthotics, pain management, TENS unit, and hearing aids, the Plan will pay an Allowable Charge instead of the Blue Shield of California PPO Network Rate.

ii) Out-of-network Providers

Except as described under G) No Surprise Billing, if you use an out-of-network provider, the Fund's payment of benefits for Medically Necessary Covered Services will be based on a percentage of an Allowable Charge.

The Allowable Charge is determined based on several factors applied when the claim is submitted. Any charges that exceed the Allowable Charge are Out-of-Pocket expenses to you. If you want to know what the Allowable Charge will be before you schedule your treatment, you may contact the Fund Office and request this information.

iii) Continuity of Coverage

The Plan provides "continuity of coverage" in certain situations where a termination of a contractual arrangement changes the in-network status of a provider or facility to out-of-network (except in the case of a termination of the contract for failure to meet applicable quality standards or fraud).

Specifically, if you are a "Continuing Care Patient," you will be notified by Blue Shield of California of the contract termination and your right to elect continued transition care from the provider or facility; and, you will be allowed ninety (90) days of continued transitional care from the provider or facility at in-network cost sharing to allow you time to transition to a new in-network provider of facility (provided you remain eligible for Plan coverage).

A Continuing Care Patient, is an individual, who, with respect to a provider or facility: (1) is undergoing a course of treatment for an acute illness (serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm) or chronic illness or condition (life-threatening, degenerative, potentially disabling, or congenital; an requires specialized medical care over a prolonged period of time); (2) is undergoing a course of institutional or inpatient care from the provider or facility; (3) is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility; (4) is pregnant or undergoing a course of treatment for the pregnancy from the provider or facility; or (5) is or was determined to be terminally ill (under Social Security Act § 1862(dd)(3)(A)) and is receiving treatment for such illness from such provider or facility.

F) Out-of-Area Services

Benefits will be provided for Covered Services received outside of California within the United States, Puerto Rico, and U.S. Virgin Islands. The Southern California Pipe Trades Health and Welfare Fund, the "Fund", calculates the Participant's copayment either as a percentage of the allowable amount or a dollar copayment, as defined in this SPD. 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 SPD.

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 SPD.

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

When you require Covered Services while traveling outside of California:

1. Call BlueCard Access® at 1-800-810-BLUE (2583) to locate Physicians and Hospitals that participate with the local Blue Cross and/or Blue Shield plan, or go on-line at www.bcbs.com

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 the Southern California Pipe Trades Health and Welfare Fund, the out-of-area provider should call the customer service number noted on the back of your identification card.

i) BlueCard Program

Under the BlueCard® Program, when you obtain Covered Services within the geographic area served by a Host Plan, the Plan will remain responsible for any payment due, excluding the Participant's liability (e.g., Copayment and Plan Deductible amounts shown in the Benefits SPD). However, the Host Blue 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 SPD.

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 SPD.

ii) Non-Preferred Provider

If you do not see 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 pay you at the Non-preferred provider benefit level. Remember, your copayment is higher when you see a non-preferred provider. You will be responsible for paying the entire difference between the amount paid by the Southern California Pipe Trades Health and Welfare 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.

iii) Care for 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 the Fund at the customer service 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 your local Customer Service office for the most current listing of providers world-wide or you can go on-line at www.bcbs.com.

IMPORTANT	**No health care provider is an agent or representative of the Plan or the Board of Trustees. The Fund does not provide medical services itself, nor does it control or direct the provision of health care services or supplies 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 healthcare providers, including both Blue Shield of California PPO network providers and out-of-network providers under the terms of the Plan, and all entities (and their agents, employees, and representatives) that contract with the Fund to offer health-related services or supplies. Nothing in this Plan restricts the ability of a provider to disclose alternative treatment options.**

G) No Surprise Billing

Notwithstanding any language to the contrary in this SPD, under the federal No Surprises Act, for some out-of-network services you may receive, you are protected from receiving a bill from a provider for the difference between the provider's bill and the Plan's out-of-network payment to the provider. After you have satisfied your deductible, when you receive services under the following conditions, you will be responsible for the Plan's in-network cost-sharing only:

i) Emergency care at an out-of-network facility (hospital or freestanding emergency facility) or from an out-of-network provider at an emergency facility; or
ii) Any type of medical care from an out-of-network provider at an in-network hospital or ambulatory surgical center; or
iii) Emergency transportation by an out-of-network air ambulance provider.

The Plan will pay the difference between your cost-sharing and the balance due to the provider. You will not receive an additional bill from the provider. In addition, your cost-sharing will count toward your in-network out-of-pocket maximums.

There are some exceptions. A provider may charge you an additional amount over the Plan's payment and your cost-sharing if you have provided written consent to obtain treatment from an out-of-network provider in an in-network facility.

If you appeal a Fund Office decision to the Appeals Committee of the Board of Trustees and the Committee denies your appeal, in whole or in part, and the appeal involves balance billing or an issue that you believe violates the no surprise billing rules, you may file a request for your appeal to be reviewed by an Independent Dispute Resolution entity. Contact the Fund Office if you believe you have such an appeal.

SECTION 8. QUARTERLY STATEMENT

The Fund Office issues a quarterly statement that you should carefully review, showing any hours worked and reported to the Fund Office, Base Contributions paid on your behalf by your Employer, your projected eligibility, and other benefit information. The following "Quarterly Statement Schedule" summarizes the statement cycle for Quarterly Statements

Quarterly Statement Schedule

Hours Worked During:*	Deposits Processed During:	Date of Quarterly Statement
January 1st through March 31st	February 1st through April 30th	May 1
April 1st through June 30th	May 1st through July 31st	August 1
July 1st through September 30th	August 1st through October 31st	November 1
October 1st through December 31st	November 1st through January 31st	February 1

* Delinquent reporting or payment by the Employer will affect the work months appearing on the statement.

A quarterly HRA Statement showing your beginning HRA Allowance, any activity during the statement period, and your ending HRA Allowance is also made available to you.

SECTION 9. MEDICAL BENEFITS

Benefits are listed in alphabetical order.

Acupuncture

The Plan will pay 100% of the Blue Shield of California PPO Network Rate or 100% of the Allowable Charge, whichever is applicable, not to exceed 20 visits per Calendar Year.

Allergy Testing

The Plan will pay 100% of the Blue Shield of California PPO Network Rate or 100% of the Allowable Charge, whichever is applicable.

Allergy Treatment

For allergy treatment provided by a Blue Shield of California PPO Network Provider, the Plan will pay 95% of the Blue Shield of California PPO Network Rate.

For allergy treatment provided by an out-of-network provider, the Plan will pay 95% of the Allowable Charge up to a maximum of $75 per vial.

The Plan will pay for up to a three-month supply of antigens but will do so no more than four times in any 12-month period.

Ambulance/Air Ambulance

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, for professional ground ambulance or air ambulance services deemed Medically Necessary.

A) The Plan will pay for the following:
   i) Ground ambulance transportation to a Hospital in the area of an emergency;
   ii) Ground ambulance service between a Hospital or Extended Care Facility in connection with a confinement;
   iii) Ground ambulance service to the air ambulance;
   iv) Transportation from one Hospital to another for Medically Necessary specialized care (i.e., to a pediatric facility required for the patient's condition); and
   v) Air ambulance service to a medical facility.

B) The Plan will not pay for the following:
   i) The use of a ground ambulance or air ambulance due to lack of other transportation or for personal preference, such as your desire to use your own Physician, your desire to be near home and family, or your desire to be treated at a different facility; or
   ii) Stand-by time charged by any ambulance; or
   iii) Chartered aircraft instead of air ambulance unless a bona fide air ambulance is not available; or
   iv) More than one air ambulance charge per Illness or Injury; or
   v) Transportation from a nursing facility to a Hospital or vice versa for tests, X-rays, scans, etc.; or
   vi) EMS (Emergency Medical Service) with no transport.

Anesthesia

The Plan will pay 100% of the Blue Shield of California PPO Network Rate or 100% of the Allowable Charge, whichever is applicable. For pain management benefits, see this section, page 40.

IMPORTANT	**Effective January 1, 2021, for emergency care, or certain out of network care at an in-network facility, you are protected from receiving a surprise bill from a provider for the following services:** • **Emergency care at a out-of-network facility (hospital or freestanding emergency facility) or from an out-of-network provider at an in-network emergency facility.** • **Any type of medical care from an out-of-network provider at an in-network hospital or ambulatory surgical center (unless you sign a consent form).** • **Emergency transportation for an out-of-network air ambulance provider.** **You should never be asked to consent to balance billing in an emergency situation, by resident doctors in the hospital, or by intensive care physicians. For more information on the No Surprises Act you may visit www.cms.gov/nosurprises.**

NOTE	For pain management services, see this section, page 40.

Bariatric Surgery

The Plan will pay 100% of the Blue Shield of California PPO Network Rate. Bariatric surgery must be Medically Necessary, pre-authorized, and rendered by a Blue Shield of California PPO network provider. This benefit is for the surgeon's fees. Bariatric surgery services are rendered in a Hospital or Outpatient facility. See this section, page 38, for facility benefits.

Cardiac Rehabilitation

For cardiac rehabilitation provided by a Blue Shield of California PPO network provider, the Plan will pay 100% of the Blue Shield of California PPO Network Rate.

For cardiac rehabilitation provided by an out-of-network provider, the Plan will pay 100% of the Allowable Charge up to a maximum of $25 per visit.

Cardiac rehabilitation services rendered in a Hospital or Outpatient facility will be paid under the Hospital benefit.

Chemotherapy

The Plan will pay 95% of the Blue Shield of California PPO Network Rate or 95% of the Allowable Charge, whichever is applicable.

Chiropractic Care

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

For chiropractic care provided by an out-of-network provider, the Plan will pay 100% of the Allowable Charge up to a maximum of $54 per visit, three visits per week, not to exceed 35 visits per Calendar Year.

The maximum visits of 35 per year can be a combination of Blue Shield of California PPO network and out-of-network providers.

Massage therapy is not a Covered Service unless performed by a Chiropractor in conjunction with a manipulation.

Children under seven years of age require a referral to the Chiropractor by their attending Physician.

Colonoscopy/Sigmoidoscopy (Screening)

The Plan will pay 100% of the Blue Shield of California PPO Network Rate or 100% of the Allowable Charge, whichever is applicable, for a screening colonoscopy or sigmoidoscopy once every five years for Patients age 45 and older.

A colonoscopy/sigmoidoscopy rendered in a Hospital or Outpatient facility setting will be paid under the Hospital benefit.

Dependent Child Special Disability Benefit

If an eligible child incurs expenses for disabilities resulting from Illness or Injury and the expense is not covered under any other benefit provided by the Plan, the Plan will pay 90% of the Blue Shield of California PPO Network Rate or 90% of the Allowable Charge, whichever is applicable. A maximum benefit of $2,500 per Calendar Year applies for non-essential services, such as prosthetic devices, corrective shoes, braces, or casts. For example:

A) Essential Services
   i) Corrective Surgery rendered by a provider acting within the scope of their license; and
   ii) Therapy rendered in an institution, office, home, clinic, or academic school.
B) Non-Essential Services
   i) Prosthetic devices and their repair; and
   ii) Corrective shoes, braces, or casts and their repair.

This benefit has the following additional exclusions and limitations:

A) Treatment by corrective Surgery, therapeutic treatment, or need for prosthetic devices or orthopedic supplies must be certified as Medically Necessary by the Physician and approved by the Plan;
B) This benefit does not provide coverage for Deductibles or Coinsurance or charges above the Blue Shield of California PPO Network Rate or the Allowable Charge;
C) This benefit does not provide coverage for developmental delay; and
D) Benefits available through a government entity will not be duplicated.

Dialysis (Renal)

A) Physician's office:
The Plan will pay 95% of the Blue Shield of California PPO Network Rate or 95% of the Allowable Charge, whichever is applicable, for services rendered in a professional office.

B) Hospital services:
For renal dialysis provided by a Blue Shield of California PPO network provider, the Plan will pay 95% of the Blue Shield of California PPO Network Rate per visit.

For renal dialysis provided by an out-of-network provider, the Plan will pay 90% of the Allowable Charge up to a maximum of $200 per visit.

Durable Medical Equipment

The Plan will pay 95% of the Blue Shield of California PPO Network Rate or 95% of the Allowable Charge, whichever is applicable, for the Durable Medical Equipment listed below, if Medically Necessary and authorized by a licensed Physician or Podiatrist:

A) Rental of a wheelchair, 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 wheelchairs, electric scooters, or electric hospital beds).
B) Prosthetic devices (including orthopedic appliances and plaster molds in connection with treating Temporomandibular Joint Dysfunction) that improve or maintain the function of an impaired body part.
C) Insulin pumps.
D) CPAP devices.
E) Foot orthotics, except:
   i) Benefits are limited to $200 per condition (except conditions related to diabetes are not subject to the $200 limit, but all other Plan limitations and cost-sharing provisions apply); and
   ii) Replacement is permitted for the same condition for a Patient who is still growing or has been documented to have experienced significant changes in build.
F) TENS (Transcutaneous Electrical Nerve Stimulation) unit, except:
   i) The unit must be prescribed by a Physician or Psychiatrist;
   ii) The benefit is limited to $300 per Calendar Year for the unit and supplies combined; and
   iii) The dollar coverage limit applies to the purchase, rental, or replacement of the unit.

Benefits paid on a rental-to-purchase basis are based on the Patient's monthly eligibility.

Replacement or repair of Durable Medical Equipment is permitted no more often than once every 36 months, except for orthotics, which are once per condition maximum.

See Section 20, page 58, for further Exclusions and Limitations for Durable Medical Equipment.

Emergency Services by Out-of-Network Providers

When a claim for Medically Necessary Emergency Services performed in the United States by an out-of-network provider is received, and the Plan determines that the services rendered are due to an Emergency Medical Condition, the Plan will pay the Qualifying Payment Amount agreed upon between Blue Shield and the provider of service.

For emergency services performed outside the United Stated the Plan will pay the Allowable Charge, or an amount that is reasonable as determined by the Plan. This amount may be calculated using Medicare rates, UCR (usual, customary, and reasonable) or negotiated with the provider.

An Emergency Medical Condition is a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention could reasonably result in one or more of the following: (1) placing the health of the individual (or, with respect to a pregnant eligible Participant, Spouse, or Domestic Partner, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Emergency Services with respect to an Emergency Medical Condition means: (1) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of hospital, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; (2) Any such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department, as are require under the section 1867 o the Social Security Act (42

U.S.C. 1395dd) to stabilize the Patient, regardless of the department of the hospital in which such further examination or treatment is furnished to the Patient. The term "to stabilize" with respect to an Emergency Medical Condition, means to provide such medical treatment of the Emergency Medical Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the Patient from the facility; and (3) Post-stabilization services (i.e., services after the Patient has been stabilized, as part of outpatient observation, or an inpatient or outpatient stay related to the Emergency Services provided, as described above).

IMPORTANT	**Effective January 1, 2021, for emergency care, or certain out-of-network care at an in-network facility, you are protected from receiving a surprise bill from a provider for the following services:** • **Emergency care at a out-of-network facility (hospital or freestanding emergency facility) or from an out-of-network provider at an in-network emergency facility.** • **Any type of medical care from an out-of-network provider at an in-network hospital or ambulatory surgical center (unless you sign a consent form).** • **Emergency transportation for an out-of-network air ambulance provider.** **You should never be asked to consent to balance billing in an emergency situation, by resident doctors in the hospital, or by intensive care physicians. For more information on the No Surprises Act you may visit www.cms.gov/nosurprises**

Family Planning

Services to treat infertility are not a covered benefit under the Plan. The Plan provides benefits for only these family planning services:

A) Intrauterine Devices (IUDs) for you and your Eligible Dependents. The Plan will pay 100% of the Blue Shield of California PPO Network Rate if the device is obtained from a Blue Shield of California PPO network provider or 100% of the Allowable Charge if an out-of-network provider is used. For IUDs that contain hormones, the device will be covered under the Prescription Drug benefit.
B) Hormonal methods of contraception for you and your Eligible Dependents under the Prescription Drug benefit.
C) Vasectomy services for you, your eligible Spouse, or your eligible Domestic Partner. The Plan will pay 100% of the Blue Shield of California PPO Network Rate if the service is obtained from a Blue Shield of California PPO network provider or 100% of the Allowable Charge if an out-of-network provider is used.
D) Tubal ligation for you, your eligible Spouse, or your eligible Domestic Partner. The Plan will pay 100% of the Blue Shield of California PPO Network Rate if the service is obtained from a Blue Shield of California PPO network provider or 100% of the Allowable Charge if an out-of-network provider is used.
E) Elective and Medically Necessary abortion services for you, your eligible Spouse, or your eligible Domestic Partner.

Genetic Testing

The Plan will pay 100% of the Blue Shield of California PPO Network Rate or 100% of the Allowable Charge, whichever is applicable, for genetic testing or screening deemed Medically Necessary.

Medical Necessity is as determined by the Plan and generally must meet all of the following three criteria:

A) One of the following:
   i) Family history suggestive of a heritable condition;
   ii) Specific symptoms suggestive of a heritable condition;
   iii) Results of a prenatal or newborn screening suggesting a heritable condition; or
   iv) Medical management that requires consideration of genetic variants; and
B) Testing will impact treatment or heighten monitoring for early detection of disease; and
C) Evidence-based data supports the validity and utility of the test.

Hearing Aid Benefit

The Plan will pay 100% of the charge after a separate $50 Deductible per device up to a maximum of $1,000 per device for replacement or repair, not to exceed one device per ear in a 36-month period. Replacements or repairs will not be covered until 36 months have elapsed from the date the expense was incurred for the existing device.

EXAMPLE	If a right ear device was dispensed on March 21, 2023, no additional benefits would be permitted until March 22, 2025. If a left ear device is dispensed on October 14, 2025, no additional benefits will be allowed until October 15, 2028.

Home Health Nursing

For home health nursing provided by a Blue Shield of California PPO network registered nurse, nurse practitioner, licensed vocational nurse, or skilled practical nurse, the Plan will pay 95% of the Blue Shield of California PPO Network Rate.

For home health nursing provided by an out-of-network registered nurse, nurse practitioner, licensed vocational nurse, or skilled practical nurse, the Plan will pay 95% of the Allowable Charge up to a maximum of $94.05 per day.

The Plan limits home health nursing benefits to 120 visits per Calendar Year. The 120 visits per year can be a combination of in-network and out-of-network providers.

Home Intravenous (IV) Therapy

The Plan will pay 95% of the Blue Shield of California PPO Network Rate or 95% of the Allowable Charge, whichever is applicable.

Hospice

The Plan will pay 95% of the Blue Shield of California PPO Network Rate or 95% of the Allowable Charge, whichever is applicable, if you have been diagnosed as Terminally Ill and elect, with the approval of a Physician, to be treated by a Hospice Care Program at a Hospice facility or at home.

Covered Services include those provided by a registered nurse, nurse practitioner, licensed vocational nurse, skilled practical nurse, or home health aide.

Hospital

A) Introduction

The Plan will pay for room and board and Medically Necessary services and supplies billed by a Hospital. For other services, such as Physician visits, see the relevant part of this alphabetical listing.

You are responsible for the Coinsurance percentage indicated below and for any non-covered services, which may include, but are not limited to:

i) Guest expenses;
ii) Telephone charges;
iii) Charges by a Hospital for any standby services, including the availability of a “trauma team”.

See also Exclusions and Limitations, Section 20, page 58.

B) Inpatient

i) Blue Shield of California PPO Network Hospital
The Plan will pay 95% of the Blue Shield of California PPO Network Rate.

ii) Out-of-Network Hospital
The Plan will pay 90% of the Allowable Charge, up to a maximum of $1,215 per day, except where the Plan determines that the services rendered are due to an Emergency Medical Condition. (See this section, page 36.)

NOTE	A fully itemized bill is required from the facility.

C) Outpatient

The Plan covers expenses that you incur for Medically Necessary facility services and supplies received in the Outpatient department of a Hospital, as follows:

i) Blue Shield of California PPO Network Hospital
The Plan will pay 95% of the Blue Shield of California PPO Network Rate.

ii) Out-of-Network Hospital
The Plan will pay 90% of the Allowable Charge, up to a maximum of $1,215 per day, except where the Plan determines that the services rendered are due to an Emergency Medical Condition. (See this section, page 36.)

iii) Hospital services for dental procedures must be Medically Necessary and authorized by the attending Physician, whereupon the maximum allowable for approved hospital care is $2,500, payable at 95% for a Blue Shield of California PPO Network Hospital or 90% for an Out-of-Network Hospital.

NOTE	For pain management services, see this section, page 40.

Immunizations

The Plan will pay 100% of the Blue Shield of California PPO Network Rate or 100% of the Allowable Charge, whichever is applicable, based on Blue Shield of California's recommended schedule.

Laboratory

The Plan will pay 100% of the Blue Shield of California PPO Network Rate or 100% of the Allowable Charge, whichever is applicable.

Laboratory services rendered in a Hospital or Outpatient facility will be paid under the Hospital benefit.

Medical Supplies

The Plan will pay 95% of the Blue Shield of California PPO Network Rate or 95% of the Allowable Charge for the items listed below if Medically Necessary and authorized by a licensed Physician or Podiatrist:

A) Blood and blood plasma;
B) Surgical dressings, splints, casts, and other devices for the reduction of fractures and dislocations;
C) Oxygen and rental of equipment for its administration;
D) Trusses, braces, or crutches; or
E) Diabetic supplies, including glucose monitors, test strips, and other self-testing supplies.

Mental Health

A) Introduction
Hospital or office visits for mental health care are Covered Services when provided by a practitioner who is acting within the scope of their license in the state in which they practice.

You are responsible for the Coinsurance percentage listed below and for any non-covered services which may include, but are not limited to:

a) Guest expenses;
b) Telephone charges;
c) Charges by a Hospital or any standby services, including the availability of a "trauma team".

See also Exclusions & Limitations, Section 20, page 58.

B) Adult Day Health Care Center (ADHC)
Placement in an ADHC or "Community-Based Adult Services" facility requires certification by a Physician or Psychiatrist. Custodial care, transportation to and from the facility, and meals are not covered under this benefit.

i) Blue Shield of California PPO Network Facility
The Plan will pay 95% of the Blue Shield of California PPO Network Rate, up to a maximum of $27 per day.
ii) Out-of-Network Facility
The Plan will pay 90% of the Allowable Charge, up to a maximum of $27 per day.

C) Inpatient Hospital

i) Blue Shield of California PPO Network Hospital
The Plan will pay 95% of the Blue Shield of California PPO Network Rate.
ii) Out-of-Network Hospital
The Plan will pay 90% of the Allowable Charge, up to a maximum of $1,215 per day, except where the Plan determines that the services rendered are due to an Emergency Medical Condition. (See this section, page 36.)

D) Outpatient – Office

i) Blue Shield of California PPO Network Provider
The Plan will pay 100% of the Blue Shield of California PPO Network Rate.

ii) Out-of-Network Provider
The Plan will pay 100% of the Allowable Charge.

E) Partial Hospitalization
Partial hospitalization requires a referral by a Physician or Psychiatrist. Custodial care and meals are not covered under this benefit.

i) Blue Shield of California PPO Network Facility
The Plan will pay 95% of the Blue Shield of California PPO Network Rate.
ii) Out-of-Network Facility
The Plan will pay 90% of the Allowable Charge, up to a maximum of $1,215 per day.

F) Residential Treatment Center
Placement in a Residential Treatment Center requires either a (1) court order or (2) certification by a Physician or Psychiatrist. Custodial care is not covered under this benefit.

i) Blue Shield of California PPO Network Facility
The Plan will pay 95% of the Blue Shield of California PPO Network Rate.
ii) Out-of-Network Facility
The Plan will pay 90% of the Allowable Charge, up to a maximum of $1,215 per day.

Midwife Services

The Plan will pay 100% of the Blue Shield of California PPO Network Rate or 100% of the Allowable Charge, whichever is applicable, for Medically Necessary pre- and post-partum services rendered by a state-licensed midwife. The Plan will pay 100% of the Blue Shield of California PPO Network Rate or 100% of the Allowable Charge, whichever is applicable, for Medically Necessary delivery services by a licensed midwife in a Hospital or state-licensed birthing center only.

Non-prescription and Over-the-counter Drugs

Non-prescription and over-the-counter drugs are not a covered benefit under this Plan.

Nutritional Counseling

The Plan will pay 100% of the Blue Shield of California PPO Network Rate or 100% of the Allowable Charge, whichever is applicable, for Medically Necessary nutritional counseling when rendered by a Physician or registered dietician. The Plan will pay up to eight visits per Calendar Year.

Occupational Therapy

For occupational therapy, the Plan will pay 100% of the Blue Shield of California PPO Network Rate per visit, or 100% of the Allowable Charge, whichever is applicable.

These services require a prescription from your Physician. Services must be rendered by a licensed occupational therapist.

Occupational therapy rendered in an Inpatient Hospital will be paid under the Hospital benefit.

Opioid Drug Testing

The Plan will pay 100% of the Blue Shield of California PPO Network Rate or 100% of the Allowable Charge, whichever is applicable.

The Plan will cover opioid drug testing per Medicare guidelines, except that the Plan will cover opioid drug testing no more than once every three months. This limitation does not apply to substance use disorder treatment.

Pain Management

The Plan will pay 100% of the Blue Shield of California PPO Network Rate for all services, with a maximum of three injections per day.

The Plan will pay 100% of the Allowable Charge for all services, not to exceed $1,215 for surgery center or Hospital fees, with a maximum of three injections per day.

Physical Examinations – Adults 18 and Over

If you incur any of the preventive expenses listed below while undergoing a physical examination performed by a Physician, the Plan will pay 100% of the Blue Shield of California PPO Network Rate or 100% of the Allowable Charge, whichever is applicable. The Plan covers only one routine physical examination per Calendar Year per person. However, an additional examination will be permitted if a pap smear was not performed during a routine physical examination earlier in the Calendar Year.

A physical examination includes, but is not limited to:

- Physician's Examination
- Urine Analysis
- Complete Blood Count (CBC)
- General Health Blood Panel
- Electrocardiogram (EKG)
- Chest X-ray
- Occult Blood
- Proctosigmoidoscopy (office only)
- Prostate Specific Antigen (PSA)
- Pap Smear; Mammography – Screening

Physical Therapy

For physical therapy, the Plan will pay 100% of the Blue Shield of California PPO Network Rate per visit, or 100% of the Allowable Charge up to a maximum of $70 per visit, whichever is applicable.

These services require a prescription from your Physician. Services must be rendered by a Registered Physical Therapist or Registered Physical Therapist Assistant under the supervision of a Registered Physical Therapist.

Physical therapy rendered in an Inpatient Hospital will be paid under the Hospital benefit.

Physician or Psychiatrist Visits/Professional Services

The Plan will pay 100% of the Blue Shield of California PPO Network Rate or 100% of the Allowable Charge, whichever is applicable.

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

A) A pediatrician during a cesarean section for the delivery of a baby; or
B) A trauma team in the emergency room; or
C) A "standby" surgeon or anesthesiologist during a surgical procedure.

Radiation Therapy

The Plan will pay 95% of the Blue Shield of California PPO Network Rate or 90% of the Allowable Charge, whichever is applicable.

Radiation therapy rendered in a Hospital or Outpatient facility will be paid under the Hospital benefit.

Radiology

The Plan will pay 100% of the Blue Shield of California PPO Network Rate or 100% of the Allowable Charge, whichever is applicable, for services rendered in a professional office.

Radiology services rendered in a Hospital or Outpatient facility will be paid under the Hospital benefit.

Skilled Nursing Facility or Convalescent Care Facility/Extended Care Facility/Adult Day Health Care

The Plan will pay 95% of the Blue Shield of California PPO Network Rate or 90% of the Allowable Charge, whichever is applicable.

The Plan will pay a maximum of $27 per day if you are confined in a Convalescent Care, Extended Care, or Adult Day Health Care Facility.

This benefit does not cover Custodial Care, companion care, etc.

Sleep Study

The Plan will pay 100% of the Blue Shield of California PPO Network Rate or 100% of the Allowable Charge, whichever is applicable.

A sleep study rendered in a Hospital will be paid under the Hospital benefit.

Specialty Medication

A Prescription Drug is covered as a Specialty Medication when the Fund determines that the medication:

A. Requires special delivery, preparation, or handling; or
B. Requires special administration or monitoring; or
C. Treats a complex condition; or
D. Costs $1,000 or more for a 30-day supply.

The Plan will pay 95% of either (1) the cost or (2) the "Red Book" average wholesale price of the Specialty Medication, whichever is lower. A Specialty Medication requires prior authorization from the Fund Office. Generic or other lower-cost drug substitutes may be

required. Maintenance medication for a chronic or long-term condition (such as diabetes), other than one that costs $1,000 or more for a 30-day supply, is not considered a Specialty Medication.

The Plan requires a Physician's letter of Medical Necessity and medical records annually.

Speech Therapy

For speech therapy, the Plan will pay 100% of the Blue Shield of California PPO Network Rate or 100% of the Allowable charge up to a maximum of $22.50 per visit, whichever is applicable.

These services require a prescription from your Physician. Services must be rendered by a qualified speech pathologist.

Speech therapy rendered in an Inpatient Hospital will be paid under the Hospital benefit.

Substance Use Disorder

A) Introduction

Hospital or office visits for substance use disorder treatment are Covered Services when provided by a practitioner acting within the scope of their license in the state where they practice.

You are responsible for the Coinsurance percentage listed below and for any non-covered services which may include, but are not limited to:

a) Guest expenses;
b) Telephone charges;
c) Charges by a Hospital or any standby services, including the availability of a "trauma team".

See also Exclusions & Limitations, Section 20, page 54.

B) Inpatient Hospital

i) Blue Shield of California PPO Network Hospital
The Plan will pay 95% of the Blue Shield of California PPO Network Rate.
ii) Out-of-Network Hospital
The Plan will pay 90% of the Allowable Charge, up to a maximum of $1,215 per day, except where the Plan determines that the services rendered are due to an Emergency Medical Condition.

C) Outpatient – Office

i) Blue Shield of California PPO Network Provider
The Plan will pay 100% of the Blue Shield of California PPO Network Rate.
ii) Out-of-Network Provider
The Plan will pay 100% of the Allowable Charge.

D) Partial Hospitalization

Partial hospitalization requires a referral by a Physician or Psychiatrist. Custodial care and meals are not covered under this benefit.

i) Blue Shield of California PPO Network Facility
The Plan will pay 95% of the Blue Shield of California PPO Network Rate.
ii) Out-of-Network Facility
The Plan will pay 9% of the Allowable Charge, up to a maximum of $1,215 per day.

E) Residential Treatment Center

Placement in a Residential Treatment Center requires either a (1) court order or (2) certification by a Physician or Psychiatrist. Custodial care is not covered under this benefit.

i) Blue Shield of California PPO Network Facility
The Plan will pay 95% of the Blue Shield of California PPO Network Rate.
ii) Out-of-Network Facility
The Plan will pay 90% of the Allowable Charge, up to a maximum of $1,215 per day.

F) Laboratory Testing

i) Blue Shield of California PPO Network Provider

The Plan will pay 100% of the Blue Shield of California PPO Network Rate.

ii) Out-of-Network Facility
The Plan will pay 100% of the Allowable Charge.

Laboratory services rendered in a Hospital or Outpatient facility will be paid under the Hospital benefit.

Surgery

The Plan will pay 100% of the Blue Shield of California PPO Network Rate or 100% of the Allowable Charge, whichever is applicable, for services rendered in a professional office.

Surgery rendered in a Hospital or Outpatient facility will be paid under the Hospital benefit.

Temporomandibular Joint Dysfunction (TMJ)

The Plan will pay 100% of the Blue Shield of California PPO Network Rate or 100% of the Allowable Charge, whichever is applicable, for services and supplies when authorized by a licensed Physician or Dentist and Medically Necessary.

There are two exceptions to this:

A) Physiotherapy
For physiotherapy provided by a Blue Shield of California PPO network provider, the Plan will pay 100% of the Blue Shield of California PPO Network Rate up to a maximum of $35 per visit.

For physiotherapy provided by an out-of-network provider, the Plan will pay 100% of the Allowable Charge up to a maximum of $35 per visit.

B) Plaster molds
Plaster molds are covered under a different formula set forth in this section, page 36, under Durable Medical Equipment

Transplants

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

Artificial part transplants are limited to joint replacement for functional reasons; skin; heart valves, vascular grafts, and patches; pacemakers; metal plates; and eye lenses after cataract Surgery.

Bone marrow is not usually considered an organ, so the maximum benefit limitations described in this section do not apply.

The maximum benefit payable in connection with any one-organ transplant is $100,000. If a Blue Shield of California PPO network provider is used, the Plan will pay 60% of the excess of the applicable percentage of the Blue Shield of California PPO Network Rate over $100,000, depending on the services provided. The applicable percentage is 95% for facility charges and 100% for professional charges from Blue Shield of California PPO network providers. This benefit includes all pre- and post-transplant care including, but not limited to, chemotherapy, radiation therapy, laboratory services, X-rays, scans, and prescription medication.

Plan benefits are payable for an organ donor at the Blue Shield of California PPO Network Rate or the Allowable Charge, whichever is applicable, up to the maximum benefit limit, whether or not the donor is eligible under the Plan. To be covered, services must be directly related to the transplant Surgery, and the organ recipient must be eligible under this Plan. Not covered are expenses that are payable from any other source, including, but not limited to, medical plans, medical research organizations, and charitable organizations.

The Blue Shield of California PPO Network Rate or the Allowable Charge for an organ donor is included in the maximum payable for any organ transplant of $100,000.

Well-Child Services – Children through age 17

Well-Child Services are a covered benefit. The Plan will pay 100% of the Blue Shield of California PPO Network Rate or 100% of the Allowable Charge, whichever is applicable.

SECTION 10. PRESCRIPTION DRUG BENEFITS

A) Benefit Limitations

The Prescription Drug benefit will be paid as described below after you meet your $50 Calendar Year Prescription Drug Deductible.

Tier	Amount Submitted	Plan Pays
1	$0.01 - $1,800.00	100%
2	$1,800.01 - $6,000.00	50%
3	Over $6,000.00	65%

EXAMPLE	**You paid $6,550 for covered Prescription Drugs in 2024. The first $50 you paid was applied to your Prescription Drug Deductible. The next $1,800 you paid was reimbursed at $1,800 ($1,800 x 100%). The next $4,200 you paid was reimbursed at $2,100 ($4,200 x 50%). The remaining $500 you paid was reimbursed at $325 ($500 x 65%). In total, you received $4,225 in Prescription Drug reimbursements.**

The $50 Prescription Drug Deductible is not applied to the $250 medical Deductible. The $250 medical Deductible does not apply to the Prescription Drug benefit.

The Plan covers only Prescription Drugs that are lawfully prescribed and purchased from a licensed Pharmacy located in the United States. The Plan does not cover Prescription Drugs bought out of the country unless the Participant submits proof of residency in the country where the services were rendered or in case of an Accident or life-threatening Emergency Medical Condition.

Prescription Drugs dispensed in a provider's office are not a covered benefit under the Plan. The Plan will cover off-label Prescription Drugs if such use is supported by at least two peer-reviewed clinical studies, and/or recognized as industry standard by appropriate professional associations or recognized clinical guidelines.

Implantable devices that contain hormone medication may be covered under more than one benefit.

Certain specialty medications are covered as a medical benefit. See section page 41.

EXAMPLE	**The Patient receives services for implanting an intrauterine device containing progestin. Because the implant includes hormones, the cost of the device would be covered under the Prescription Drug benefit, and the implantation charges billed by the Physician or anesthesiologist would be covered under medical benefits. Implanted devices that do not contain Prescription medication, such as the copper IUD, would also be covered under medical benefits.**

Prescription Drugs include up to 30 pills annually to treat erectile dysfunction for you, your eligible Spouse, or your eligible Domestic Partner.

B) Claim Requirements

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

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

A printout from a licensed Pharmacy may be substituted for a receipt, but it must include all the above information.

IMPORTANT	**Services, prescriptions, medications, and supplies purchased 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 Medical Condition that occurred outside of the United States and its territories or (2) the Participant submits proof of residency in the country where the services were rendered.**

SECTION 11. VISION BENEFITS

The Vision Service Plan (VSP) program offers many vision services for a minimal copayment. VSP pays benefits regardless of where you obtain vision services, but you will maximize your benefits by using VSP network providers.

The VSP program is offered at no additional cost to Participants in the Active Plan. However, you must enroll to take advantage of the VSP program. If you do not enroll, you will have no vision coverage.

A) Other Plan Rules

Generally, existing Active Plan rules apply to VSP program benefits, including rules related to the commencement of eligibility, suspension or termination of eligibility, and COBRA benefits.

Note that the Health & Welfare Plan's rules determine who is an Eligible Dependent for all benefits, including the VSP program benefits. Some VSP program documents may imply that a broader range of persons qualify as Eligible Dependents. Only Spouses, Domestic Partners, and children up to age 26 (including adopted children and children for whom you are the legal guardian as of the placement date) are covered as Eligible Dependents under the Active Plan.

B) Claims and Appeals Procedures

If you disagree with a Fund Office decision, such as eligibility to participate in the VSP program, you may appeal the decision to the Board of Trustees under the Plan's normal claims and appeals procedure, as set forth in the Summary Plan Description. Other disagreements regarding VSP program benefits, including issues regarding network providers, covered procedures, and charges for procedures, should be appealed to VSP. VSP's claims and appeals procedures are enclosed. All appeals under VSP's purview will be decided finally by VSP with no additional appeal to the Board of Trustees.

SECTION 12. DENTAL BENEFITS

You may choose coverage in the MetLife PPO option or the DeltaCare USA DHMO option when you first become eligible for Plan benefits and during the annual open enrollment period.

A) Enrollment

There is no default dental option. To enroll, you must complete a Dental Enrollment Form. You may obtain a Dental Enrollment Form from any local Union office, the Fund Office, or the Fund Office website at www.scptac.org.

i) Initial Enrollment

You must enroll no later than 60 days from your initial eligibility date. If you enroll after the first 60 days, your dental coverage will be effective the month following the date the form is received, not retroactive to your initial eligibility date.

ii) Changing Plans

Once enrolled, you can change your enrollment during the annual open enrollment period.

B) Benefit Options

i) The MetLife PPO option allows you to see any Dentist (although you'll be subject to lower Out-of-Pocket costs when you use a PPO network Dentist). In the PPO option, you must first pay the Calendar Year dental Deductible of $50 per person but not more than $150 per family. The Calendar Year maximum claims payment for the PPO dental option is $1,800 for each person.

The separate benefit for orthodontia is $1,800 per lifetime per person. It does not count toward the $1,800 Calendar Year maximum mentioned above.

ii) The DeltaCare USA DHMO option requires you to see your assigned DHMO network Dentist, but neither a dental Deductible nor a benefit maximum applies.

A more thorough description of these options is available by contacting MetLife at (800) 942-0854 for the PPO option or DeltaCare USA at (800) 422-4234 for the DHMO option.

C) Benefit Limitations

See the MetLife PPO materials, or the DeltaCare USA DHMO materials, for detailed information regarding rules and benefits, as applicable.

If you choose the DeltaCare USA DHMO option, you must live within the DHMO's service area to qualify for benefits. You must use only your assigned Dentist in the DeltaCare USA DHMO network. Before enrolling, you should check that the DeltaCare USA DHMO network is available where you live.

The Plan's rules determine who is an Eligible Dependent for all benefits, including either dental option. Some dental documents may imply that a broader range of persons qualify as Eligible Dependents. Only Spouses, Domestic Partners, and children up to age 26 (including adopted children and children for whom you are the legal guardian as of the placement date) are covered under the Plan.

D) Claims Procedures

Dental claims are processed by MetLife PPO or DeltaCare USA.

If you elected the MetLife PPO option, dental claims should be sent to:

MetLife Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282

If you elected the DeltaCare USA DHMO option, dental claims should be sent to:

DeltaCare USA
Claims Department
P.O. Box 1810
Alpharetta, CA 30023

E) Appeals Procedures

If you disagree with a Fund Office decision, such as eligibility to participate in either dental option, you may appeal the decision to the Board of Trustees under the Plan's normal claims and appeals procedure, as set forth in this SPD.

Other disagreements regarding dental benefits, including issues about network providers, covered procedures, and charges for procedures, should be appealed to MetLife PPO, or DeltaCare USA. If you elect either dental option, you will be given the applicable claims and appeals procedure. All appeals under MetLife PPO, or DeltaCare USA's purview will be decided finally by the dental carrier with no additional appeal to the Board of Trustees.

F) Option Comparison

Question	MetLife PPO	DeltaCare USA DHMO
Can I go to any Dentist?	You can visit any licensed Dentist, but you'll save the most by visiting a MetLife PPO contracted Dentist. You can change your dentist at any time without contacting us.	You must visit your assigned DeltaCare USA DHMO primary care Dentist to receive benefits. You can change your assigned Dentist online or by telephone, generally effective the following month.

Question	MetLife PPO	DeltaCare USA DHMO
What procedures are covered?	Your plan covers a wide range of services without any pre-existing condition limitations. Diagnostic, preventive, basic restorative, endodontic, and periodontic services; oral surgery; and orthodontia are covered at 100%, while major services like crowns, dentures, and bridges are covered at 90%, subject to the MetLife PPO contracted fee schedule.	Your plan covers over 300 procedures without any pre-existing condition limitations. You are not subject to any copayments for covered services.
Are there Deductibles and maximums?	Yes, a $50 per Patient (max $150 per family) Deductible and $1,800 maximum plan benefit apply each Calendar Year. Orthodontia has a lifetime benefit of $1,800 and is not counted towards the $1,800 Calendar Year maximum.	There are no Calendar Year Deductibles or maximums.
What happens if I need to see a specialist?	You do not need a referral from your Dentist.	Contact your DeltaCare USA DHMO primary care Dentist to coordinate your referral.
What is my out-of-area coverage?	You can visit any licensed Dentist.	You have a limited benefit for out-of-network emergency care.

SECTION 13. WEEKLY ACCIDENT AND SICKNESS BENEFIT

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

The day of disability on which benefits begin is:

For an Accident: First day

For an Illness: Eighth calendar day

The benefit is increased by the amount necessary to cover the Employer's share of the FICA tax. That tax is then paid on your behalf. A W-2 form will be issued from the Fund Office each year by the legal deadline.

Weekly payments for periods of disability that extend from one to seven days will be made at the rate of one-fifth of the weekly benefit ($8.00 per day) for each weekday of disability.

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

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

To secure proper disability credit in the Fund's records, you must periodically submit a disability certification form completed by your Physician, Chiropractor, or Doctor of Podiatric Medicine. These forms can be obtained from any local Union office, the Fund Office, or the Fund Office website at www.scptac.org.

You must be covered under the Active Plan when the disability period begins to be eligible for this benefit. No benefit is payable if you are:

A) Covered under COBRA, including the Subsidized Self-Pay Program;
B) Retired and using your Active Eligibility Bank;
C) Covered as a Contributing Employer;
D) Covered under a Participation Agreement; or

E) Disabled due to an Illness or Injury not covered by the Plan, except for a Workers' Compensation Illness or Injury; or
F) A Transitioning Employee.

Claims submitted more than 12 months after the date you are determined to be disabled will be automatically denied.

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

IMPORTANT	Crediting of Hours While Totally Disabled
	If you become Totally Disabled and are eligible for weekly accident and sickness benefits, your Eligibility Bank will be credited at $38.30 per day up to a maximum of $191.50 per week, but not more than $766 per month or $2,489.50 per year. These amounts will be adjusted proportionally whenever the Base Contribution rate changes and will be effective the first day of the second month following the month the change is effective. You will be required to refund any amounts paid should you retire retroactively, effective before the date for which accident and sickness benefits were paid. This will also result in reduced health & welfare contributions made through the accident and sickness benefit and the forfeiture of Pension Credits earned through the accident and sickness benefit. (See also COBRA Continuation Coverage in Section 5, page 18.)

SECTION 14. DEATH BENEFITS

If a Participant or Eligible Dependent dies for any reason (including work-related Illness or Injury) while covered under the Plan or within 31 days after the termination of eligibility, the Plan will pay the following death benefits:

Deceased Person	Amount Paid
Participant	$5,000
Eligible Dependent	$2,500

This benefit is not available to individuals covered under the Plan through COBRA or the Subsidized Self-Pay Program.

Written notice of death, including a copy of the death certificate issued by the appropriate government agency, must be submitted to the Fund Office within one year from the date of death. No death benefits will be paid under this provision unless all supporting documentation is received by the Fund Office within 12 months after the date of death. However, the Fund Office should be notified within 60 days of the death of any person covered by the Plan. If the Fund Office is not notified, COBRA, Pensioners Health Fund coverage, and other benefits, if applicable, may not be offered.

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

You may make or change a beneficiary designation at any time by completing and executing a Beneficiary Form. The beneficiary designation will take effect when the Fund Office receives the signed form. If you do not designate a Beneficiary or if the Beneficiary predeceases you, the Plan will pay benefits in the following order:

A) To your surviving lawful Spouse or Domestic Partner;
B) If none, divided equally among your surviving child(ren), including legally adopted child(ren) and children for whom you are the legal guardian;
C) If none, divided equally to your surviving parent(s);
D) If none, divided equally among your surviving sibling(s); or
E) If none, to your estate.

If you name your Spouse or Domestic Partner as Beneficiary, but you later divorce or dissolve your partnership, your beneficiary designation is automatically revoked as of the date of divorce or dissolution. If you wish to keep your former Spouse or Domestic Partner as the Beneficiary after the end of your marriage or partnership, you must file a new Beneficiary Form after the end of your marriage or partnership.

You may obtain a Beneficiary Form from any local Union office, the Fund Office, or the Fund Office website at www.scptac.org.

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

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

NOTE	**No death benefits are payable under COBRA or the Subsidized Self-Pay Program.**

SECTION 15. ACCIDENTAL DEATH / DISMEMBERMENT BENEFITS

A) Accidental Death or Dismemberment

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

i) Accidental death of Participant: $5,000; or
ii) Accidental dismemberment of Participant:
  a) Loss of any one hand, one foot, or the sight of one eye: $2,500.
  b) Loss of any two of hands, feet, and eyes: $5,000.

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

Accidental death or dismemberment benefits are not payable for individuals maintaining coverage under the Plan through COBRA, including the Subsidized Self-Pay Program.

B) Accidental Death or Dismemberment Exclusions and Limitations

Accidental death or dismemberment benefits are not payable for any death or dismemberment that results from:

i) Any attempt at suicide or intentionally self-inflicted Injury, while sane or insane;
ii) War or any act of war; active participation in a riot, insurrection, or terror activity;
iii) Bacterial infections (except pyogenic (pus-producing) infections coinciding with and in consequence of bodily Injury for which Accidental death or dismemberment benefits are payable);
iv) Bodily or mental infirmity, disease of any kind, or as a result of medical or surgical treatment; or
v) Travel in any aircraft as a pilot or crew member or in any aircraft privately owned, operated, or leased.

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

SECTION 16. PROCESSING CLAIMS FOR BENEFITS

A) How to File a Medical or Prescription Claim for Payment

For the Fund to pay a benefit, the Fund's claims procedures must be followed. A written claim form and an itemized billing must be filed with the Fund by the Patient or provider. Casual inquiries about benefits or the circumstances under which benefits might be paid are not claims under these procedures.

Providers should send medical claims to:	**Blue Shield of California** **P.O. Box 272540** **Chico, CA 95927-2540**

You should send your HRA or prescription claims to:	Southern California Pipe Trades Health & Welfare Fund Claims Department 501 Shatto Place, Suite 500 Los Angeles, CA 90020

Claims cannot be submitted by phone. Providers may file electronic claims via Electronic Data Interface ("EDI").

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

Claims 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.

Disagreements or claims involving eligibility to participate in the Plan or to receive benefits under the Plan must be submitted in writing to the Fund Office. No particular form is required.

Claims will be considered submitted upon receipt by the Fund Office.

Follow these guidelines for prompt claims processing:

i) Make sure you submit the Plan's Annual Coordination of Benefits Form, available from any local Union office, the Fund Office, or the Fund Office website at www.scptac.org. A fully completed Annual Coordination of Benefits Form is required once every Calendar Year.

ii) In case of any injury, submit the Plan's Injury and Third Party Liability Form.

iii) Submit the provider's fully itemized bill, which must include the following:
   a) Participant's name and the last four digits of their Social Security Number or Blue Shield ID number;
   b) Patient's name, date of birth, and the last four digits of their Social Security Number or Blue Shield ID number;
   c) Diagnosis or diagnosis code number (ICDA);
   d) Date(s) of service;
   e) Procedure codes (e.g. CPT); and
   f) Charge for each service.

iv) Submit a prescription claim receipt from a Pharmacy, which must include the following:
   1) Name of Patient;
   2) Name of medication;
   3) Date dispensed;
   4) Name, address, and phone number of Pharmacy;
   5) Name of prescribing Physician;
   6) Prescription number;
   7) National Drug Code (NDC) number; and
   8) Cost of Prescription Drug.

The Fund may require additional information to process the claim, such as:

i) Patient employment status;
ii) 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 cost (e.g., the Patient is employed by a Hospital or Physician and care received at that facility of by that Physician is at no charge or a reduced rate);
iii) Operative reports;
iv) Laboratory results;
v) X-ray results; or
vi) Detailed information when the claim may be related to an Accident including, but not limited to, circumstances surrounding: tripping, slipping, falling, dog bites, foreign objects (in the eye, ear, etc.), being hit by a projectile or another person, automobile Accidents, and bicycle Accidents.

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

Dental claims should be sent to:	**DeltaCare USA** **Claims Department** **P.O. Box 1810** **Alpharetta, GA 30023**
	MetLife PPO **MetLife Dental Claims** **P.O. Box 981282** **El Paso, TX 79998-1282**

Vision claims should be sent to:	**Vision Service Plan** **Attention: Claims Services** **P.O. Box 495918** **Cincinnati, OH 45249-5918**

B) Timely Filing

Claims should be submitted 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.

When the Plan is not the primary payer, the deadline for filing a claim is 12 months after the primary insurance has adjudicated the claim.

Replies to the Fund Office's request for information on claims should be submitted within 90 days of the request. Replies submitted more than 12 months from the date of request will not be accepted.

See Section 6, page 23, for information regarding Health Reimbursement Arrangement (HRA) claim deadlines.

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

All claims for weekly accident and sickness benefits must be filed with the Fund Office in writing on the forms available from any local Union office, the Fund Office, or the Fund Office website at www.scptac.org. The claim will be considered submitted as soon as the Fund Office receives a written claim. Claims are not accepted via phone.

Claims for weekly accident and sickness benefits that are filed more than 12 months after the date of the Accident or onset of the sickness will be denied.

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

To claim this benefit, advise the Fund Office of the death or dismemberment and provide a copy of the death certificate if applicable.

Claims for death benefits and accidental death or dismemberment benefits submitted more than 12 months after the dismemberment or death will be denied.

E) Processing Claims

The time limits in which the Fund Office will respond to your claim depends on the type of claim filed.

i) Urgent Care Claim

An urgent care claim is a claim that involves emergency medical care needed immediately to avoid serious jeopardy to your life, health, or ability to regain maximum function or which a physician with knowledge of your medical condition thinks would subject you to severe pain if your claim were not dealt with in the "urgent care" time frame, which is as follows. The Fund Office will notify you whether your urgent care claim is approved or denied as soon as possible but not later than 72 hours after it receives your claim unless your claim is incomplete. The Fund Office will notify you as soon as possible if your claim is incomplete, but not more than 24 hours after receiving your claim. The Fund Office may notify you orally unless you request written notification. You will then have 48 hours to provide the specified information. Upon receiving this additional

information, the Fund Office will notify you of its determination as soon as possible, within the earlier of 48 hours after receiving the information or the end of the period within which you must provide the information.

ii) Pre-Service Claim

A pre-service claim is a claim that conditions receipt of a benefit, in whole or part, on pre-approval of the benefit. Hospital admission pre-certification is an example of a pre-service claim. The Fund Office will notify you whether your claim is approved or denied within a reasonable time, but not later than 15 days after receipt of your claim. This period may be extended by one 15-day period if special circumstances beyond the control of the Fund Office require that additional time is needed to process your claim. If an extension is needed, the Fund Office will notify you before the expiration of the initial 15-day period of the circumstances requiring an extension and the date by which the Fund Office expects to reach a decision. If the Fund Office needs an extension because you have submitted an incomplete claim, the Fund Office will notify you of this within five days of receipt of your claim. The notice will describe the information needed to make a decision. If the Fund Office needs more information from you, its time for making a decision on your claim will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request.

iii) Post-Service Claim

A post-service claim is a claim submitted after the service or procedure has occurred. Most claims will fall under this category. The Fund Office will notify you of its determination within a reasonable time, but not later than 30 days after receipt of your claim. This period may be extended by one 15-day period if special circumstances beyond the control of the Fund Office require that additional time is needed to process your claim. If an extension is needed, the Fund Office will notify you before the expiration of the initial 15-day period of the circumstances requiring an extension and the date by which the Fund Office expects to reach a decision. If the Fund Office needs an extension because you have not submitted information necessary to decide the claim, the notice will also describe the information it needs to make a decision. You will have until 45 days after receiving this notice to provide the specified information. If the Fund Office needs more information from you, its time for making a decision on your claim will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request.

iv) Concurrent Care Claim

A concurrent care claim is any claim to extend the course of treatment beyond the period of time or number of treatments that the Plan has already approved as an ongoing course of treatment to be provided over a period of time or number of treatments. A concurrent care claim can be an urgent care claim, a pre-service claim, or a post-service claim. If the Fund Office has approved an ongoing course of treatment to be provided over a period of time, it will notify you in advance of any reduction in or termination of this course of treatment. If you submit a claim to extend a course of treatment, and that claim involves urgent care, the Fund Office will notify you of its determination within 24 hours after receiving your claim, provided that the Fund receives your claim at least 24 hours before the expiration of the course of treatment. If the claim does not involve urgent care, the request will be decided in the appropriate time frame, depending on whether it is a pre-service or post-service claim.

v) Disability Claim

A disability claim which includes weekly accident and sickness benefits will be handled like post-service medical claims. However, there are some special time periods that apply to processing a disability claim. The Fund Office will notify you of its determination within a reasonable time, but not later than 45 days after receipt of your claim. This period may be extended for up to two additional 30-day periods for circumstances beyond the control of the Fund Office if the Fund Office notifies you of the extensions before the expirations of the initial 45 days and first 30-day extension period, respectively. Any notice of extension will identify the circumstances requiring an extension, the date by which the Fund Office expects to reach a decision, the standards upon which entitlement to a benefit is based, the unresolved issues that require an extension, and additional information needed, if any, to resolve those issues. If the Fund Office needs more information from you, its time for making a decision on your claim will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request.

You will be provided, free of charge and before an adverse benefit determination is issued, with (a) any new or additional evidence considered, generated, or used by the Plan concerning the claim and (b) any new or additional rationale on which the adverse benefit determination will be based. The new or additional evidence or rationale must be provided as soon as possible and sufficiently before an adverse benefit determination is due to give you a reasonable opportunity to respond to the new information before the adverse benefit determination is issued.

F) Notice of Denial of Claim

If a claim for benefits is denied, in whole or in part, or if there has been a rescission of your coverage, the Fund Office will provide you a written notice that (1) states the specific reason(s) for the denial, (2) refers to the specific Plan provisions on which the denial or rescission 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 standard will be provided, or you will receive a statement that such a rule, guideline, protocol, or similar standard was relied on in making the adverse determination, and a copy of the rule, guideline, protocol, or other standard will be provided upon request.

If your claim relates to a disability benefit and it is denied, the Fund Office will provide you, if applicable, with (1) any specific internal criteria, including any internal rules or guidelines used in making the determination, and (2) an explanation of any disagreement with any determination from a health care/vocational professional who treated or evaluated you, a medical/vocational expert whose advice was obtained by the Fund, or an SSA disability determination.

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

A "rescission" of coverage is a retroactive cancellation or termination of your coverage. The Plan may rescind coverage if the person whose coverage is rescinded (or the person through whom coverage of a dependent is obtained) performs an act, practice, or omission that constitutes fraud or if the individual makes an intentional misrepresentation of material fact. Termination of coverage for failure to pay a premium, including a COBRA or premium, or to have contributions made on an individual's behalf is not a rescission. Likewise, termination of coverage retroactive to the date of divorce (or other event making a dependent ineligible for coverage) is not a "rescission" where the Fund Office is not notified of a divorce or other Qualifying Event and COBRA is not elected and/or the full COBRA premium is not paid by the employee or ex-spouse for coverage. Prospective termination is not a rescission. The Fund must provide 30 days' notice to each participant who would be affected by the rescission before a rescission can occur.

SECTION 17. APPEALS PROCEDURE

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

A) Appealing a Benefit Denial

If your claim for benefits is denied, in whole or in part, or if there has been a rescission of your coverage, you may request that the Board of Trustees review the benefit denial or rescission of coverage. The Board of Trustees has delegated the responsibility to decide appeals to its Appeals Committee. (In some cases, the Board of Trustees may choose to consider an appeal, and in other cases, the Appeals Committee may delegate the responsibility to consider an appeal to a subset of the Committee.) All appeals, except for urgent care appeals, must be in writing. An urgent care appeal may be oral or written and may be made by telephone, facsimile, or other available means. All appeals must be received by the Fund within 180 calendar days after you receive the notice of the denial or rescission of coverage from the Fund Office. Failure to file a timely written appeal will constitute a complete waiver of the right to appeal, and the decision of the Fund will be final and binding.

In presenting your appeal, you can submit written comments, documents, records, and other information relating to your claim for benefits or objection to the rescission of coverage. You are also entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits or rescission of coverage. Personal appearances on appeals are at the discretion of the Appeals Committee.

Your appeal should state the specific reasons why you believe the denial of your claim was in error. You should also submit any documents or records that support your claim. This does not mean that you are required to cite all of the Plan provisions that apply or to make "legal" arguments; however, your appeal should state clearly why you believe you are entitled to the benefits or other relief you are claiming. The Appeals Committee can best consider your position if it clearly understands your claims, reasons, or objections.

The review by the Appeals Committee will consider all comments, documents, records, and other information you submit, without regard to whether such information was submitted to or considered by the Fund Office in its determination. The Appeals Committee will also not afford deference to the initial determination by the Fund Office.

The Fund Office 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.

In deciding an appeal of a Fund Office determination that was based, in whole or in part, on a medical judgment (including determinations about whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate), the Appeals Committee will, when appropriate, consult with a health care professional who has appropriate training and expertise in the particular field of medicine, and who was not consulted by the Fund Office in connection with its determination. You 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.

B) Timing of Appeals Committee Decisions

The Appeals Committee (or a subset thereof or the Board of Trustees itself) will decide all appeals.

Post-Service Claims Appeals. Most claims will be post-service claims appeals. 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 Office. 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 you before the beginning of the extension. Such an extension may only last until the third meeting following receipt of the appeal.

C) Notice of Decision on Appeal

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

Urgent Care Claims Appeals. An urgent care claim appeal will be decided as soon as possible but not later than 72 hours after Fund Office receives it.

Pre-Service Claims Appeals. A pre-service claims appeal will be decided within a reasonable time, but not later than 15 days after the Fund Office receives it.

Concurrent Claims Appeals. A concurrent claim appeal will be decided either in the time period of a post-service claim appeal or a pre-service claim appeal, depending on the type of claim.

Disability Claims Appeals. If your claim pertains to total disability or weekly accident and sickness benefits, it will be decided in the time period of a post-service claim appeal.

If your appeal is denied, in whole or in part, you will receive a written decision that will include: (1) the specific reason(s) for the denial; (2) the specific Plan provisions on which the denial is based; (3) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; and (4) a statement of your right to bring a lawsuit under Section 502(a) of ERISA.

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

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

If your appeal relates to a disability benefit and it is denied, you will be provided, if applicable, with: (1) any specific internal criteria, including any internal rules or guidelines used in making the determination, and (2) an explanation of any disagreement with any determination from a health care/vocational professional who treated or evaluated you, a medical/vocational expert whose advice was obtained by the Fund, or an SSA disability determination.

If in reviewing your appeal for a disability benefit, the Appeals Committee or Board of Trustees considers, relies upon, or generates any new or additional evidence, or if the Committee or Board is considering denying your appeal based on new or additional rationale, you will be provided with this information, free of charge, and provided a reasonable opportunity to respond before an adverse decision is made.

D) Decisions on Appeal are Final and Binding

The decision of the Appeals Committee is final and binding on all parties, including anyone claiming a benefit on your behalf.

Once a final decision is made, there is no right to re-file the same appeal or to request reconsideration. If such an appeal or request for reconsideration is filed, the Appeals Committee may refuse to consider it.

As a committee of the Trustees, the Appeals Committee has full discretion and authority to determine all matters relating to the benefits provided under this Plan, including, but not limited to, all questions of coverage, eligibility, and methods of providing or arranging for benefits. As a committee of the Trustees, the Appeals Committee also has full discretion and authority over the standard of proof required for any inquiry, claim, or appeal and over the application and interpretation of the Plan. The Board of Trustees has delegated its authority to make final decisions on appeals to the Appeals Committee. To the extent the Board of Trustees does not delegate this authority for an appeal, the Board of Trustees will be substituted for the Appeals Committee in this appeal procedure and will have the full discretion in deciding an appeal as set forth in this paragraph.

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

E) Right to Authorized Representative

In making a claim or appeal, you may be represented by an authorized representative. If your representative is not an attorney or court-appointed guardian, you 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. However, neither you nor your representative has a right to an in-person hearing or appearance before the Trustees or the Appeals Committee.

F) Other Appeals

If you receive any written correspondence from the Fund Office that could be interpreted as adversely affecting your interest, you 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 calendar days of receipt of the correspondence from the Fund Office. Such appeals will be processed in the same manner as appeals for claims for benefits.

SECTION 18. COORDINATION OF BENEFITS

A) General Rules

This Plan has been designed to assist with the cost of covered expenses. The Plan generally does not pay more than you would be required to pay for any services. Benefits under this Plan will be coordinated with the other coverage you have under any other plan, including but not limited to the following:

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

For any Covered Service, the Plan will not pay more than it would have had it been primary.

B) Benefit Reduction

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

If an eligible Dependent could have been covered as an employee under another plan with no premium paid by the employee but declined such coverage, the benefit payable shall be reduced to 20% of the Blue Shield of California PPO Network Rate or the Allowable Charge, whichever is applicable.

C) Which Plan Pays First – Coordination of Benefits

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

i) If you and your Eligible Dependent are employed and have coverage:
   a) The plan covering the Patient as an employee is the primary payer.
   b) The plan covering the Patient as a dependent is the secondary payer.

ii) If your Spouse/Domestic Partner is retired and has medical coverage:
   a) The plan providing active coverage is the primary payer.

b) The plan providing retiree coverage is the secondary payer.

iii) If you are retired and using your Eligibility Bank to maintain coverage under the Active Plan and your Spouse/Domestic Partner is actively employed with coverage:
   a) The plan providing coverage for an active employee is the primary payer.
   b) The plan covering the Participant using the Eligibility Bank is the secondary payer.

iv) If the Patient is a child who is employed and has medical coverage:
   a) The plan covering the child as an employee is the primary payer.
   b) The plan covering the child as a dependent is the secondary payer.

v) If the Patient is a minor child whose parents both have coverage and are living together:
   a) The plan covering the parent whose birthday falls earlier in the year is the primary payer for the child.
   b) The plan covering the parent whose birthday falls later in the year is the secondary payer for the child.

EXAMPLE	**Father's date of birth: October 3, 1984** **Mother's date of birth: April 20, 1985** **The plan covering the mother of the child is the primary payer. The plan covering the father of the child is the secondary payer.**

vi) If the Patient is a minor child whose parents both have coverage but are not living together:
   a) The plan covering the parent with custody is the primary payer for the child.
   b) The plan covering the parent without custody is the secondary payer for the child.

vii) If the Patient is a child whose parents both have medical coverage and are not living together and a court has decided on responsibility for health care insurance:
   a) The plan covering the parent that the court has made responsible is the primary payer.
   b) The plan covering the parent that the court has not made responsible is the secondary payer.

   These rules do not apply to any Plan Year during which benefits are paid or provided before the Fund knows about the court's determination or the parental custody agreement.

viii) If the Patient is a child whose parents both have medical coverage and are not living together and a court has not decided on responsibility for health care insurance:
   a) The plan covering the parent with custody is the primary payer for the child.
   b) The plan covering the parent without custody is the secondary payer for the child.

   These rules do not apply to any Plan Year during which benefits are paid or provided before the Fund knows about the court's determination or the parental custody agreement.

If the Patient is an adult Eligible Dependent with no coverage as an employee whose parents and/or spouse have coverage, then the plan that has been in effect longer is the primary payer.

D) Coordination of Benefits with Medicare

The Social Security Administration advises eligible individuals to apply for Medicare 90 days before their 65th birthday. Medicare will then become effective the first of the month in which the individual attains the age of 65. Regardless of whether or not a Medicare-eligible Participant, Spouse, or Domestic Partner timely applies for Medicare, the Fund will pay benefits as if the individual timely applied and was covered by Medicare on this date. Similarly, for an individual eligible for Medicare due to a disability or end-stage renal disease, the Fund will pay benefits as if the individual timely applied for and was covered by Medicare on the earliest possible date permitted by Medicare for it to act as the primary coverage.

Below are some examples of how the Plan coordinates benefits with Medicare.

i) If the Participant and Spouse are both employed with coverage and eligible for Medicare:
   a) Plan providing active coverage is the primary payer.
   b) Plan providing dependent coverage is the secondary payer.
   c) Medicare is the third payer.

ii) If the Participant is actively employed with medical coverage and the Spouse is retired with coverage, and both are eligible for Medicare:
   a) Plan providing active coverage is the primary payer.
   b) Medicare is the secondary payer.
   c) Plan providing retiree coverage is the third payer.

iii) If the Participant is retired and using their Eligibility Bank to maintain coverage under the Active Plan and is eligible for Medicare:
   a) Plan using Eligibility Bank is the primary payer.
   b) Medicare is the secondary payer.

IMPORTANT	**Once you retire, to get full benefits under the Plan, you must enroll in both Medicare Parts A and Part B before you become eligible for Medicare. Medicare is the primary payer of your benefits once your Eligibility Bank is exhausted.** **Medicare is considered by this Plan to be the primary payer of benefits for Pensioners and their eligible Spouses who are eligible for Medicare whether or not they are enrolled in the Medicare Program. This means that if you do not enroll in Medicare as soon as you qualify, this Plan will not pay for benefits that Medicare would have paid had you been enrolled in Medicare.**

E) Medicare Part D

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

Each Medicare-eligible covered individual will periodically receive a notice, called a Notice of Creditable Coverage, advising whether the Fund's prescription plan continues to be actuarially equivalent to Medicare Part D. Such individuals are also entitled to receive such notices upon request to the Fund Office.

Whether or not you enroll in Part D, you will still be eligible for prescription drug benefits from the Fund. The Fund Office will coordinate benefits with Medicare Part D.

SECTION 19. THIRD PARTY LIABILITY

This Plan does not cover any Illness, Injury, or other condition for which a third party may be liable or legally responsible because of negligence, an intentional act, or breach of any legal obligation on the part of that third party and against whom a Participant or Eligible Dependent has a claim. However, the Plan will conditionally pay for benefits for such Illness or Injury while the claim is being adjudicated, providing the Patient executes an agreement to reimburse the Fund, and will cover such benefits to the extent recovery against the third party is unsuccessful.

If any service is provided or medical claims paid in connection to any Illness or Injury caused by a third party, and you recover from a third party, insurance policy, or uninsured motorist coverage, you must reimburse the Plan from the recovered funds for medical claims paid in connection with the Illness or Injury. You 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, you will pay the Plan the recovered funds up to the full amount of medical claims paid on your 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 you 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. Without waiving its rights herein, the Plan may, at its sole discretion, agree to reduce the full amount to which it is entitled under this provision to contribute to reasonable attorney's fees and costs incurred by you in collecting a recovery from the third party.

By making payments on your behalf, the Plan is granted a lien on such recovery. The Plan shall be entitled to enforce this requirement through any remedy permitted by equity. By accepting payments from the Plan, you 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.

You must complete and sign an agreement to reimburse the Fund in such a form as the Plan may require before any benefits are paid. If you refuse to sign an agreement to reimburse, or any other such agreement the Plan may require, you will not be eligible for benefits under the Plan for medical claims related to this Illness or Injury. You may not assign any rights or cause of action that you may have against a third party to recover medical expenses without the express written consent of the Plan. You may be requested to agree to subrogate any claim you may have against a third party in favor of the Plan as a condition of receiving benefits under the Plan. As a condition of receiving benefits, you will be required to fully cooperate with the Plan to the extent the Plan pursues any subrogated claim.

If the Plan pays benefits on your behalf and you recover any proceeds from or on behalf of a third party, any insurance policy, or from uninsured motorists coverage, and you do not reimburse the Plan, you will be ineligible for Plan benefit payments until the Plan has withheld an amount equal to the amount which has not been reimbursed.

SECTION 20. EXCLUSIONS & LIMITATIONS

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

A) Medical

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

1) A claim for a service or procedure not expressly covered by the Plan;
2) Any claim for treatment, services, or supplies, including any additional information requested, that is not filed within 12 months from the date the expense is incurred (60 months for HRA claims);
3) Services that are not reasonably necessary for the care or treatment of bodily Injuries or Illness as determined by the Fund, except for routine vision benefits, dental benefits, or routine physical examinations expressly covered by the Plan;
4) Any services or procedures that are Experimental Treatments or investigational or are not within the standards of generally accepted medical practice, or medical services or supplies, including Prescription Drugs, considered educational, investigational, or experimental. Experimental or investigational means:
    a) It is a drug or device that cannot be lawfully marketed without the 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 ongoing 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 among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, 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, medical treatment, or procedure;
5) Services, prescriptions, medications, and supplies received outside of the United States and its territories unless:
    a) the services, medications, or supplies were the result of an Accident, urgent care requirement, or life-threatening Emergency Medical Condition or
    b) the Eligible Participant submits proof of residency in the country where the services were rendered;
6) Charges for missed or broken appointments;
7) Charges for completion of forms;
8) Charges for phone consultations other than telemedicine (e.g., reading of EKGs or fetal monitoring over the phone);
9) Hospital or Extended Care Facility charges for personal items such as charges for radio, television, telephone, guest expenses, and other similar items;
10) Charges for personal comfort, beautification, or convenience items or services;
11) Custodial Care as defined in this SPD except as covered under the Hospice benefit;
12) Housekeeping services;

13) "Standby" charges (charges in which a Physician is present but is not providing care, treatment, or a diagnosis). This includes, but is not limited to, standby charges for an anesthesiologist, pediatrician, or trauma team;
14) Additional charges for "after-hours" and weekend services by a Physician;
15) Expenses for travel or transportation, except as provided under ambulance benefits;
16) EMS (Emergency Medical Service) with no transport;
17) Services by a provider who is a family member of the Patient;
18) Vitamins, including prenatal vitamins (prescription and over-the-counter);
19) Prescription Drugs dispensed in a Physician's office;
20) Over-the-counter medications and medical supplies, such as gauze, bandages, breast pumps, shoe inserts, and herbal medicines;
21) Blood pressure monitors, thermometers, vaporizers;
22) Certain types of Durable Medical Equipment, such as cervical traction units, cervical collars, hot/cold therapeutic devices, bone growth stimulators, canes, Bionicare knee devices, humidifiers, and nasal pillows;
23) Replacement or repair of Durable Medical Equipment within 36 months unless otherwise specified;
24) Cosmetic Surgery, except for Medically Necessary treatment resulting from Accidental Injury, Injury caused by domestic violence, self-injury, functional disorders, congenital malformations, treatments related to Gender Identity Disorder, or revisions associated with a medical condition. (It is suggested, but not required, that the eligible individual's Physician submit the proposed procedure to the Fund before the procedure to determine if benefits are available under the Plan.);
25) Weight control programs, medications, exercise programs, regardless of any medical condition, related or otherwise;
26) Any surgical procedure to reduce weight regardless of any underlying medical conditions that are exacerbated by the weight (e.g., hypertension, diabetes, arthritis, etc.), except Medically Necessary, pre-authorized bariatric surgery;
27) Goal-oriented behavior modification therapy for smoking cessation, or weight loss;
28) Exercise equipment, tanning booths, whirlpools, swimming pools, saunas, spas, massage therapy, or gym membership;
29) Charges for obtaining, testing, and storing the Patient's blood before a medical procedure of any kind;
30) Charges or treatment related to a surrogacy arrangement or any arrangement in which the covered individual agrees to surrender the baby (or babies) to another person or persons who intend to raise the child (or children). This exclusion includes charges related to conception, pregnancy, delivery, postpartum care, or any related medical condition or complications, as well as any coverage for the resultant baby (or babies);
31) Newborn "cord blood" testing or storage;
32) Testing for or treatment of infertility, including artificial insemination and in-vitro fertilization, or any charges associated with the direct inducement of pregnancy, any testing during and related to the treatment of infertility or related conditions or complications of the treatment (but any resulting pregnancy of you or your eligible Spouse or Domestic Partner would be covered);
33) Reversal or attempted reversal of an elective sterilization procedure;
34) Care or treatment for pregnancy or related conditions or complications for anyone other than you or your eligible Spouse or Domestic Partner;
35) 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;
36) Care by homeopathic practitioners, naturopathic practitioners, and doctors of oriental medicine (OMD);
37) Any refractive eye Surgery (e.g., Lasik), regardless of the diagnosis;
38) Dental examinations or treatment, except as specifically provided.

B) Third-Party Liability

In addition to the Exclusions and Limitation listed elsewhere in this SPD, except as explicitly provided under Third Party Liability (see Section 19, page 57), the Plan will not provide benefits for:

39) Any charges or medical claims for which a third party may be liable or legally responsible, unless payable under the terms of the Plan's Third Party Liability recovery provisions;
40) Any charges paid for or payable by another plan or insurance;
41) Charges for services, treatments, or supplies for the care and treatment of an Injury or Illness that exceed the charges that would have been made in the absence of the benefits provided by the Plan;
42) Any Illness, Injury, or disability covered by any Workers' Compensation laws except as provided under the weekly accident and sickness benefit;
43) Care or treatment obtained in a federal or state facility, or a facility operated by a government agency, for which you are not required to pay except to the extent benefits are required by law to be paid by the Plan;
44) Conditions caused by an act of war, armed invasion, or insurrection;
45) Care or treatment in any penal institution.

C) Other

In addition to the Exclusions and Limitations listed elsewhere in this SPD, the Plan will not:

46) Pay interest on unpaid balance(s);
47) Reissue a benefit payment more than two years after it was first issued;
48) Pay for any charge by a financial institution including, but not limited to, the deposit or cashing of:

a) A check upon which a stop payment has been placed, or
b) A stale-dated check.

IMPORTANT	**No healthcare provider is an agent or representative of the Plan or 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 or supplies to you 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 all health care providers, including both Blue Shield of California PPO network providers and out-of-network providers under the terms of the Plan, and to all entities (and their agents, employees, and representatives) that contract with the Plan to offer contract networks, or health-related services or supplies to you. Nothing in this Plan affects the ability of a provider to disclose alternative treatment options to you.**

SECTION 21. IMPORTANT NOTICES

A) No Assignment of Benefits

No one, including, but not limited to, a Participant or an Eligible Dependent, is permitted to assign any benefits, rights, or claims for benefits to any third party including, but not limited to, a provider or a facility, without the express written consent of the Board of Trustees. Accordingly, unless written consent is provided, the Plan will not recognize or accept any assignment of benefits, rights, or claims for benefits or any appeal of a denied claim. "Benefits, rights or claims for benefits" includes, but is not limited to: (i) a claim, or an appeal of a denied claim, for payment of a benefit under the terms of the Summary Plan Description or other Plan document or communication; (ii) a claim for benefits or other relief under Section 502(a) of ERISA; (iii) a breach of fiduciary duty claim under ERISA or common law; (iv) a claim brought under state law; or (v) a claim for penalties assessable under any law or regulation.

A Participant or an Eligible Dependent may direct that benefits payable from this Plan to them be paid to a provider or a facility that delivered the related medical care to the Participant or Eligible Dependent. However, the Plan is not obligated to accept such direction, and no payment made by the Plan to the provider, nor any communication about benefits or payments between representatives of the Plan and a provider or a facility, shall be considered an assignment of the benefit, an assignment of a claim or an appeal, waiver of this no assignment provision, or a contract with the provider or the facility to pay benefits.

B) Erroneous Payments

Every effort will be made to ensure accuracy in paying your benefits. If an error is discovered regardless of how long ago it occurred, and it is determined that the Fund has paid any benefits you are not entitled to, you are obligated to reimburse the Fund for the erroneous payments. The Trustees have the right to seek repayment from you through any legal means, including the right to reduce future benefit payments for you or your Eligible Dependents by the amount of the erroneous payment.

C) 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 erroneous amounts paid by the Fund, 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.

D) No Fund Liability

Using the services of any Hospital, Physician, or other healthcare provider, whether designated by the Fund or otherwise, is your voluntary act. Nothing in this SPD 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 or subcontractors 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.

Neither the Plan, nor the Board of Trustees, nor any of their designees are 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. In addition, neither the Plan, nor 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 because of negligence, failure to provide care or treatment, or otherwise.

SECTION 22. INFORMATION REQUIRED BY ERISA

The following additional information concerning the Plan is provided to you per the Employee Retirement Security Act of 1974 (ERISA). Unless capitalized, the terms in this section are generally as defined in ERISA.

A) Name and Type of Plan

The name of the Plan is the Southern California Pipe Trades Health and Welfare Plan. It is sometimes called the "Active Plan" because it covers active Employees. It is a multi-Employer health and welfare benefit plan. It provides medical, Prescription Drug, vision, dental, death, accidental death or dismemberment, weekly accident and sickness, hearing aid, and other benefits.

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

B) Identification Numbers

The Fund's Internal Revenue Service tax identification number is 95-1867598. The Plan number is 501.

C) Plan Year

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

D) Plan Sponsor, Named Fiduciary, and Administrator

The Plan is maintained pursuant to a collectively bargained labor-management trust. The Board of Trustees is the plan sponsor, the plan administrator, and the named fiduciary under ERISA.

E) Board of Trustees

The Board of Trustees consists of Employer and Union representatives selected by the Employers and Unions under 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	(800) 595-7473
Southern California Pipe Trades Health and Welfare Fund	(213) 385-6161
501 Shatto Place, Suite 500	www.scptac.org
Los Angeles, CA 90020	info@scptac.org

F) Fund Office

The Board of Trustees has designated the Southern California Pipe Trades Administrative Corporation to perform the daily business functions of the Plan. You may contact the Fund Office at:

Southern California Pipe Trades Administrative Corporation	(800) 595-7473
Attention: CEO/Administrator	(213) 385-6161
501 Shatto Place, Suite 500	www.scptac.org
Los Angeles, CA 90020	info@scptac.org

G) Agent for Service of Legal Process

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

Southern California Pipe Trades Health and Welfare Fund
Attention: CEO/Administrator
501 Shatto Place, Suite 500
Los Angeles, CA 90020

Service of legal process may also be made upon a plan trustee or the plan administrator.

H) Source of Contributions and Identity of any Organization Through Which Benefits are Provided

Contributions to the Fund are made by:

i) Employers in accordance with their Collective Bargaining Agreements or under the terms of a Participation Agreement, which require that contributions be made to the Fund; and

ii) Self-payment for continuation coverage as described in Section 5, page 18.

Upon written request, the Fund Office will provide you with a complete list of Employers and Unions that are parties to a Collective Bargaining Agreement and their addresses. The Fund Office will also provide information about whether a particular employer is obligated to contribute to the Fund on behalf of employees working under a Collective Bargaining Agreement or Participation Agreement and the address of any such employer.

The Fund's assets are held in trust by the Board of Trustees. Custody of the Fund's assets is with U.S. Bank, N.A. Benefits are provided directly from the Fund's assets, which are accumulated under the provisions of the Trust Agreement, except for certain insured dental and vision benefits. The assets are used exclusively for providing benefits to participants and beneficiaries per the provisions of the Plan and for paying the reasonable administrative expenses of the Fund.

All benefits provided by the Plan for active Employees are set forth in this SPD. There is a separate Plan with its own SPD covering benefits for Pensioners and Survivors.

I) Collective Bargaining Agreement

Contributions to the Fund are made per Collective Bargaining Agreements between Employers and District Council No. 16 of the United Association or affiliated local Unions of District Council No. 16 or the United Association. The United Association local Unions affiliated with District Council No. 16 are 78, 114, 230, 250, 345, 364, 398, 403, 460, 484, 582, and 761. The Fund Office will provide you, upon written request, a copy of the applicable Collective Bargaining Agreement. The Collective Bargaining Agreement is also available for examination at the Fund Office. The following are the employer associations with which District Council No. 16 has a bargaining relationship that requires contributions to this Fund:

i) California Plumbing & Mechanical Contractors Association (CPMCA);
ii) Airconditioning, 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 this Plan will continue indefinitely, but the Board of Trustees reserves the right to change or discontinue the Plan at any time. Assets may also be transferred to a successor fund providing health care benefits. The Trustees may terminate the Plan 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 Plan may also be terminated if no individuals living can qualify as participants or beneficiaries or if there are no longer any Collective Bargaining Agreements requiring contributions to the Fund. The Trustees have the complete discretion to determine when and if the Plan should be terminated.

If the Plan is terminated, the Trustees will: (i) pay the expenses of the Fund incurred up to the date of termination as well as the expenses in connection with the termination; (ii) arrange for a final audit of the fund; (iii) give any notice and prepare and file any reports required by law; and (iv) apply the assets of the Fund per the law and the Plan, including amendments adopted as part of the termination, until the assets are distributed. Under no circumstances will any portion of the Fund revert to the benefit of an Employer, any employer association, or the Union.

Upon termination of the Plan and Fund, the Trustees will promptly notify the Union, any employer association, Employers, and all other interested parties. The Trustees will continue as Trustees to wind up the affairs of the Plan.

K) Actions of Trustees

The Trustees have full discretion and authority over the standard of proof for any inquiry, claim, or appeal and over the application and interpretation of the Plan and trust. No legal proceeding may be filed in any court or before an administrative agency against the Plan or its Trustees unless all review procedures with the Trustees have been exhausted. No legal action may be commenced against the trust, the Plan, or the Trustees more than two years after a claim has been denied.

L) Right to Amend

The Trustees have complete discretion to amend or modify the Plan or trust and any of their provisions, 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 Participants, Eligible Dependents, and Beneficiaries. The Trustees may also modify any eligibility requirements for coverage.

M) ERISA Rights

As a participant in the Southern California Pipe Trades Health and Welfare 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

a) Examine, without charge, at the plan administrator's office and 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 Employee Benefits Security Administration.

b) 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 an updated summary plan description. The administrator may make a reasonable charge for the copies.

c) Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

ii) Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse, or dependents if coverage under the Plan is lost due to a Qualifying Event. You or your dependents will 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.

iii) Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, must 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.

iv) Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time periods.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits 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 the 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.

v) Assistance with Your Questions

If you have any questions about your Plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the 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.

N) Preferred Providers and Pre-paid Plans

The Board of Trustees may, from time to time, in its sole discretion, enter into written agreements with preferred provider (PPO) organizations or pre-paid plans.

The current PPO network for medical services is:

Blue Shield of California
P.O. Box 272540
Chico, CA 95927
(800) 541-6652

The current PPO network for dental services is:

MetLife PPO
P.O. Box 981282
El Paso, TX 79998-1282
(800) 942-0854

The current DHMO network for dental services is:

DeltaCare USA
P.O. BOX 1810
Alpharetta, GA 30023
(800) 422-4234

The current network for vision services is:

VSP
P.O. Box 495918
Cincinnati, OH 45249-5918
(800) 877-7195

The existence of any preferred provider or pre-paid plan agreement shall not, in any manner, imply an endorsement of any specific provider, nor shall it constitute any guarantee of the services rendered.

SECTION 23. OTHER FEDERAL LAWS

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

i) Protected Health Information

The U.S. Department of Health & Human Services issued the Standards for the Privacy of Individually Identifiable Health Information. Under HIPAA, these rules give you greater control over who may access the information in your medical records. Health plans, such as this Plan, cannot share Protected Health Information ("PHI") under many circumstances without written authorization.

ii) 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, fulfill its coverage responsibilities, provide benefits under the Plan, and 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 purpose of payment.
b) Health Care Operations are certain administrative, financial, legal, and quality improvement activities of the Fund that are necessary to run the Fund 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 a 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.
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 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 to identify or locate 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, 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 their 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 Uniformed 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.

Notwithstanding the foregoing, neither the Fund nor any of its business associates, may use or disclose your PHI for the following purposes:

a) To conduct a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating lawful reproductive health care.
b) To impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating lawful reproductive health care.
c) To identify any person for any purpose described in a) or b).

The prohibition on the use or disclosure of PHI related to reproductive health care applies when the reproductive health care at issue (1) is lawful under the law of the state in which such health care is provided; (2) is protected, required, or authorized by Federal law, including the United States Constitution, under the circumstances in which such health care s provided, regardless of the state in which it is provided; or (3) is provided by another person and presumed lawful.

The Fund may use or disclose your PHI to you, to your personal representative, to a third party (such as your Spouse or Domestic Partner) pursuant to a General Authorization Form, and to the Board of Trustees of the Fund but only for the purposes and to the extent specified in the Plan and permissible under applicable law:

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 complete and sign a General Authorization Form. You can revoke this authorization 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 per the provisions of the Fund's Privacy Policy and the provisions of the Plan.

iii) Individual Rights

You have certain important rights concerning 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 the 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.

iv) 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 you a paper copy of the notice currently in effect upon request.
d) If a breach of your PHI is discovered, the Fund has certain obligations to provide a notice to you.

v) 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 before issuing the revised notice.

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

vi) 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:

Southern California Pipe Trades
Health and Welfare Fund
Attention: Privacy Officer
501 Shatto Place, Suite 500
Los Angeles, CA 90020

(800) 595-7473
(213) 385-6161
www.scptac.org
info@scptac.org

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 anyone for filing a complaint.

vii) For More Information About Privacy

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

B) Family and Medical Leave Act (FMLA)

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

i) The Employer has at least 50 Employees working within a 75-mile radius; and
ii) You worked for the Employer for at least 12 months and for a total of at least 1,250 hours during the most recent 12 months; and
iii) Your leave is required for one of the following reasons:
   a) Birth or placement of a child for adoption or foster care;
   b) To care for your child, Spouse, or parent with a serious health condition; or
   c) Your own serious health condition; or
   d) A "qualifying exigency" as defined in applicable regulations arising from the fact that a covered family member is on active duty or called to active duty status in the National Guard or Reserves in Support of a federal contingency operation. In addition, the FMLA provides that an eligible Employee who is a qualifying family member or next of kin of a covered military service member can take up to 26 work weeks of leave in a single 12-month period to care for the covered service member with a serious illness or injury incurred in the line of duty.

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

The California Family Rights Act ("CFRA") provides much of the same protections as the FMLA. If you are on leave granted under the CFRA, your Employer may be obligated to continue to pay contributions on your behalf to provide you with uninterrupted coverage under this Fund during your leave, similar to the requirements imposed on employers by the FMLA. You should contact your Employer if you believe you are entitled to leave under the CFRA.

C) Women's Health

i) Pregnancy

The Plan will pay benefits for your pregnancy (or your Spouse's or Domestic Partner's pregnancy) on the same basis as an Illness or Injury. The Plan does not pay benefits for pregnancy, pregnancy-related conditions, or complications for eligible children.

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

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

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

ii) Women's Health and Cancer Rights

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

The Plan also provides benefits for the following procedures:

a) All stages of reconstruction of the breast on which the mastectomy was performed;
b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
c) Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the Physician and the Patient.

Benefits are determined based on the nature of the treatment and whether or not you choose a Blue Shield of California PPO network provider, and per Plan limits.

D) Grandfathered Health Plan

This Southern California Pipe Trades Health and Welfare Fund believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement to provide preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Office administrator at (800) 595-7473. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or https://www.healthcare.gov/health-care-law-protections/grandfathered-plans/. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

E) Compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA)

All group health plans that provide both medical/surgical benefits and mental health and/or substance use disorder benefits, must provide such benefits subject to the following requirements: (1) the financial requirements applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan, and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; (2) the treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits; and (3) the Plan must make available to all Participants, upon request, the criteria for medical necessity determinations for mental health and substance use disorder benefits and provide the reason for any denial of reimbursement or payment for services.

SECTION 24. 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.

Active Plan

This Southern California Pipe Trades Health and Welfare Plan

Adult Day Health Care Center (ADHC) Program

A licensed community-based day health program that provides services to older persons and adults with chronic medical, cognitive, or mental health conditions or disabilities that are at risk of needing institutional care. A Community-Based Adult Services (CBAS) program is a similar and related program. Licensed ADHC/CBAS centers provide professional nursing services; physical, occupational, and speech therapies; mental health services; therapeutic activities; social services; personal care; hot meals and nutritional counseling; and transportation to and from the participant's residence. Both ADHC and CBAS centers require the certification of a Physician or Psychiatrist.

Allowable Charge

The dollar amounts for services that the Plan uses to determine how much it will pay, and how much your Out-of-Pocket cost will be, when you use an out-of-network provider. These dollar amounts are generally less than the amount the provider bills and less than the Blue Shield of California PPO Network Rate for in-network providers. For a few types of benefits (orthotics, pain management, tens unit, convalescent or extended care, and hearing aids), an Allowable Charge also applies to Blue Shield in-network providers instead of the Blue Shield of California PPO Network Rate. Any amount that exceeds the Allowable Charge is not considered by the Plan. You are responsible for the Coinsurance amount, if any, and for any charges that exceed the Allowable Charge, but such amounts may be eligible for reimbursement from your HRA Allowance. When the Plan determines that the services rendered by an out-of-network provider are due to an Emergency Medical Condition, but are not subject to the No Surprises Act, the Plan will pay an amount that is reasonable, as determined by the Plan, that may be more than the Allowable Charge. This amount is calculated using Medicare rates, UCR (usual, customary, and reasonable), or negotiation with the provider.

Appeals Committee

A subset of the Board of Trustees empowered to review any claims as described in Section 17.

Base Contribution
The portion of an Employer's contribution or a reciprocal contribution that is credited to a Participant's Eligibility Bank to establish or maintain eligibility.

Beneficiary
Beneficiary means the person entitled to receive Death or Accidental Death benefits from this Plan according to the Participant's designation on a Beneficiary Form or according to the Terms of the Plan. See also Qualified Beneficiary.

Blue Shield of California
Blue Shield of California is a non-profit organization created to contract with healthcare providers to offer you quality healthcare services with lower Out-of-Pocket expenses.

Blue Shield of California PPO Network Rate
The fee charged for services rendered by participating providers with Blue Shield of California.

Board of Trustees
All of the Trustees established as one body according 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 their license, holding the degree of Doctor of Chiropractic (DC), and who is legally entitled to provide chiropractic care in all its branches under applicable laws where the services are rendered.

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

Coinsurance
Coinsurance is a predetermined percentage of the Blue Shield of California PPO Network Rate or Allowable Charge that the Patient must pay Out-of-Pocket for Covered Services and is applicable after the Patient's Deductible has been met.

Collective Bargaining Agreement
Any negotiated labor agreement between a Contributing Employer, or employer association acting on behalf of Employers, and Southern California Pipe Trades District Council No. 16 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada ("United Association"), or any local Union affiliate of the District Council that requires contributions to the Southern California Pipe Trades Health and Welfare Fund. It also refers to an agreement, to which the United Association is a party, requiring contributions to the Fund.

Contributing Employer
An Employer signed to a Collective Bargaining Agreement or Participation Agreement, or an Employer that assigns its bargaining rights to an employer association signed to a Collective Bargaining Agreement, that requires contributions to the Fund.

Coordination of Benefits Form
The form required by the Fund to provide information necessary to process claims. One complete routine Coordination of Benefits Form is required per Patient per Calendar Year. An Injury and Third Party Liability Form is required for any Injury.

Covered Employment
Work by an Employee under a Collective Bargaining Agreement.

Covered Services
Services that are expressly listed as covered by the Plan.

Custodial Care
Care that is primarily to meet personal needs which could be provided by persons without professional skills or training. This includes, but is not limited to, help with 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 considers 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, PPO Dental, and hearing aid benefits.

Dentist
A person acting within the scope of their license, holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD), 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.

Domestic Partner
A person with whom a Participant has established and registered a domestic partnership with the State of California or who has validly established and registered a domestic partnership, or similar union, in another state substantially similar to a domestic partnership recognized in California.

Durable Medical Equipment
Equipment that meets the following criteria:

A) Can withstand repeated use;
B) Is primarily and customarily used for a medical purpose and is not generally useful in the absence of Injury or Illness;
C) Is not primarily used for exercise;
D) Is not disposable or non-durable; and
E) Is used by the Patient only.

Eligibility Bank
The Eligibility Bank is funded by contributions from Contributing Employers on an Employee's behalf. Eligibility is determined by the contributions credited and debited to and from the Eligibility Bank as set forth in Section 4, page 10.

Eligible Dependent
The Participant's Spouse or Domestic Partner, if timely enrolled, or children up to and up to age 26, who satisfy the requirements of the Plan.

Emergency Medical Condition
A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention could reasonably result in one or more of the following:

A) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
B) Serious impairment to bodily functions; or
C) Serious dysfunction of any bodily organ or part.

This term is defined in greater detail in Section 9, "Medical Benefits."

Emergency Services
A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and, within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required to stabilize the Patient.

This term is defined in greater detail in Section 9, "Medical Benefits."

Employee
An Employee is anyone employed by a Contributing Employer in a position for which the Employer contributes to the Fund under a Collective Bargaining Agreement. Employees may also include an Employer or someone employed by an organization signatory to a Participation Agreement.

Employer
See Contributing Employer.

ERISA
Employee Retirement Income Security Act of 1974, as amended.

Exclusion or Limitation
Any medical, dental, or vision services or supplies that the Plan does not cover. 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 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, medical treatment, or procedure is considered experimental or investigational if:

A) It is a drug or device that cannot be lawfully marketed without the 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 ongoing 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 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.

Explanation of Benefits
An Explanation of Benefits (commonly referred to as an EOB) is a statement sent by the Plan to you explaining what treatments or services were processed on your behalf.

Extended Care Facility
An institution, or a distinct part thereof, that is licensed under applicable laws and is operated primarily to provide skilled nursing care and treatment for a Participant or Eligible Dependent convalescing from Injury or Illness and:

A) Is approved by and is a participating extended care facility of Medicare;
B) Has organized facilities for medical treatment and provides 24-hour nursing services under the full-time supervision of a Physician or Registered Nurse;
C) Maintains daily clinical records on each Patient and has available the services of a Physician under the established agreements;
D) Provides appropriate methods for dispensing and administering Prescription Drugs;
E) 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
F) Is not an institution that is primarily a place for rest, a place for Custodial Care, a place for the aged, a hotel, or a similar institution.

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

Fund Office
Southern California Pipe Trades Administrative Corporation
501 Shatto Place, Suite 500
Los Angeles, CA 90020

(800) 595-7473
(213) 385-6161
www.scptac.org
info@scptac.org

Hospice
A facility that provides a Hospice Care Program and operates under applicable law is a Hospice. It serves 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 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 Disorder treatment facilities 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 hotel, or a similar institution.

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.

Independent Freestanding Emergency Facility
A health care facility that is geographically separate and distinct, and licensed separately from a hospital under applicable law, and which provides Emergency Services.

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

Injury and Third-Party Liability Form
A form required by the Fund to provide information necessary to process claims related to an accident or injury. One complete Injury and Third-Party Liability form is required per Injury to determine third-party liability for claims reimbursement purposes.

Inpatient
Treatment or services received after you have been admitted to the Hospital with a Physician's order.

Medically Necessary/Medical Necessity
Appropriate for the condition being treated, per 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.

Medical Necessity, when used concerning genetic testing, generally must meet all of the following three criteria:

A) One of the following:
   i) Family history suggestive of a heritable condition;
   ii) Specific symptoms suggestive of a heritable condition;
   iii) Results of a prenatal or newborn screening suggestive of a heritable condition; or
   iv) Medical management requires consideration of genetic variants; and
B) Testing will impact treatment or heighten monitoring for early detection of disease; and
C) Evidence-based data supports the validity and utility of the test.

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

Mental Disorder
A condition, Illness, disease, or disorder listed in the most recent edition of the International Classification of Diseases (ICD) as a psychosis, neurotic disorder, or personality disorder; and other non-psychotic disorders listed in the ICD.

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

Nurse
A person acting within the scope of their license and holding a degree/licensure of a Registered Nurse (RN), Certified Nurse Midwife (CNM), Licensed Vocational Nurse (LVN), or Licensed Practical Nurse (LPN).

Optometrist
A person acting within the scope of their license and holding the degree Doctor of Optometry (OD) who is legally entitled to practice optometry in all its branches under applicable laws.

Out-of-Pocket (OOP)
The amount the Patient may owe over what the Fund has paid. This includes Deductibles, Coinsurance, and non-covered charges. This is also called the "amount you may owe" on your Explanation of Benefits statement.

Out-of-Pocket Maximum
The most you have to pay for Covered Services in a Calendar Year. After you spend this amount on your Deductibles and Prescription Drug and medical Coinsurance for Covered Services, the Plan pays 100% of the costs for Covered Services. This does not include amounts that are above the Allowable Charge.

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

Partial Hospitalization (for Mental Health and Substance Use Disorders)
Medically directed intensive, or intermediate short-term, mental health and substance use disorder treatment, for a period of less than 24 hours but more than four hours in a day in a licensed or certified freestanding or hospital-based facility or program.

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

Participation Agreement
An agreement approved by the Board of Trustees permitting a Contributing 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 not covered by a Collective Bargaining Agreement.

Patient
The Participant or Eligible Dependent receiving care, equipment, or Prescription Drugs.

Pensioner
A retired Employee who has satisfied the rules to become eligible under the terms of the Pensioners Health Plan.

Pensioners Health Plan
The Southern California Pipe Trades Pensioners and Surviving Spouses Health Fund.

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 their license and holding the degree of Doctor of Medicine (MD) or Doctor of Osteopathy (DO) who is legally entitled to practice medicine in all its branches under applicable laws. Providers such as Homeopathic Practitioners, Naturopaths (NP), and Doctors of Oriental Medicine (OMD) are not included.

Plan
The benefits, rules, Exclusions or Limitations, and other provisions described in this SPD.

Plan Year
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.

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 Disorder who is licensed to practice as a psychiatrist in the jurisdiction where the services are provided.

Psychologist
A person trained in the care and treatment of Mental Disorders who is licensed to practice as a psychologist in the jurisdiction where the services are provided.

Qualified Beneficiary
Qualified Beneficiary means the Participant, Spouse, or child who is entitled to elect COBRA coverage after the loss of coverage under the Plan due to a Qualifying Event. See also Beneficiary.

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

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

Qualifying Payment Amount
The Qualifying Payment Amount for a given item or service is an amount calculated based on the median contracted rate for all plans offered by BSC in the self-funded group medical benefits plan market for the same or similar item or service that is: (1) provided by a health care provider in the same or similar specialty or facility of the same or similar facility type; and (2) provided in the geographic region in which the item or service is furnished.

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

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

Residential Treatment Center
A) A facility that provides 24-hour care to children under 18 in a structured environment under a court order; or
B) A residential home for adults ages 18 through 59 with mental health care needs or who have physical or developmental disabilities and require assistance with care and supervision, when prescribed by a Physician or Psychiatrist; or
C) A residential home that provides 24-hour services for up to five adults with developmental disabilities who have special health care and intensive support needs and who would otherwise need to reside in an institution as certified by a Physician or Psychiatrist; or
D) A facility licensed or certified by the jurisdiction in which it is located to operate a program for the treatment and care of persons diagnosed with substance use disorders or mental health conditions.

Special Extension Period
In this Plan, a period of zero to three months of health coverage in the Pensioners Health Plan in the event of the Participant's death. In the Pensioners Health Plan, the three-month period after the Pensioner's death during which free Pensioners Health Plan coverage is offered to a Survivor. Dental and Vision coverage are available at an additional cost.

SPD
Summary Plan Description. This document. A description of the provisions of, and benefits available under, the Southern California Pipe Trades Health & Welfare Fund.

Spouse
Any person to whom a Participant is legally married.

Subsidized Self-pay Program
A program under which certain Participants may be eligible to pay a reduced premium for COBRA continuation coverage for up to six months.

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

Survivor Premium Program
Coverage available in the Pensioners Health Plan for a Survivor.

Survivor
Any Spouse or Domestic Partner of a deceased Participant who continues to participate in this Plan under the Participant's Eligibility Bank or COBRA (Spouse only) or who satisfies the eligibility requirements for the Pensioners Health Plan upon losing coverage under this Plan. A Survivor does not include any eligible children.

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

Totally Disabled
Wholly prevented by bodily Injury or Illness from engaging in any occupation or employment and, in the case of an eligible child, totally unable to perform the daily living activities of a person of comparable age.

Transitioning Employee
See Section 4(H), page 16.

Trust Agreement
The written document titled "Restated Agreement and Declaration of Trust Continuing the Southern California Pipe Trades Health and Welfare Fund" under which the Fund has been established and maintained, and to which this Plan has been adopted, and any amendments to it.

Trustees
Employer and Union representatives who oversee the Fund.

Uniformed Service and Qualified Uniformed Service
Uniformed Service is duty in the armed forces of the United States, the National Guard, the commissioned corps of the Public Health Service, and such other services designated by the President, which may entitle a Participant to the protections of USERRA.

Qualified Uniformed Service is Uniformed Service meeting the requirements under USERRA that establish reemployment and other rights.

Union(s)
Southern California Pipe Trades District Council No. 16 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada, AFL-CIO ("United Association"), and its affiliated local Unions, and such other unions which have or may in the future become parties to and agree to be bound by the Trust Agreement.

USERRA
Uniformed Services Employment and Reemployment Rights Act of 1994.

Well Child Services
Routine examinations, laboratory testing, and immunizations for children from birth to age 17.

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

SECTION 25. TRUSTEES

The following is a list of the Trustees as of the publication date of this SPD. The members of the Board of Trustees may change from time to time. If you want a current listing of the Trustees, contact the Fund Office.

A) Employer Trustees

RYAN CAVANAUGH
Murray Company
5995 Plaza Drive
Cypress, CA 90630

ROBERT FELIX
All Area Plumbing/ACCO Engineered Systems, Inc.
6446 E. Washington Blvd.
Commerce, CA 90040

JASON GORDON
Prime SC Mechanical, Inc.
7392 Earl Circle
Huntington Beach, CA 92647

JEFF HACHEY
H.L. Moe Company, Inc.
526 Commercial Street
Glendale, CA 91203

ADAM KAPLAN
Sierra Commercial Plumbing, Inc.
4645 Industrial Street, Unit C
Simi Valley, CA 93063

CHIP MARTIN
CPMCA
1735 Flight Way, Suite 204
Tustin, CA 92782

JOHN MODJESKI
University Mechanical & Engineering Contractors
1168 Fesler Street
El Cajon, CA 92020

JEFF STEVANUS
Southland Industries
12131 Western Avenue
Garden Grove, CA 92841

BRYAN SUTTLES
Suttles Plumbing
2267 Agate Court
Simi Valley, CA 93065

STEVE VALOT
Pan-Pacific Mechanical
18250 Euclid Street
Fountain Valley, CA 92708

LAWRENCE VERNE
Verne's Plumbing, Inc.
8561 Whitaker Street
Buena Park, CA 90621

PIP ZAIDE
Allegiant Mechanical, Inc.
7776 Westminster Blvd.
Westminster, CA 92683

B) Union Trustees

DAVID BALDWIN
U.A. Local No. 403
3710 Broad Street
San Luis Obispo, CA 93401

STEVEN BERINGER
U.A. Local No. 230
6313 Nancy Ridge Drive
San Diego, CA 92121

SHANE BOSTON
U.A. Local No. 484
1955 N. Ventura Avenue
Ventura, CA 93001

BEN CLAYTON
U.A. Local No. 250
18355 South Figueroa Street
Gardena, CA 90248

RODNEY COBOS
District Council No. 16
501 Shatto Place, Suite 400
Los Angeles, CA 90020

JEREMY DIAZ
U.A. Local No. 78
1111 W. James M. Wood Blvd.
Los Angeles, CA 90015

STEVEN GOMEZ
U.A. Local No. 460
6718 Meany Avenue
Bakersfield, CA 93308

ROBERT JAMES
U.A. Local No. 582
1916 W. Chapman Avenue
Orange, CA 92868

GREG LEWIS
U.A. Local No. 761
1305 North Niagara Street
Burbank, CA 91505

RICARDO PEREZ
U.A. Local No. 345
1430 Huntington Drive
Duarte, CA 91010

JOE RAYMOND
U.A. Local No. 364
223 S. Rancho Avenue
Colton, CA 92324

BILL STEINER
U.A. Local No. 398
8590 Utica Avenue, Suite 200
Rancho Cucamonga, CA 91730

SASHA STEVENS
U.A. Local No. 114
93 Thomas Road
Buellton, CA 93427

Summary Plan Description / Plan Rules & Regulations

of the

Southern California Pipe Trades

HEALTH & WELFARE FUND
VACATION & HOLIDAY BENEFIT

Contents

SECTION 1. INTRODUCTION

The Southern California Pipe Trades Health & Welfare Fund Vacation & Holiday Benefit ("Fund" or "Plan") was established in 1971 through the negotiating efforts of District Council No. 16 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada ("United Association") and Employers in the plumbing and pipefitting industry in Southern California. Union and Employer Trustees manage the Fund.

A) This Summary Plan Description

This Summary Plan Description/Plan Rules and Regulations ("SPD") summarizes the provisions of the Southern California Pipe Trades Health & Welfare Fund Vacation & Holiday Benefit. It applies on and after September 1, 2025. It is very important that you read this SPD carefully to understand how the Plan works. Please keep this SPD for future reference.

Plan rules may change from time to time, in which case a written notice explaining any important change will be sent to all covered households. Please read all Plan communications and keep them with this SPD.

B) Purpose of the Plan

The Plan was set up to provide paid time off benefits. The Plan is funded by Employers who contribute on behalf of their Employees on a per-hour basis under a Collective Bargaining Agreement or a Participation Agreement.

C) Role of the Board of Trustees

The Board of Trustees is authorized to interpret all Plan rules and documents, including the Trust Agreement and this SPD. The Board of Trustees has the discretion to decide all questions about the Plan including, but not limited to, questions about eligibility for participation in the Plan, rights to benefits, the amount of benefits that are payable, the information and proof necessary to substantiate a claim for benefits, and the definition of any Plan term. The Board of Trustees also has the authority to make any factual determinations concerning claims. No individual Trustee, Employer, or Union representative has the authority to interpret any Plan document on behalf of the Board of Trustees or to act as an agent of the Board of Trustees. The Board of Trustees may delegate its authority to a subcommittee or other subset of the Board of Trustees.

The Trustees intend to continue the Fund indefinitely. However, the Board of Trustees has the authority to amend or terminate the Plan as they deem appropriate.

D) Role of the Fund Office

The Board of Trustees has authorized the Fund Office to respond in writing to written correspondence. As a courtesy, the Fund Office may also respond informally to questions by telephone, email, or in person at the Fund Office. However, such information and answers are not binding upon the Board of Trustees and cannot be relied upon in any dispute. Remember 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 your entitlement to benefits.

NOTE	**If you have any questions regarding eligibility, benefits, or procedures, contact the Fund Office.** **Southern California Pipe Trades Administrative Corporation** **501 Shatto Place, Suite 500** **Los Angeles, CA 90020** **Toll-Free: (800) 595-7473 / Outside U.S.: (213) 385-6161** **Website: www.scptac.org / Email: vacation@scptac.org** **Change of Address Form submission: coa@scptac.org**

NOTE	**Capitalized terms are defined in Section 15, page 12.**

SECTION 2. COVERAGE AND CONTRIBUTIONS

You are eligible to participate in the Health & Welfare Fund Vacation & Holiday Benefit if you work in a job covered by a Collective Bargaining Agreement or Participation Agreement that requires contributions to the Plan, and your Employer makes contributions to the Plan on your behalf as required by the agreement. The agreement determines the amount to be contributed. Employees of District Council No. 16, its affiliated local Unions, and other organizations related to the Union, are also eligible to participate in the Plan, provided there is a Participation Agreement between the employing organization and the Fund. Generally, an Employer's employees are not covered by this Plan if they are not working under a Collective Bargaining Agreement.

All contributions made to the Plan on your behalf are placed in the trust fund for the benefit of all Plan Participants. The Trustees of the Plan establish and maintain an Individual Account for each Participant. You are qualified to receive a benefit from this Plan if your Employer has paid in contributions on your behalf for work covered by the Plan.

SECTION 3. ENROLLMENT

When your Employer contributes to the Plan for hours worked, the contributions are credited to your Individual Account in the Plan. You will receive a statement from the Fund Office each quarter. You are automatically enrolled in the Plan when contributions are received on your behalf.

At the time you begin working, you should complete a Beneficiary form. This form allows you to name a Beneficiary for the different funds you may participate in, including the Health & Welfare Fund Vacation & Holiday Benefit. You may obtain a Beneficiary Form from any local Union office, the Fund Office, or the Fund Office website at www.scptac.org.

IMPORTANT	**If there is a change in your family status, such as marriage, divorce, or a change in status of a Beneficiary, or if your address changes, notify the Fund Office as soon as possible, but no later than 90 days after the change.**

SECTION 4. PLAN BASICS

The contributions paid by your Employer accumulate in your Individual Account. The Normal Benefit payment schedule of the Plan is a 12-month cycle ending with the work month of October of each year. Contributions for the work month of October are generally received in November. Therefore, the contributions received during the 12 months ending November 30 usually are paid out automatically, 30% in December and 70% in the following April. Any late payments received from December through March, for hours worked through October, will be paid in full the following April.

When you take an Interim Withdrawal, or choose the Monthly Benefit option, the amount of your Normal Benefit payments will be reduced or eliminated.

In addition to the contributions from your Employer, your Individual Account will share in any Surplus Income based upon the balance in your account as of November 30. Participants who choose the Monthly Benefit option do not receive any Surplus Income.

IMPORTANT	**You will only receive the amounts that have actually been contributed by your Employer. If your Employer fails to contribute to the Plan for the work that you perform, you will not receive those amounts unless and until the Fund Office has collected and processed the contributions from your Employer.**

SECTION 5. QUARTERLY STATEMENT

The Fund Office issues quarterly statements that you should carefully review. Any hours worked, and contributions to or disbursements from your Individual Account, will appear on these statements. The "Quarterly Statement Schedule" set forth below summarizes the statement cycle.

Quarterly Statement Schedule

Hours Worked During:*	Deposits Processed During:	Date of Quarterly Statement
January 1 through March 31	February 1 through April 30	May 1
April 1 through June 30	May 1 through July 31	August 1
July 1 through September 30	August 1 through October 31	November 1
October 1 through December 31[t]	November 1 through January 31	February 1

* Delinquent reporting by the Employer will affect the work months that appear on the statement.

SECTION 6. BENEFIT PAYMENTS

There are two automatic Normal Benefit payments every year called the December Payment and the April Payment. There is also an early payment option, called an Interim Withdrawal, and a Monthly Benefit. Benefit payments are disbursed as shown in the "Summary of Benefit Payment Options" chart and explained in more detail below. All benefits will be paid by check unless the appropriate direct deposit form is accurately and timely filed.

Only contributions received timely by the Fund from the Employer can be paid to you. The amount of your benefit also cannot exceed the Available Balance in your Individual Account. Contributions received by the Fund Office will be included in your Available Balance after the later of (1) the date the Fund Office has processed the contributions or (2) seven calendar days from the date the funds are deposited.

You can obtain any forms referred to in this section from the Fund Office, any local Union office, or online at www.scptac.org.

Summary of Benefit Payment Options

Benefit Payment	Date of Payment	Amount of Payment	Forms Required	Fees Charged*
December Payment	Dec 1 – Dec 10	30% of the balance of contributions received through November	Automatic – no form required	No fee charged
April Payment	April 1 – April 10	The remaining balance of contributions received through the previous November	Automatic – no form required	No fee charged
Interim Withdrawal	Only one Interim Withdrawal will be permitted each Calendar Year	100% of the Available Balance in your Individual Account	Request for Interim Withdrawal Form	No fee charged
Monthly Benefit Option	During the first seven business days of the month	100% of the Available Balance in your Individual Account, less administrative fees	Monthly Benefit Election Form	No fee charged

* Fees effective at the time of publication. The Trustees may change the fee at any time.

A) Normal Benefit Option

The Normal Benefit is the default option under the Plan.

i) December Payment

During December 1 through December 10 of each year, the December Payment will be issued to you equal to:

a) 30% of the Available Balance in your Individual Account as of November 30 (generally for hours worked through the month of October); plus
b) 30% of any Surplus Income posted to your Individual Account; and minus
c) Any individual fees or amounts paid as an Interim Withdrawal or as a Monthly Benefit.

ii) April Payment

During April 1 through April 10 of each year, the April Payment will be issued to you equal to:

a) 70% of your Available Balance as of the prior November 30; plus
b) 70% of any Surplus Income posted to your Individual Account; and minus
c) Any individual fees or amounts paid as an Interim Withdrawal or as a Monthly Benefit.

iii) Forms of Payment

You may choose to receive the Normal Benefit (December and April) payments via check or direct deposit (ACH transfer) to your bank account.

a) Via Check: The default option is to send a check to your address on file with the Fund Office.
b) Via Direct Deposit: If you want your benefit to be paid by direct deposit to your bank account, you must submit a Normal Benefit Election Authorization Agreement for Direct Deposit, which includes a voided check (or deposit slip in the case of a savings account) which must be received by the Fund Office by the 20th day of the month before the month in which the benefit is paid. If the form is not received timely, a check will be issued to the address on file with the Fund Office. You need only submit the Normal Benefit Election Authorization Agreement for a Direct Deposit once. It will remain in effect for all subsequent payments until you cancel it in writing.

B) Interim Withdrawal Option

You may receive the Available Balance in your Individual Account early by requesting an Interim Withdrawal. An Interim Withdrawal will disburse 100% of your Available Balance. Only one Interim Withdrawal will be permitted each Calendar Year. That one withdrawal will be free of charge. No other Interim Withdrawals will be permitted.

i) Application

To request an Interim Withdrawal, you must complete the Request for Vacation & Holiday Interim Withdrawal Form and submit it to the Fund Office. If the form is in proper order, the disbursement generally will be issued by the Fund Office within 14 calendar days of receipt of the request, except during the prohibited periods as described below.

Note that:

a) Interim Withdrawals are not permitted from approximately November 20 through December 10 and from March 20 through April 10 of each year due to the preparations necessary for processing the Normal Benefit.
b) An Interim Withdrawal or Monthly Benefit may affect the amount of the Surplus Income allocated to your Individual Account. Any Surplus Income allocated to your account will be based on the balance in your Individual Account as of November 30. If the balance in your Individual Account as of November 30 is zero or reduced due to an Interim Withdrawal or a Monthly Benefit, you will receive no Surplus Income or a reduced amount of Surplus Income.

ii) Forms of Payment

You may choose to receive your Interim Withdrawal via check or direct deposit (ACH transfer) to your bank account.

a) Via Check: The default option is to send a check to your address on file with the Fund Office. However, if you have provided direct deposit information for your Normal Benefit, your Interim Withdrawal will also be sent via direct deposit.
b) Via Direct Deposit: If you have not previously provided direct deposit information for your Normal Benefit and you want your Interim Withdrawal to be paid by direct deposit to your bank account, you must submit with your application a Normal Benefit Election Authorization Agreement for Direct Deposit, which includes a voided check (or deposit slip in the case of a savings account). If the form is not received with your application, a check will be issued to the address on file with the Fund Office. You need only submit the Normal Benefit Election Authorization Agreement for a Direct Deposit once. It will remain in effect for all subsequent payments until you cancel it in writing.

IMPORTANT	**From November 20 through December 10 and March 20 through April 10, Interim Withdrawals may be unavailable due to the preparations necessary for processing the Normal Benefit.**

C) Monthly Benefit Option

You may receive the Available Balance in your Individual Account early by requesting the Monthly Benefit option. The Monthly Benefit option will disburse 100% of your Available Balance via direct deposit (ACH transfer) to your bank account. To request Monthly Benefit payments, you must complete the Monthly Benefit Election Form.

i) Application

To request the Monthly Benefit option, you must complete the Monthly Benefit Election Form and submit it to the Fund Office. The form and a voided check (or deposit slip in the case of a savings account) must be received by the Fund Office by the 20th day of the month for monthly direct deposit to begin the following month.

Note that:

a) An Interim Withdrawal or Monthly Benefit may affect the amount of the Surplus Income allocated to your Individual Account. Any Surplus Income allocated to your account will be based on the balance in your Individual Account as of November 30. If the balance in your Individual Account as of November 30 is zero or reduced due to an Interim Withdrawal or a Monthly Benefit, you will receive no Surplus Income or a reduced amount of Surplus Income.

b) Once you are enrolled in the Monthly Benefit option, you will have no Interim Withdrawal option for the remainder of that Calendar Year.

c) You may switch between the Normal Benefit option and the Monthly Benefit option at any time by completing the required forms, subject to the deadlines established elsewhere in this section.

ii) Form of Payment

This benefit will only be paid via direct deposit (ACH transfer) to your bank account. The Fund Office will initiate a direct deposit to the account on or about the fifth business day of each month. The amount deposited will be the Available Balance of your Individual Account, less the administrative fee, if any.

NOTE	Direct Deposits
	A direct deposit can only be made to a bank account of which you are the owner or a co-owner. No benefit payment will be made to any party other than you. **Your bank account must be open and capable of receiving deposits at the time of the direct deposit. If not, the money will be returned to the Fund and held until:** **1. You submit revised direct deposit information (in which case your benefit will be resent via direct deposit on the next available transfer date);** **2. You rescind your direct deposit instructions (in which case a check will be issued within 14 calendar days); or** **3. The next Normal Benefit (April or December) payment (in which case a check will be issued to your address on file with the Fund Office).**

EXAMPLE

Vacation & Holiday Payment Cycle

Work Month	Deposit Date	Contribution Amount	Benefit Distributions	Balance in Individual Account
Nov 2024	12/10/2024	$500.00		$500.00
Dec 2024	01/10/2025	$500.00		$1,000.00
Jan 2025	02/10/2025	$500.00		$1,500.00
Feb 2025	03/10/2025	$500.00		$2,000.00
Mar 2025	04/10/2025	$500.00		$2,500.00
Apr 2025	05/10/2025	$500.00		$3,000.00
May 2025	06/10/2025	$500.00		$3,500.00
Jun 2025	07/10/2025	$500.00		$4,000.00
Jul 2025	08/10/2025	$500.00		$4,500.00
Aug 2025	09/10/2025	$500.00		$5,000.00
Sep 2025	10/10/2025	$500.00		$5,500.00
Oct 2025	11/10/2025	$500.00		$6,000.00
Surplus Income	12/01/2025	$30.00		$6,030.00
December Payment	12/05/2025		- $1,809.00	$4,221.00
Nov 2025	12/10/2025	$500.00		$4,721.00
Dec 2025	01/10/2026	$500.00		$5,221.00
Jan 2026	02/10/2026	$500.00		$5,721.00
Feb 2026	03/10/2026	$500.00		$6,221.00
April Payment	04/05/2026		-$4,221.00	$2,000.00

Notes on this example:

- This example assumes that no Interim Withdrawals are taken and no Monthly Benefit payments are made.
- The accumulation period is for hours worked from November 2024 through October 2025. The total contributions during this period are $6,000.00.
- Surplus Income of $30 was posted to the Individual Account based on the balance as of 11/30/2025.
- The December Payment is 30% of the contributions paid plus 30% of the Surplus Income: $6,030.00 x 30% = $1,809.00.
- The April Payment is the remaining 70% of the Individual Account at the time of the December Payment: $4,221.00.
- The balance of $2,000.00 left after the April Payment goes towards the accumulation for the next year's cycle and will be included in the payments issued in December 2026 and April 2027.

SECTION 7. TAXATION OF BENEFITS

Contributions to the Plan are included in your taxable income reported by your Employer and are reported on Form W-2. Your pro-rata share of any Surplus Income is considered taxable income to you. The Fund Office will issue a Form 1099-MISC if your surplus income paid during any Plan Year totals $600 or more. For questions on taxes that may be due on this income, you should consult a tax professional.

SECTION 8. DEATH BENEFITS & BENEFICIARIES

When you complete your Beneficiary Form, you will designate one or more Beneficiaries to receive your benefits in the event of your death. If you die, the Available Balance in your Individual Account will be paid to your Beneficiary(ies). You may change your Beneficiary(ies) at any time by completing a new form.

If you do not designate a Beneficiary and submit the Beneficiary Form to the Fund Office before your death or if your Beneficiary dies before you do and no new Beneficiary Form is timely submitted to the Fund Office, the benefit will be paid to the following in order of priority:

A) First, to your Spouse, if any;

B) Second, to your child(ren), if you have no surviving Spouse;
C) Third, to your parent(s), if you have no surviving Spouse or child(ren);
D) Fourth, to your sibling(s) (brothers and sisters), if you have no surviving Spouse, child(ren), or parent(s); or
E) Fifth, to your estate, if you have no surviving Spouse, child(ren), parent(s), or sibling(s).

If you designate your Spouse as your Beneficiary and subsequently get divorced, your former Spouse is automatically revoked as the Beneficiary upon the date of divorce. Therefore, it is important that you complete a new Beneficiary Form following a divorce, particularly if you want your former Spouse to remain your Beneficiary.

IMPORTANT	**If there is a change in your family status, such as marriage, divorce, or a change in status of a Beneficiary, or if your address changes, notify the Fund Office as soon as possible, but no later than 90 days after the change.**

SECTION 9. PLAN EXPENSES AND INVESTMENT INCOME

The income from Plan investments, if any, less a small amount held in reserve, is called the Surplus Income, which is paid to you if you accept the Normal Benefit option. The Trustees reserve the right to offset this Surplus Income by some or all of the expenses incurred in administering this benefit.

The amount of Surplus Income is calculated based on the Plan's operations for the 12 months ending November 30.

If you accept the Normal Benefit option, Surplus Income, if any, is credited to your Individual Account just before the December Payment. It is distributed pro-rata based on the account balances as of November 30. An Interim Withdrawal or Monthly Benefit payment before November 30 will affect the amount of Surplus Income received.

NOTE	**The Plan's Surplus Income, if any, is allocated to all the Individual Accounts on a pro-rata basis. So the larger your balance as of November 30th, the larger your share of the Surplus Income will be.**

SECTION 10. FORFEITURE OF UNCLAIMED BENEFITS

Any contributions or Surplus Income that have been credited to an Individual Account and not withdrawn or claimed by the Employee or Beneficiary within two years following the end of the Plan Year the account was credited will be forfeited to the Fund. No Employer or Union, nor any Employee or Beneficiary, nor any person, firm, or association other than the Fund, has any right, title, or interest in such monies.

SECTION 11. DEDUCTIONS FROM BENEFITS

Your benefits may be subject to a lien or levy if a legal court order is received by the Fund. Any amounts deducted for a lien or levy will appear on your quarterly statement.

The Trustees may permit you to authorize, in writing, deductions from distributions made to you from the Plan to an Employer or the Union for funding established programs generally funded by employee or member contributions. Any such Participant authorizations are entirely voluntary and may be revoked at any time. Any such authorized deductions will only be made at the time a distribution is made from the Plan. Only those deductions approved by the Trustees at the request of an Employer or the Union are permissible. The Fund Office will provide information to you on permissible deductions upon request.

SECTION 12. APPLICATION AND APPEALS PROCEDURE

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

A) Processing a Claim for Benefits

The Fund will treat any application or written request for a Plan benefit or any other written claim for Fund action made by you or your authorized representative per the procedures described in this SPD as a "claim for benefits". You can appeal any Fund decision regarding the amount or timing of a benefit or any other Fund decision affecting your rights under the Plan using the procedures set forth below.

Except for benefits from the Fund that are paid automatically, to make a claim for benefits, you must obtain an application form from the Fund Office. The form must be completed, signed, and submitted to the Fund Office. A claim will be treated as submitted on the date it is received by the Fund Office. If your application is incomplete, you will be notified as soon as possible with a written request for additional information.

Every effort will be made to process your claim within 90 days after receipt by the Fund Office. This 90-day period will begin upon receipt of the completed and signed application form by the Fund Office without regard to whether all of the information necessary to decide the application has been submitted.

If a decision on your claim for benefits cannot be made within 90 days of its receipt, a letter will be sent to you before the expiration of the 90 days explaining the special circumstances requiring another 90 days to take action. If final action cannot be taken at the end of the second 90-day period, you will be sent a written explanation in advance of the expiration of the second 90-day period. Where appropriate, you will be awarded any partial benefits that can be determined with the available information. If partial benefits cannot be awarded because of a lack of necessary information, the Fund Office will conditionally deny your claim. The Fund Office will continue to seek the necessary information to make a final determination.

B) Notice of Decision on Your Claim

If your claim for benefits is denied, in whole or in part, the Fund Office will provide you with a written notice that states (1) the specific reason(s) for the denial, (2) refers to the specific Plan provisions on which the denial is based, (3) describes any additional material or information that might help your 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 lawsuit under Section 502(a) of ERISA.

C) Appealing a Benefit Denial

If your claim for benefits is denied, in whole or in part, you may request that the Board of Trustees review the benefit denial. The Board of Trustees has delegated the responsibility to decide appeals to its Appeals Committee. (In some cases, the Board of Trustees may decide to consider an appeal and, in other cases, the Appeals Committee may delegate the responsibility to consider an appeal to a subset of the Committee.) All appeals must be in writing and must be received by the Fund Office within 180 calendar days after you receive the written notice of the denial from the Fund Office. Failure to file a timely written appeal shall constitute a complete waiver of your right to appeal, and the decision of the Fund Office will be final and binding.

In presenting your appeal, you can submit written comments, documents, records, and other information about your claim. You are also entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. Personal appearances on appeals are at the discretion of the Appeals Committee.

Your written appeal should state the specific reasons why you believe the denial of your claim was in error. You should also submit any documents or records that support your claim. This does not mean that you are required to cite all of the Plan provisions that apply or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefits or other relief you are claiming. The Appeals Committee can best consider your position if it clearly understands your 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 or considered by the Fund Office in its determination. The Appeals Committee will also not afford deference to the initial determination by the Fund Office.

The Fund Office 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.

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 Office. 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 you before the beginning of the extension. Such an extension may only last until the third meeting following receipt of the appeal.

D) Notice of Decision on Appeal

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

If your appeal is denied, in whole or in part, you will receive a written decision that will include: (1) the specific reason(s) for the denial; (2) the specific Plan provisions on which the denial is based; (3) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your appeal; and (4) a statement of your right to bring a lawsuit under Section 502(a) of ERISA.

E) The Decision on Appeal is Final and Binding

The decision of the Appeals Committee is final and binding on all parties, including anyone claiming a benefit on your behalf.

Once a final decision is made, there is no right to re-file the same appeal or to request reconsideration, and if you file such an appeal or request for reconsideration, the Appeals Committee may refuse to consider it.

The Board of Trustees and, by delegation, the Appeals Committee, has full discretion and authority to determine all matters relating to appeals including, but not limited to, eligibility for benefits, the amount of benefits to which individuals are entitled, the standard of proof required for any claim and the application and interpretation of the Plan. The Board of Trustees has the ultimate authority to hear any appeal and has generally delegated this authority to the Appeals Committee to decide appeals. However, the Board of Trustees has the right and authority to hear any appeal and, in such case, the rights and procedures set forth herein shall apply equally to the Board of Trustees.

If the Appeals Committee denies your appeal and you decide to seek judicial review, the Appeals Committee's decision will be subject to limited judicial review to determine only whether the decision was arbitrary and capricious. Generally, 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 your appeal. No legal action may be commenced against the Trust, the Plan, or the Trustees more than two years after the claim has been denied on appeal.

F) Right to Be Represented

In making a claim or appeal, you may be represented by any authorized representative. If your representative is not an attorney or court-appointed guardian, you must designate the representative by a signed written statement. However, neither you nor your representative has a right to an in-person hearing or appearance before the Trustees or the Appeals Committee.

G) Any Adverse Decision May be Appealed

The recipient of any written correspondence from the Fund Office that could be interpreted as adversely affecting the recipient's interest may appeal to the Appeals Committee for a determination on the content of that correspondence. Such a request for review must be in writing and must be made within 180 calendar days after receipt of the correspondence from the Fund Office. Such appeals will be processed in the same manner as appeals from determinations on benefit applications.

SECTION 13. IMPORTANT NOTICES

A) No Assignment of Benefits

You may not pledge your Individual Account as security for a loan or any other purpose. You may not assign your benefit to any other individual, entity, or party. Also, as a welfare benefits plan, the Health & Welfare Fund Vacation & Holiday Benefit does not recognize Qualified Domestic Relations Orders and will not pay benefits to a former Spouse or any alternate payee under a Qualified Domestic Relations Order.

B) Erroneous Payments

Every effort will be made to ensure accuracy in paying your benefits. If an error is discovered, regardless of how long ago it occurred, and it is determined that the Fund has paid any benefits you are not entitled to, you must reimburse the Fund for the erroneous payments. 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.

C) 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 erroneous amounts paid by the Fund, and you will be liable for all costs of collection, including attorneys' fees. 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 payment made because of fraud or misrepresentation.

SECTION 14. INFORMATION REQUIRED BY ERISA

The following additional information concerning the Plan is provided to you per the Employee Retirement Security Act of 1974 (ERISA). The terms in this section are generally as defined in ERISA unless capitalized.

A) Name and Type of Plan

The name of the Plan is the Southern California Pipe Trades Health & Welfare Fund Vacation & Holiday Benefit. It is a multiemployer welfare benefit plan.

B) Identification Numbers

The Fund's Internal Revenue Service tax identification number is 95-1867598. The Plan number is 502.

C) Plan Year

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

D) Plan Sponsor, Named Fiduciary, and Administrator

The Plan is maintained under a collectively bargained, jointly trusteed labor-management trust. The Board of Trustees is the plan sponsor, the legal plan administrator, and the named fiduciary under ERISA.

E) Board of Trustees

The Board of Trustees consists of Employer and Union representatives, selected by the Employers and Union, 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	(800) 595-7473
Southern California Pipe Trades Health & Welfare Fund	(213) 385-6161
Vacation & Holiday Benefit	www.scptac.org
501 Shatto Place, Suite 500	info@scptac.org
Los Angeles, CA 90020	

F) Fund Office

The Board of Trustees has designated the Southern California Pipe Trades Administrative Corporation to perform the daily business functions of the Plan. You may contact the Fund Office at:

Southern California Pipe Trades Administrative Corporation	(800) 595-7473
Attention: CEO/Administrator	(213) 385-6161
501 Shatto Place, Suite 500	www.scptac.org
Los Angeles, CA 90020	info@scptac.org

G) Agent for Service of Legal Process

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

Southern California Pipe Trades Health & Welfare Fund Vacation & Holiday Benefit
Attention: CEO/Administrator
501 Shatto Place, Suite 500
Los Angeles, CA 90020

Service of legal process may also be made upon a plan trustee or the plan administrator.

H) Source of Contributions

All contributions to the Fund are made by Employers per their Collective Bargaining Agreements or the terms of a Participation Agreement. The Collective Bargaining Agreements and Participation Agreements require that contributions be made to the Fund at fixed rates per hour of work.

The Fund Office will provide you, upon written request, a complete list of Employers and Unions that are parties to Collective Bargaining Agreements and their addresses. The Fund Office will also provide information about whether a particular employer is obligated to contribute to the Fund on behalf of employees working under a Collective Bargaining Agreement or Participation Agreement and the address of any such employer.

The Fund's assets are held in trust by the Board of Trustees. Custody of the Fund's assets is with U.S. Bank, N.A. Benefits are provided directly from the Fund's assets, which are accumulated under the provisions of the Trust Agreement. The assets are used exclusively for providing benefits to participants and beneficiaries per the provisions of the Plan and for paying the reasonable administrative expenses of the Fund.

All of the types of benefits provided by the Plan are set forth in this SPD.

I) Collective Bargaining Agreement

Contributions to the Fund are made per Collective Bargaining Agreements between Employers and District Council No. 16 of the United Association or affiliated local Unions of District Council No. 16 or of the United Association. The United Association local Unions affiliated with District Council No. 16 are 78, 114, 230, 250, 345, 364, 398, 403, 460, 484, 582, and 761. The Fund Office will provide you, upon written request, a copy of the applicable Collective Bargaining Agreement. The Collective Bargaining Agreements are also available for examination at the Fund Office. The following are the employer associations with which District Council No. 16 has a bargaining relationship that requires contributions to this Fund:

i) California Plumbing & Mechanical Contractors Association (CPMCA);
ii) Airconditioning, 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 this Plan will continue indefinitely, but the Board of Trustees reserves the right to change or discontinue the Plan at any time. The Trustees may terminate the Plan 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 become due. The Plan may also be terminated if no individuals living can qualify as participants or beneficiaries under the Plan or if there are no longer any Collective Bargaining Agreements requiring contributions to the Fund. The Trustees have the complete discretion to determine when and if the Fund should be terminated.

If the Plan is terminated, the Trustees will: (i) pay the expenses of the Fund incurred up to the date of termination as well as the expenses in connection with the termination; (ii) arrange for a final audit of the Fund; (iii) give any notice and prepare and file any reports required by law; and (iv) apply the assets of the Fund per the law and the Plan, including amendments adopted as part of the termination, until the assets are distributed, including paying benefits to the Participants or Beneficiaries. Under no circumstances will any portion of the Fund revert to the benefit of an Employer, any employer association, or the Union.

Upon termination of the Plan and Fund, the Trustees will promptly notify the Union, any employer association, Employers, and all other interested parties. The Trustees will continue as Trustees to wind up the affairs of the Plan.

K) Actions of Trustees

The Trustees have full discretion and authority over the standard of proof for any inquiry, claim, or appeal, and over the application and interpretation of the Plan and trust. No legal proceeding may be filed in any court or before an administrative agency against the Plan or its Trustees unless all review procedures with the Trustees have been exhausted. No legal action may be commenced against the trust, the Plan, or the Trustees more than two years after a claim has been denied on appeal.

L) Right to Amend

The Trustees have the complete discretion to amend or modify the Plan or Trust Agreement and any of their provisions, in whole or in part, at any time.

M) ERISA Rights

As a participant in the Southern California Pipe Trades Health & Welfare Fund Vacation & Holiday Benefit, 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

a) Examine, without charge, at the plan administrator's office and 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 Employee Benefits Security Administration.

b) 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 an updated summary plan description. The administrator may make a reasonable charge for the copies.

c) Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

ii) 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, must 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.

iii) Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits 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.

iv) Assistance with Your Questions

If you have any questions about your Plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the 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.

IMPORTANT	**None of the benefits described in this SPD/Rules & Regulations are insured by any contract of insurance, and there is no liability on the part of the Board of Trustees or any individual or entity to provide payment over and above the amounts in the Fund collected for such purpose.**

SECTION 15. DEFINITIONS

Appeals Committee

A subset of the Board of Trustees empowered to review any claims as described in Section 12.

April Payment

The Normal Benefit payable in April. See Section 6(A)(ii), page 4.

Available Balance
The portion of your Individual Account that has been on deposit with the Plan for at least seven days.

Beneficiary
A Beneficiary is a person designated by you or by the Plan to receive benefits when you die.

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

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

Collective Bargaining Agreement
Any and all negotiated labor agreements between an Employer, or employer association acting on behalf of Employers, and Southern California Pipe Trades District Council No. 16 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada ("United Association"), or any local union affiliate of the District Council that requires contributions to the Southern California Pipe Trades Health & Welfare Fund Vacation & Holiday Benefit. It also refers to an agreement, to which the United Association is a party, requiring contributions to the Fund.

December Payment
The Normal Benefit payable in December. See Section 6(A)(i), page 4.

Employee
An Employee is anyone employed by a Contributing Employer in a position for which the Employer contributes to the Fund under a Collective Bargaining Agreement. Employees may also include an Employer or someone employed by an organization signatory to a Participation Agreement.

Employer
An Employer signed to a Collective Bargaining Agreement or Participation Agreement, or an Employer that assigns its bargaining rights to an employer association signed to a Collective Bargaining Agreement, that requires contributions to the Fund.

ERISA
Employee Retirement Income Security Act of 1974, as amended. See Section 14(M), page 11, for an explanation of your ERISA rights.

Fund
The Southern California Pipe Trades Health & Welfare Fund Vacation & Holiday Benefit created by the Trust Agreement establishing that Fund.

Fund Office
Southern California Pipe Trades Administrative Corporation
501 Shatto Place, Suite 500
Los Angeles, CA 90020

(800) 595-7473
(213) 385-6161
www.scptac.org
info@scptac.org

Individual Account
The account established in the Plan for each Participant. The balance of your Individual Account equals all contributions made by your Employer plus any Surplus Income allocated to you.

Interim Withdrawal
A voluntary withdrawal of 100% of your Individual Account balance permitted once during each Calendar Year. See Section 6(B), page 4.

Monthly Benefit
A voluntary option to withdraw 100% of your Individual Account balance each month. See Section 6(C), page 5.

Normal Benefit
The automatic benefit paid by the Plan. Contributions received during the twelve months ending November 30th are paid 30% in December and 70% in the following April. See Section 6(A), page 4.

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 permitting a Contributing 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.

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

Plan Year
January 1st through December 31st of each year.

SPD
Summary Plan Description. This document. A summary of the provisions of, and benefits available under, the Southern California Pipe Trades Health & Welfare Fund Vacation & Holiday Benefit.

Spouse
Any person to whom a Participant was legally married at the time of the Participant's death.

Surplus Income
Investment earnings, less a small amount held in reserve.

Trust Agreement
The written document titled "Restated Agreement and Declaration of Trust Continuing the Southern California Pipe Trades Health & Welfare Fund" pursuant to which the Fund has been established and maintained and to which this Plan has been adopted and any amendments thereto.

Trustees
Employer and Union representatives designated under the Trust Agreement as the individuals responsible for overseeing and administering the Fund.

Union(s)
Southern California Pipe Trades District Council No. 16 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada, AFL-CIO ("United Association"), and its affiliated local Unions, and such other unions which have or may in the future become parties to and agree to be bound by the Trust Agreement.

SECTION 16. TRUSTEES

The following is a list of the Trustees as of the publication date of this SPD. The members of the Board of Trustees may change from time to time. If you want a current listing of the Trustees, contact the Fund Office.

A) Employer Trustees

RYAN CAVANAUGH
Murray Company
5995 Plaza Drive
Cypress, CA 90630

ROBERT FELIX
All Area Plumbing/ACCO Engineered Systems, Inc.
6446 E. Washington Blvd.
Commerce, CA 90040

JASON GORDON
Prime SC Mechanical, Inc.
7392 Earl Circle
Huntington Beach, CA 92647

JEFF HACHEY
H.L. Moe Company, Inc.
526 Commercial Street
Glendale, CA 91203

ADAM KAPLAN
Sierra Commercial Plumbing, Inc.
4645 Industrial Street, Unit C
Simi Valley, CA 93063

CHIP MARTIN
CPMCA
1735 Flight Way, Suite 204
Tustin, CA 92782

JOHN MODJESKI
University Mechanical & Engineering Contractors
1168 Fesler Street
El Cajon, CA 92020

JEFF STEVANUS
Southland Industries
12131 Western Avenue
Garden Grove, CA 92841

BRYAN SUTTLES
Suttles Plumbing
2267 Agate Court
Simi Valley, CA 93065

STEVE VALOT
Pan-Pacific Mechanical
18250 Euclid Street
Fountain Valley, CA 92708

LAWRENCE VERNE
Verne's Plumbing, Inc.
8561 Whitaker Street
Buena Park, CA 90621

PIP ZAIDE
Allegiant Mechanical, Inc.
7776 Westminster Blvd.
Westminster, CA 92683

B) Union Trustees

DAVID BALDWIN
U.A. Local No. 403
3710 Broad Street
San Luis Obispo, CA 93401

STEVEN BERINGER
U.A. Local No. 230
6313 Nancy Ridge Drive
San Diego, CA 92121

SHANE BOSTON
U.A. Local No. 484
1955 N. Ventura Avenue
Ventura, CA 93001

BEN CLAYTON
U.A. Local No. 250
18355 South Figueroa Street
Gardena, CA 90248

RODNEY COBOS
District Council No. 16
501 Shatto Place, Suite 400
Los Angeles, CA 90020

JEREMY DIAZ
U.A. Local No. 78
1111 W. James M. Wood Blvd.
Los Angeles, CA 90015

STEVEN GOMEZ
U.A. Local No. 460
6718 Meany Avenue
Bakersfield, CA 93308

ROBERT JAMES
U.A. Local No. 582
1916 W. Chapman Avenue
Orange, CA 92868

GREG LEWIS
U.A. Local No. 761
1305 North Niagara Street
Burbank, CA 91505

RICARDO PEREZ
U.A. Local No. 345
1430 Huntington Drive
Duarte, CA 91010

JOE RAYMOND
U.A. Local No. 364
223 S. Rancho Avenue
Colton, CA 92324

BILL STEINER
U.A. Local No. 398
8590 Utica Avenue, Suite 200
Rancho Cucamonga, CA 91730

SASHA STEVENS
U.A. Local No. 114
93 Thomas Road
Buellton, CA 93427

Summary Plan Description / Plan Rules & Regulations

of the

Southern California Pipe Trades

PENSIONERS & SURVIVING SPOUSES HEALTH FUND

Contents

SECTION 1. INTRODUCTION

The Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund ("Fund" or "Plan") was established in 2011 through the negotiating efforts of District Council No. 16 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada ("United Association") and Employers in the plumbing and pipefitting industry in Southern California. Union and Employer Trustees manage the Fund.

A) This Summary Plan Description

This Summary Plan Description/Plan Rules and Regulations ("SPD") is the plan document of the provisions of the Southern California Pipe Trades Pensioners & Surviving Spouses Health Plan. It applies to all claims for services rendered on and after September 1, 2025. Prior written material applies only to claims for services rendered before September 1, 2025. You must read this SPD carefully to understand how the Plan works. Please keep this SPD for future reference.

Plan rules may change from time to time, in which case a written notice explaining any important change will be sent to all covered households. Please read all Plan communications and keep them with this SPD.

B) Purpose of the Plan

The Plan was set up to provide medical, Prescription Drug, and other benefits. The Plan is funded by active union members, whose Employers make contributions on their behalf per hour under a Collective Bargaining Agreement or a Participation Agreement and by premiums paid by Participants and Survivors. The Plan pays claims only for benefits provided under the Plan. The Plan does not pay benefits for work-related Illnesses and Injuries. This Plan does not cover Active Participants whose benefits are covered under the Southern California Pipe Trades Health & Welfare Fund, which has a separate SPD.

C) Role of the Board of Trustees

The Board of Trustees is authorized to interpret all Plan rules and documents, including the Trust Agreement and this SPD. The Board of Trustees has the discretion to decide all questions about the Plan including, but not limited to, questions about eligibility for participation in the Plan, rights to benefits, the amount of benefits payable, the information and proof necessary to substantiate a claim for benefits, and the definition of any Plan term. The Board of Trustees also has the authority to make any factual determinations concerning claims. No individual Trustee, Employer, or Union representative has the authority to interpret any Plan document on behalf of the Board of Trustees or to act as an agent of the Board of Trustees. The Board of Trustees may delegate its authority to a subcommittee or other subset of the Board of Trustees.

The Trustees intend to continue the Fund indefinitely. However, the Board of Trustees has the authority to amend or terminate the Plan as they deem appropriate.

D) Role of the Fund Office

The Board of Trustees has authorized the Fund Office to respond in writing to your written questions. As a courtesy, the Fund Office may also respond informally to questions by telephone, email, or in person at the Fund Office. However, such information and answers are not binding upon the Board of Trustees and cannot be relied upon in any dispute. Remember 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 independently determine your entitlement to benefits.

NOTE	
	If you have any questions regarding eligibility, benefits, or procedures, contact the Fund Office. **Southern California Pipe Trades Administrative Corporation** **501 Shatto Place, Suite 500** **Los Angeles, CA 90020** **Toll-Free: (800) 595-7473 / Outside U.S.: (213) 385-6161** **Website: www.scptac.org / Email: info@scptac.org**
	Contact health@scptac.org for questions relating to: • **Annual Coordination of Benefits Form** • **Change of Address Form** • **Injury and Third Party Liability Form** • **Specialty Medication** • **Therapy related Prescriptions**

NOTE	Capitalized terms are defined in Section 20, page 54.

SECTION 2. SUMMARY OF PLAN BENEFITS

The Plan partners with Blue Shield of California to lower and control Patient Out-of-Pocket costs while expanding the network of providers available. Blue Shield provides network access and some administrative services only. The Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund determines, administers, and pays Plan benefits. Note that Blue Shield does not administer the Fund's dental, vision, or prescription benefits.

	Benefit	Amount
DEDUCTIBLES	Medical services	$250 per person
	Dental benefit (applies only to the MetLife PPO option, not the DeltaCare USA DHMO option)	$50 per person
	Prescription Drugs	$50 per person
	Hearing aids	$50 per device

LIFETIME MAXIMUM BENEFIT (LMB) Effective January 1, 2019	LMB Per Person
	$2,000,000

SUMMARY OF PLAN BENEFITS

Benefit details are listed in alphabetical order in Section 8 beginning on page 25.

TYPE OF SERVICE	BLUE SHIELD OF CALIFORNIA (BSC) PPO NETWORK PROVIDER Plan Pays:	OUT-OF-NETWORK PROVIDER Plan Pays:
ACUPUNCTURE Not to exceed 20 visits per Calendar Year.	80% of the BSC PPO Network Rate	80% of the Allowable Charge
ALLERGY TESTING	80% of the BSC PPO Network Rate	80% of the Allowable Charge
ALLERGY TREATMENT The Plan will pay up to $75 per vial and for no more than a three-month supply, not to exceed four times in any 12-month period, and not to exceed $750.	80% of the BSC PPO Network Rate	80% of the Allowable Charge
AMBULANCE	80% of the BSC PPO Network Rate	80% of the Allowable Charge
ANESTHESIA For Pain Management injections, see the Pain Management benefit.	80% of the BSC PPO Network Rate	80% of the Allowable Charge

SUMMARY OF PLAN BENEFITS

Benefit details are listed in alphabetical order in Section 8 beginning on page 25.

TYPE OF SERVICE		BLUE SHIELD OF CALIFORNIA (BSC) PPO NETWORK PROVIDER Plan Pays:	OUT-OF-NETWORK PROVIDER Plan Pays:
BARIATRIC SURGERY		NOT COVERED	
CARDIAC REHABILITATION	**Performed in a Physician's Office**	80% of the BSC PPO Network Rate	80% of the Allowable Charge up to $20 per visit
	Outpatient Hospital or Facility	85% of the BSC PPO Network Rate	80% of the Allowable Charge up to $20 per visit
	Inpatient Hospital or Facility	85% of the BSC PPO Network Rate	80% of the Allowable Charge up to $1,080 per day for all Hospital or facility service
CHEMOTHERAPY		80% of the BSC PPO Network Rate	80% of the Allowable Charge
CHIROPRACTIC Maximum of three visits per week, not to exceed $600 per Calendar Year.		80% of the BSC PPO Network Rate	80% of the Allowable Charge
COLONOSCOPY / SIGMOIDOSCOPY SCREENING Covered once every five years for Patients age 45 and older.		80% of the BSC PPO Network Rate	80% of the Allowable Charge
CONVALESCENT CARE FACILITY / EXTENDED CARE FACILITY / ADULT DAY HEALTH CARE		85% of the BSC PPO Network Rate up to $27 per day	80% of the Allowable Charge up to $27 per day
DENTAL		Benefits are insured by DeltaCare USA (HMO) and by MetLife (PPO) for a separate premium paid by the Participant. • HMO: Covered benefits depend on the option chosen. • PPO: Preventive, basic restorative, and orthodontia services are covered at 100%. Major restorative services are covered at 90%. A $1,800 per patient benefit maximum applies each calendar year. Orthodontia has a lifetime benefit maximum of $1,800 per patient.	
DIALYSIS (Renal)	**Performed in a Physician's Office**	80% of the BSC PPO Network Rate	80% of the Allowable Charge
	Performed in a Hospital or Facility	80% of the BSC PPO Network Rate	80% of the Allowable Charge up to $200 per visit for all Hospital or facility services

SUMMARY OF PLAN BENEFITS

Benefit details are listed in alphabetical order in Section 8 beginning on page 25.

TYPE OF SERVICE		BLUE SHIELD OF CALIFORNIA (BSC) PPO NETWORK PROVIDER Plan Pays:	OUT-OF-NETWORK PROVIDER Plan Pays:
DURABLE MEDICAL EQUIPMENT Replacement or repair is allowed once every 36-months, except for orthotics have a lifetime maximum benefit.		Benefits are paid on a rental-to-purchase basis based on the Patient's monthly eligibility.	
		80% of the BSC PPO Network Rate	80% of the Allowable Charge
GENETIC TESTING		80% of the BSC PPO Network Rate	80% of the Allowable Charge
HEARING AID Replacement or repair is allowed once every 36 months, with a separate $50 deductible per device.		80% of the BSC PPO Network Rate up to $800 per device	80% of the Allowable Charge up to $800 per device
HOME HEALTH NURSING Not to exceed 120 visits per Calendar Year (combined with Skilled Nursing Facility days)		80% of the BSC PPO Network Rate	80% of the Allowable Charge up to $60 per visit
HOME INTRAVENOUS (IV) THERAPY		85% of the BSC PPO Network Rate	85% of the Allowable Charge
HOSPICE CARE PROGRAM In a Hospice Facility or at home		80% of the BSC PPO Network Rate	80% of the Allowable Charge
HOSPITAL	**Hospital Inpatient or Hospital Outpatient**	85% of the BSC PPO Network Rate	80% of the Allowable Charge up to $1,080 per day
	Emergency Services		80% of the Allowable Charge up to a maximum amount that is reasonable as determined by the Plan using independent third-party pricing sources
IMMUNIZATIONS		80% of the BSC PPO Network Rate	80% of the Allowable Charge
LABORATORY	**Performed in an Outpatient Laboratory Facility or Physician's Office**	80% of the BSC PPO Network Rate	80% of the Allowable Charge
	Performed in a Hospital or Facility	85% of the BSC PPO Network Rate	80% of the Allowable Charge up to $1,080 per day for all Hospital or facility charges

SUMMARY OF PLAN BENEFITS

Benefit details are listed in alphabetical order in Section 8 beginning on page 25.

TYPE OF SERVICE		BLUE SHIELD OF CALIFORNIA (BSC) PPO NETWORK PROVIDER Plan Pays:	OUT-OF-NETWORK PROVIDER Plan Pays:
MEDICAL SUPPLIES		80% of the BSC PPO Network Rate	80% of the Allowable Charge
MENTAL HEALTH	**Adult Day Health Care Center (ADHC)**	85% of the BSC PPO Network Rate up to $27 per day	80% of the Allowable Charge up to $27 per day
	Hospital, Partial Hospitalization, or Residential Treatment Facility	85% of the BSC PPO Network Rate	80% of the Allowable Charge up to $1,080 per day
	Office	80% of the BSC PPO Network Rate	80% of the Allowable Charge
NON-PRESCRIPTION AND OVER-THE-COUNTER DRUGS		NOT COVERED (but may be reimbursable through your Active Plan Health Reimbursement Arrangement Allowance).	
NUTRITIONAL COUNSELING Not to exceed eight visits per Calendar Year.		80% of the BSC PPO Network Rate	80% of the Allowable Charge
OCCUPATIONAL THERAPY Prescription required; not to exceed $1,200 per Calendar Year (combined with the Physical Therapy benefit).	**Performed in an Occupational Therapist's Office**	80% of the BSC PPO Network Rate	80% of the Allowable Charge
	Performed in a Hospital or Facility	85% of the BSC PPO Network Rate	80% of the Allowable Charge up to $1,080 per day for all Hospital or facility charges
OPIOID DRUG TESTING Not to exceed once every three months.		80% of the BSC PPO Network Rate	80% of the Allowable Charge
PAIN MANAGEMENT Maximum of three injections per day. $10,000 Lifetime Maximum Benefit.		80% of the BSC PPO Network Rate for all services rendered in a Physician's office or surgical suite 85% of the BSC PPO Network Rate for all services rendered in a surgery center or Hospital	80% of the Allowable Charge for all services, not to exceed $1,080 for surgery center or Hospital fees
PHYSICAL EXAMINATION Once per Calendar Year.		80% of the BSC PPO Network Rate	80% of the Allowable Charge

SUMMARY OF PLAN BENEFITS

Benefit details are listed in alphabetical order in Section 8 beginning on page 25.

TYPE OF SERVICE		BLUE SHIELD OF CALIFORNIA (BSC) PPO NETWORK PROVIDER Plan Pays:	OUT-OF-NETWORK PROVIDER Plan Pays:
PHYSICAL THERAPY Prescription required; not to exceed $1,200 per Calendar Year (combined with the Occupational Therapy benefit).	**Performed in a Physical Therapist's Office**	80% of the BSC PPO Network Rate	80% of the Allowable Charge
	Performed in a Hospital or Facility	85% of the BSC PPO Network Rate	80% of the Allowable Charge up to $1,080 per day for all Hospital or facility charges
PHYSICIAN		80% of the BSC PPO Network Rate	80% of the Allowable Charge
PRESCRIPTION DRUGS Benefits per Calendar Year.		• $50 Prescription Drug Deductible per person • Prescription Drugs are reimbursable at 100% up to $1,200 per person per Calendar Year • See also Specialty Medications below.	
RADIATION THERAPY	**Performed in a Physician's Office**	80% of the BSC PPO Network Rate	80% of the Allowable Charge
	Performed in a Hospital or Facility	85% of the BSC PPO Network Rate	80% of the Allowable Charge, up to a maximum of $1,080 per day for all Hospital of facility charges
RADIOLOGY X-rays, CAT/PET/MRI scans, etc.	**Performed in an outpatient Radiology Facility or Physician's Office**	80% of the BSC PPO Network Rate	80% of the Allowable Charge
	Performed in a Hospital	85% of the BSC PPO Network Rate	80% of the Allowable Charge, up to $1,080 per day for all Hospital or facility charges
SKILLED NURSING FACILITY Up to 120 days per Calendar Year (combined with Home Health Nursing visits).		85% of the BSC PPO Network Rate	80% of the Allowable Charge, up to $1,080 per day
SLEEP STUDY	**Physician**	80% of the BSC PPO Network Rate	80% of the Allowable Charge
	Hospital	85% of the BSC PPO Network Rate	80% of the Allowable Charge, up to $1,080 per day

SUMMARY OF PLAN BENEFITS

Benefit details are listed in alphabetical order in Section 8 beginning on page 25.

TYPE OF SERVICE		BLUE SHIELD OF CALIFORNIA (BSC) PPO NETWORK PROVIDER Plan Pays:	OUT-OF-NETWORK PROVIDER Plan Pays:
SPECIALTY MEDICATION Specialty Medications are Prescription Drugs that: • Require special handling • Require special administration/monitoring • Treat complex conditions • Cost $1,000 (average wholesale price) or more for a 30-day supply.		80% of the BSC PPO Network Rate	80% of the Allowable Charge, or 80% of the cost of the medication, whichever is less (The Allowable Charge is based on the average wholesale price)
SPEECH THERAPY Prescription required.	**Performed in a Speech Therapist's Office**	80% of the BSC PPO Network Rate	80% of the Allowable Charge, up to $18 per visit
	Outpatient Hospital or Facility	85% of the BSC PPO Network Rate	80% of the Allowable Charge, up to $18 per visit
	Inpatient Hospital or Facility	85% of the BSC PPO Network Rate	80% of the Allowable Charge, up to $1,080 per day for all Hospital or facility charges
SUBSTANCE USE DISORDER	**Hospital, Partial Hospitalization, or Residential Treatment Facility**	80% of the BSC PPO Network Rate	80% of the Allowable Charge up to $1,080 per day
	Office	85% of the BSC PPO Network Rate	85% of the Allowable Charge
SURGERY	**Physician**	80% of the BSC PPO Network Rate	80% of the Allowable Charge
	Anesthesiologist	80% of the BSC PPO Network Rate	80% of the Allowable Charge
	Hospital	85% of the BSC PPO Network Rate	80% of the Allowable Charge up to $1,080 per day
TRANSPLANTS Up to $100,000 per covered organ, except as otherwise described within the Transplants medical benefits section.	**Up to $100,000**		
	Professional	80% of the BSC PPO Network Rate	80% of the Allowable Charge
	Hospital or Facility	85% of the BSC PPO Network Rate	80% of the Allowable Charge up to $1,080 per day for all Hospital or facility charges

SUMMARY OF PLAN BENEFITS

Benefit details are listed in alphabetical order in Section 8 beginning on page 25.

TYPE OF SERVICE	BLUE SHIELD OF CALIFORNIA (BSC) PPO NETWORK PROVIDER Plan Pays:	OUT-OF-NETWORK PROVIDER Plan Pays:
VISION A deductible does not apply to this benefit.	VSP insures benefits for an additional premium paid by the Participant. Frames are covered once every 24 months. Lenses are covered every 12 months. Exams are covered every 12 months for a $20 Copayment.	
VISION – AFTER CATARACT SURGERY	$100 per eye for corrective glasses, contact lenses, or corrective intraocular lenses (IOLs)	

SECTION 3. ENROLLMENT

This Section applies to Pensioners and their Eligible Dependents. Survivors of Pensioners and Survivors of Active Plan participants should refer to Section 5, page 13.

A) Enrolling an Eligible Dependent

You must complete an Enrollment Form, including your signature, and provide any required documents, to add an Eligible Dependent. Once enrolled, you will receive new plan identification cards that include your Eligible Dependents.

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

You may obtain an Enrollment Form from any local Union office, the Fund Office, or the Fund Office website at www.scptac.org.

B) Dis-enrolling a Dependent

You must complete a Disenrollment Form, including all required signatures, and provide any required document, to dis-enroll a dependent. Forms received by the 15th of the month will be effective the first of the following month.

Once dis-enrolled, you may re-enroll your Eligible Dependent at a later date if:

i) You remain enrolled in the Plan;
ii) Your Eligible Dependent maintains Continuous Comparable Coverage during the period your Eligible Dependent is dis-enrolled in the Plan; and
iii) Proof of Continuous Comparable Coverage is submitted to the Plan.

Note that your Eligible Dependent must be enrolled in the Plan within 60 days of losing coverage under the other plan.

You may obtain a Disenrollment Form from any local Union office, the Fund Office, or the Fund Office website at www.scptac.org.

C) Required Documents

To add or remove an Eligible Dependent, you must provide the Fund Office with appropriate documentation, such as:

i) A certified copy of the marriage certificate; or
ii) An original, filed, domestic partnership registration; or
iii) A copy of the death certificate; or
iv) A copy of the final divorce decree; or
v) A copy of the dissolution of a domestic partnership; or
vi) Proof of Continuous Comparable Coverage.

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.

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

i) Marriage or Domestic Partnership Documents

You must submit a new Enrollment Form with the appropriate documentation listed above within 90 days of your marriage or domestic partnership registration. If the Enrollment Form and the required documents are not received within 90 days of the date of marriage or domestic partnership, your Spouse/Domestic Partner will never be eligible for coverage under the Plan unless Continuous Comparable Coverage is maintained (see next paragraph). You must notify the Fund Office immediately if there is a delay in obtaining a copy of the certified marriage certificate or the domestic partnership registration.

The 90-day enrollment deadline may be waived if the Fund Office is provided with (1) proof of the Spouse's/Domestic Partner's Continuous Comparable Coverage from the date of marriage/domestic partnership and (2) a completed Pensioners & Surviving Spouses Health Plan Enrollment Form, both within 60 days of losing Continuous Comparable Coverage.

The Spouse/Domestic Partner will not be permitted to enroll in the Plan if the Pensioner is not enrolled.

NOTE	Survivors of Pensioners and Survivors of Active Plan Participants must provide copies of marriage certificates or domestic partnership documents when they remarry or enter into a new domestic partnership because coverage ends in that event.

ii) Death Certificates

The Fund Office should be notified within 60 days of the death of a Participant to preserve a Survivor's right to COBRA or Survivor Premium Program coverage. A copy of the death certificate should be provided to the Fund Office as soon as it is available. If a death certificate is not provided within 12 months of the date of death, any applicable premium adjustment will be prospective only, not retroactive to the date of death.

iii) Divorce or Dissolution Documents

You must submit a copy of any final divorce decree or domestic partnership dissolution to the Fund Office as soon as it is available. You and/or your former Spouse/Domestic Partner will be required to repay to the Fund any benefits paid on behalf of a former Spouse/Domestic Partner after the date of divorce or dissolution.

E) Change of Address Form

If you want to change your address, you may obtain a Change of Address form from any local Union office, the Fund Office, or the Fund Office website at www.scptac.org. The Form must be filled out completely and returned to the Fund Office.

IMPORTANT	If there is a change in status of an Eligible Dependent (such as domestic partnership, marriage, divorce, dissolution of domestic partnership, or death), or a change of address, please notify the Fund Office as soon as possible, but no later than 90 days after the change.

SECTION 4. ELIGIBILITY

This Section applies to Pensioners and their Eligible Dependents. Survivors of Pensioners and Survivors of Active Plan participants should refer to Section 5, page 13.

A) When a Pensioner May Elect Coverage

You may elect coverage under the Plan if you meet ALL of the following criteria:

i) Option 1 – for Individuals who have Sufficient Retirement Fund Pension Credits

a) You are receiving a monthly pension from the Southern California Pipe Trades Retirement Fund based on 12 or more years of Pension Credit; and
b) You have been eligible for benefits under the Active Plan as a Participant for at least one month during the 24 months before your Annuity Starting Date; and
c) You have been eligible for benefits under the Active Plan as a Participant for at least 60 of the 120 months preceding your Annuity Starting Date; and
d) You elect coverage at the time of initial retirement; and
e) You pay the applicable monthly Premium timely; and
f) You timely file a fully completed Enrollment Form.

ii) Option 2 – for Individuals who have Sufficient Health & Welfare Fund (Active Plan) Eligibility Months

a) You fail to qualify under Option 1 above; and
b) You have retired and ceased all employment or activity of any kind, direct or indirect in any capacity, with any Employer that contributes to this Plan or that is signed to a collective bargaining agreement or participation agreement requiring contributions to this Plan. Also, you must not be engaged in "disqualifying employment" as defined by the Southern California Pipe Trades Retirement Fund (see Appendix 1, page 62; Section 4(E)(iv), page 12); and
c) You meet one of the following requirements:
   1) You have been eligible for benefits under the Active Plan as a Participant for at least 300 months before your retirement date; or
   2) You are at least age 55 as of your retirement date and have been eligible for benefits under the Active Plan as a Participant for at least 144 months before your retirement date; or
   3) You are an Active Plan Participant at the time you are deemed disabled by the Social Security Administration or 100% disabled by the U.S. Department of Veterans Affairs, and have been eligible for benefits under the Active Plan as a Participant for at least 144 months before your retirement date; and
d) You have been eligible for benefits under the Active Plan as a Participant for at least one month during the 24 months before your retirement date; and
e) You have been eligible for benefits under the Active Plan as a Participant for at least 60 of the 120 months preceding your retirement date; and
f) Your Employer contributed to coverage offered by the Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund for the same months as Active coverage; and
g) You elect coverage at the time of initial retirement; and
h) You pay the applicable monthly Premium timely; and
i) You timely file a fully completed Enrollment Form.

NOTE	**If you are eligible to participate in the Pensioners and Surviving Spouses Health Fund but initially elect COBRA Continuation Coverage under the Active Plan, you may not subsequently elect or receive coverage under the Pensioners and Surviving Spouses Plan. Similarly, if you initially elect coverage under the Pensioners and Surviving Spouses Plan, you may not subsequently elect or receive COBRA coverage under the Active Plan.**

B) When Coverage Begins

Coverage generally begins on the later of:

i) Under Option 1 above:
   a) The first day of the month for which you receive a monthly pension benefit from the Southern California Pipe Trades Retirement Fund; or
   b) The first day of the month in which you lose eligibility under the Active Plan.

ii) Under Option 2 above:
   a) The first day of the month after which you have retired; or
   b) The first day of the month in which you lose eligibility under the Active Plan.

C) Continuing Eligibility

You must pay monthly Premiums set by the Board of Trustees. Most Participants fulfill this self-pay obligation by electing to have the Premium amount deducted from their monthly pension benefit. You may also have your monthly Premium deducted from your checking or savings account electronically.

If you do not elect to have the applicable Premium paid automatically, you must personally make payments directly to the Fund to retain coverage under the Plan.

Premiums are due by the 20th of the month before the month of coverage. 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. If you do not pay by these deadlines, you will lose coverage and will not be permitted to reinstate coverage.

IMPORTANT	**If you fail to pay Premiums timely, you will permanently lose coverage under the Plan.**

D) Dependent Eligibility

i) Who is an Eligible Dependent?

Your lawful Spouse or Domestic Partner is the only Eligible Dependent under this Plan. Your Spouse or Domestic Partner cannot be enrolled in the Plan unless you are enrolled in the Plan.

Other relatives, including children, stepchildren, grandchildren, or persons for whom you are responsible due to guardianship, will not be covered even though you may be financially responsible for them.

ii) Dual Coverage

If a person has dual coverage under the Plan as both a Participant and an Eligible Dependent, then the Plan will apply coordination of benefit rules. (See Section 14, page 43.)

iii) When Eligible Dependent Coverage Starts

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

a) The date you become eligible for coverage under the Plan; or
b) The date an individual becomes your Eligible Dependent, so long as the individual is enrolled in the Plan within 90 days of the date of marriage or Domestic Partnership.
c) Within 60 days of losing Continuous Comparable Coverage if your Eligible Dependent was not enrolled at the later of the following dates: the same time you enrolled or when they became your Eligible Dependent.

E) Termination of Eligibility and Re-Enrollment

i) When Pensioner's Coverage Terminates

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

a) The first day of the month following 30 days from the date the Fund Office receives your written request to terminate coverage; or
b) The date you start performing work in the plumbing, heating, and piping industry which is not pursuant to a recognized Collective Bargaining Agreement; or
c) The first day of the month in which your monthly pension benefit from the Southern California Pipe Trades Retirement Fund stops; or
d) The date you return to work for a Contributing Employer in any capacity; or
e) Whenever a Premium is not received timely. In this case, you will be barred from establishing eligibility at a later date; or
f) The date the Plan terminates.

In some cases, you may be permitted to re-enroll in the Plan. See Section 4(E)(v) below.

ii) When Eligible Dependent Coverage Terminates

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

a) The date your eligibility ends; or
b) The date your Eligible Dependent no longer qualifies as an Eligible Dependent (e.g., upon divorce); or
c) The date your Eligible Dependent is dis-enrolled upon application by you; or
d) The date of death of your Eligible Dependent; or
e) Whenever a Premium is not received timely; or
f) The date the Plan terminates.

In some cases, you may be permitted to re-enroll in the Plan. See Section 4(E)(v) below.

iii) When Survivor Coverage Terminates

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

a) The date your Survivor remarries or enters into a domestic partnership (all benefits paid after the date of remarriage or domestic partnership must be reimbursed to the Fund, and legal action may be taken to recover such benefits); or
b) Whenever a Premium is not received timely; or
c) The date the Plan terminates.

iv) Returning to Work for a Contributing Employer

If you are retired and return to work for a Contributing Employer, you must advise the Fund Office of such employment before your employment starts. Your coverage under the Plan will be terminated, including your obligation to pay a Premium to the Plan, effective on the date you return to work for a Contributing Employer as follows:

a) Return to Work Under the Waiver Program

If you return to work covered under the Southern California Pipe Trades Retirement Fund Temporary Waiver Program (see Appendix 1), you lose coverage under this Plan but may continue coverage under the Active Plan by paying the same Premium amount you would be required to pay under this Plan.

b) Return to Work that would Result in Suspension of Pension Benefit

If you return to Covered Employment that results in the suspension of your Southern California Pipe Trades Retirement Fund pension benefit (see Appendix 1), you lose coverage under this Plan but may continue coverage under the Active Plan by paying the full COBRA rate to the Active Plan until you become eligible under the Active Plan based on contributions made to the Active Plan by your Employer for hours worked. If you do not qualify for a Retirement Fund pension benefit, the rules above apply as if you qualified for that benefit.

c) Return to Work at Age 65

If you are age 65 to age 70½ and you return to Covered Employment for 39 or fewer hours in a month (see Appendix 1), you will lose coverage under this Plan but may continue coverage under the Active Plan by paying the same Premium amount you would be required to pay under this Plan for the entire period of your Covered Employment.

d) Return to Work at Age 70½

If you are age 70½ or older and you return to Covered Employment, you lose coverage under this Plan but may continue coverage under the Active Plan by paying the same Premium amount you would be required to pay under this Plan until you become eligible under the Active Plan based on contributions made to the Active Plan by your Employer for hours worked.

e) Return to Work in a Non-Bargaining Unit Position

If you return to work in non-Covered Employment (a position not in a bargaining unit covered under a Collective Bargaining Agreement, e.g., an estimator, detailer, management, or corporate officer), you will lose coverage under this Plan for the length of your non-Covered Employment.

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

If you return to work as an instructor for the Southern California Pipe Trades Apprentice and Journeyman Training Trust Fund, you will lose coverage under this Plan. However, you may continue coverage under the Active Plan by paying the same Premium amount you would be required to pay under this Plan.

In some cases, you may be permitted to re-enroll in the Plan. See Section 4(E)(v)(b) below.

v) Re-enrollment

a) Re-enrollment after Request for Termination

If you were previously enrolled in this Plan and you decided to dis-enroll as described in Section 4(E)(i)(a), you and your Eligible Dependent, if any, may be permitted to re-enroll in the Plan if you submit a written request and provide satisfactory evidence of Continuous Comparable Coverage. If your request for re-enrollment and proof of Continuous Comparable Coverage are received by the 15th of the month, re-enrollment will be effective on the first of the following month.

b) Re-enrollment after End of Employment

If you were previously enrolled in this Plan and returned to work in the plumbing, heating, and piping industry which is not pursuant to a recognized Collective Bargaining Agreement as described in Section 4(E)(i)(b) but which would not

result in the suspension of a Retirement Fund benefit (see Appendix 1), you may re-enroll in this Plan when you cease employment, so long as you continue to satisfy all other eligibility requirements to participate in the Pensioners Health Plan, and you notify the Fund Office of the end of your employment and of your intent to re-enroll within 90 days after the end of employment. If you elect not to re-enroll in this Plan or fail to timely pay the applicable Premium, you will be barred from establishing eligibility at a later date.

If you were previously enrolled in this Plan and (1) returned to work in the plumbing, heating, and piping industry which is not pursuant to a recognized Collective Bargaining Agreement as described in Section 4(E)(i)(b) and (2) such employment resulted, or would have resulted in, the suspension of your Retirement benefits as described in Section 4(E)(i)(c) (see Appendix 1), you may re-enroll in this Plan, so long as you continue to satisfy all other eligibility requirements to participate in the Pensioners Health Plan and only after you have either (a) 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 you worked at least one hour in non-Covered Employment, or (b) worked enough hours in Covered Employment to earn at least three months of Active coverage in the Southern California Pipe Trades Health & Welfare Fund for each calendar quarter in which you worked at least one hour in non-Covered Employment. If you meet this condition, you must elect coverage at the time of reinstatement under the Southern California Pipe Trades Retirement Plan or, if you are not eligible for that benefit, within 90 days after the end of your covered employment. If you elect not to re-enroll in this Plan or fail to timely pay the applicable Premium, you will be barred from establishing eligibility at a later date.

If you were previously enrolled in this Plan and you returned to work for a Contributing Employer as described in Section 4(E)(i)(d) and 4(E)(iv), you may re-enroll in this Plan when you cease employment, and upon the exhaustion of any Eligibility Bank in the Southern California Pipe Trades Health & Welfare Fund (if applicable), and further upon the end of your suspension of benefits from the Southern California Pipe Trades Retirement Fund (if applicable), so long as you continue to satisfy all other eligibility requirements to participate in the Pensioners Health Plan, and you notify the Fund Office of the end of your employment and of your intent to re-enroll within 90 days after the end of employment. If you elect not to re-enroll in this Plan or fail to timely pay the applicable Premium, you will be barred from establishing eligibility at a later date.

SECTION 5. EXTENDING ELIGIBILITY

You may be able to extend coverage as follows:

- You may be eligible to pay for COBRA continuation coverage if you experience a Qualifying Event.
- A Surviving Spouse or Surviving Domestic Partner may be eligible for a Special Extension Period of up to 3 months.
- A Surviving Spouse or Surviving Domestic Partner may enroll in the Survivor Premium Program.
- If you are Totally Disabled, medical expenses for that disability may be covered for the first three months after your loss of coverage.

The conditions you must satisfy to qualify for these options are described below. The applications and election forms for these options will be sent to you if the Fund Office knows you are eligible for any of these options.

A) COBRA Continuation Coverage

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

a) Introduction

Federal law (COBRA) requires that most retiree group health plans (including this Plan) offer eligible Spouses who lose coverage due to divorce from, or the death of, the Pensioner 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, an eligible Spouse must pay timely monthly COBRA Premiums directly to the Fund. COBRA coverage is not available to a Domestic Partner.

Before deciding to purchase COBRA, an eligible Spouse should review the costs and benefits available through the Covered California marketplace. By enrolling in coverage through the marketplace, an eligible Spouse may qualify for lower costs on their monthly premiums and lower out-of-pocket costs. Additionally, an eligible Spouse may qualify for a 30-day special enrollment period in another employer-provided group health plan for which they are eligible, even if that plan generally doesn't accept late enrollees. COBRA coverage is not available to a Domestic Partner.

b) Rights of Eligible 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.

Because Spouses are generally eligible to pay a reduced rate for coverage under the Survivor Premium Program, it rarely makes sense for a Spouse to elect COBRA coverage.

ii) How Long will Continuation Coverage Last?

COBRA Continuation Coverage for an eligible Spouse may be continued for up to 36 months after the date of divorce or the date of the Pensioner's death.

COBRA Continuation Coverage will end before the 36-month continuation coverage period expires if the eligible Spouse:

a) Fails to pay the required Premium on time; or
b) Becomes covered by another group health Plan (except a Plan that excludes or limits benefits for a pre-existing condition affecting the eligible Spouse, and such exclusion or limitation is enforceable under Health Insurance Portability and Accountability Act (HIPAA)); or
c) Becomes entitled to Medicare.

COBRA Continuation Coverage will also end early if such coverage is no longer available under this Plan because the Plan terminates.

iii) Duty to Notify the Fund

a) Divorce or Dissolution of Domestic Partnership

Coverage for a Spouse or Domestic Partner ends on the date of divorce or dissolution of a domestic partnership. You must provide written notice of the divorce or dissolution and a copy of the final divorce/dissolution documents to the Fund Office as soon as possible but no later than 60 days after the divorce/dissolution is final.

If the required notice is not provided within the time allowed, COBRA self-payment will not be permitted, and any applicable Premium adjustment will be prospective only, not retroactive to the event date. Note that COBRA coverage is not available to a Domestic Partner.

The Pensioner and/or Spouse/Domestic Partner will be required to refund any monies paid by the Fund after the date of divorce or dissolution of domestic partnership. If the Fund Office determines a refund is due, it will be offset against overpaid claims.

No refunds will be made for partial months of coverage.

b) Death

The Fund Office should be notified within 60 days in the event of the death of any person covered by the Plan. If the Fund Office is not notified, COBRA and other benefits may not be offered.

If a death certificate is not provided within 12 months of the date of death, any applicable Premium adjustment will be prospective only, not retroactive to the date of death.

No refunds will be made for partial months of coverage.

iv) How Is Continuation Coverage Elected?

To elect continuation coverage, you must complete the election form and return it according to the directions on the form.

v) How Much Does Continuation Coverage Cost?

The amount you can be required to pay for COBRA Continuation Coverage may not exceed 102% of the cost to the group health plan for coverage of a similarly situated person who is not receiving continuation coverage. The required payment for continuation coverage is described in the notices you will receive when you qualify for COBRA coverage.

vi) When and How Payment Must be Made for Continuation Coverage?

a) Your First Payment

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

However, you must make your first payment for continuation coverage no later than 60 days from the date of your timely election. To avoid delays in confirming eligibility and paying claims, the Fund Office should receive your first payment no later than the 20th day of the month before the month of coverage. Your first payment must cover the number of months from the date coverage would otherwise have terminated through the month in which you make your first payment. There can be no gap between your regular eligibility and your COBRA eligibility. If you do not make your payment for continuation coverage in full within 60 days after the date of your timely election, you will lose all continuation coverage rights under the Plan.

You are responsible for ensuring the amount of your first payment is enough to cover this entire period. Coverage will not be confirmed until payment is received.

b) Periodic Payments for Continuation Coverage

After making your first payment for continuation coverage, you must pay for continuation coverage each subsequent month. Under the Plan, these periodic payments are due by the 20th day of the month preceding each month of coverage.

The Plan may send periodic notices of payments due for those coverage periods, but you are responsible for making the payments timely whether or not you receive the notices.

c) Grace Period for Periodic Payments

Although periodic payments are due on the dates shown above, you will be given a grace period until the end of the month of the coverage month or 30 days, whichever is greater, to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. Coverage will not be confirmed until payment is received. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

d) Form of Payment

All payments must be made by check, cashier's check, money order, electronic debit (ACH), or via reimbursement from your Active Plan Health Reimbursement Arrangement Allowance. Neither cash nor credit cards are accepted for COBRA payments.

e) Payments

Payments for continuation coverage should be sent to:

Southern California Pipe Trades Administrative Corporation
Attention: Eligibility Department
501 Shatto Place, Suite 500
Los Angeles, CA 90020

vii) Are there other coverage options besides COBRA Continuation Coverage?

Yes. In the event of the Participant's death, a special extension period is available for Survivors. This Special Extension Period for Survivors is described in detail in paragraph B). In addition, as discussed above, other coverage options may also be available through the Covered California marketplace. You can learn more about this option at www.coveredca.com.

viii) 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. For more information about the marketplace, visit www.healthcare.gov or www.coveredca.com.

B) Special Extension Period for Survivors

In the event of the Participant's death, coverage for the Survivor, if any, may be provided under this Plan at no cost for up to three months. This is called the Special Extension Period.

i) Survivors of Participants in this Plan

Special Extension Period coverage for the Survivor of a Pensioner will be provided under this Plan, at no cost, for three months following the month in which the Pensioner died.

ii) Survivors of Participants in the Active Plan

Special Extension Period coverage for the Survivor of an Active Participant in the Active Plan is available under this Plan if, at the time of the Active Participant's death, the number of months in the Active Participant's Eligibility Bank is less than three. The length of the Special Extension Period is the number of months necessary, combined with the months remaining in the

Active Participant's Eligibility Bank, to give the Survivor coverage for three months following the month in which the Active Participant died.

C) Survivor Premium Program

Two types of Survivors can qualify for the Survivor Premium Program and choose to continue coverage under this Plan.

i) Survivor of a Deceased Pensioner

a) Surviving Spouse

As of the end of the Special Extension Period, a surviving Spouse may choose to continue coverage either in this Plan through COBRA or through the Survivor Premium Program. If the surviving Spouse elects COBRA, they will not be eligible to enroll in this Plan. COBRA is rarely the better option.

b) Surviving Domestic Partner

As of the end of the Special Extension Period, a surviving Domestic Partner may choose to continue coverage in this Plan through the Survivor Premium Program. (A Domestic Partner is not a Qualified Beneficiary under COBRA and therefore cannot elect COBRA coverage in the Active Plan.)

ii) Survivor of a Deceased Active Participant

These benefits are available to a Survivor who was covered in the Active Plan on the Active Participant's date of death.

a) Surviving Spouse

As of the end of the Special Extension Period, a surviving Spouse may choose to continue coverage either in the Active Plan through COBRA or through the Survivor Premium Program. If the surviving Spouse elects COBRA, they will not be eligible to enroll in this Plan.

b) Surviving Domestic Partner

As of the end of the Special Extension Period, a surviving Domestic Partner may choose to continue coverage in this Plan through the Survivor Premium Program. (A Domestic Partner is not a Qualified Beneficiary under COBRA and therefore cannot elect COBRA coverage in the Active Plan.)

The Fund Office will provide the eligible Survivor with the Application for the Survivor Premium Program if it has been timely notified of the death. For additional information regarding this category of Survivors, see the SPD for the Active Plan.

iii) Application & Payment

a) Application and Initial Payment Deadlines

If the Fund Office is made aware timely that the Pensioner or Active Participant has died, a COBRA election form and/or a Survivor Premium Program application will be mailed to the Survivor. The complete COBRA election form (if applicable) or Survivor Premium Program application must be returned to the Fund Office within 60 days of the notice.

(A Domestic Partner is not a Qualified Beneficiary under COBRA and therefore cannot elect COBRA coverage but may participate in the Survivor Premium Program.)

Once the Survivor has made the appropriate election, they have 60 days from the loss of coverage, including the Special Extension Period, to pay the Premium due retroactive to the loss of coverage.

b) Payment Amount

At the time of publication, the Survivor Premium was $108 per month. The Trustees may change the amount from time to time.

c) Timely Premiums

Subsequent Premiums are due by the 20th of the month before the month of coverage. 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 Survivor who does not pay within these deadlines will lose coverage and will not be permitted to reinstate coverage.

You may elect to have the Premium amount deducted from your monthly pension check, if any. You may also have your monthly Premium deducted from your checking or savings account electronically. If you do not elect to have the applicable Premium paid automatically, you must make payments directly to the Fund to retain coverage under the Plan, via check, cashier's check, one-time electronic debit (ACH), money order, or via reimbursement from your Active Plan Health Reimbursement Arrangement Allowance. Neither cash nor credit cards are accepted.

IMPORTANT	**Premiums are due by the 20th of the month before the month of coverage. 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.**

d) Termination of Survivor Coverage

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

1) The date you remarry or enter into a domestic partnership. All benefits paid after the date of remarriage or domestic partnership must be reimbursed to the Fund. Legal action may be taken to recover such benefits; or
2) Whenever a Premium is not received timely; or
3) The date the Plan terminates.

NOTE	**If you fail to pay Premiums timely, you will permanently lose coverage under the Plan.**

NOTE	**If you are eligible to participate in the Pensioners and Surviving Spouses Health Fund but initially elect COBRA Continuation Coverage under the Active Plan, you cannot subsequently elect or receive coverage under the Pensioners and Surviving Spouses Plan. Similarly, if you initially elect coverage under the Pensioners and Surviving Spouses Plan, you cannot subsequently elect or receive COBRA coverage under the Active Plan.**

D) Extended Coverage in Case of Total Disability

If your eligibility, or your Eligible Dependent's eligibility, terminates while you or they are Totally Disabled, medical expense benefits will be available, for that disabling condition only, for three months after the loss of eligibility. This extension is for the disabled individual only. The extension must be requested in writing, and a statement from the attending Physician is required. This benefit is not included in COBRA coverage.

EXAMPLE	**You are Totally Disabled due to a stroke, eligibility terminates, and you receive treatment for a broken leg. No benefit is payable for your broken leg because it is unrelated to the disabling condition of the stroke.**

SECTION 6. MONTHLY PREMIUM

A) Premium Classifications and Range Classes

Your monthly Premium amount is determined by the classifications and range classes described below.

i) Premium Classifications

Participants are grouped into the following categories based on Medicare eligibility, marital or Domestic Partnership status, and the Eligible Dependent's Medicare eligibility. An individual's classification will be evaluated each month.

Classification	Definition
MM	**M**ember (Pensioner) is **M**edicare-eligible; no Eligible Dependent is covered under the Plan
MMSM	**M**ember (Pensioner) is **M**edicare-eligible; covered Eligible Dependent is **M**edicare eligible
MMSN	**M**ember (Pensioner) is **M**edicare-eligible; covered Eligible Dependent is **N**ot Medicare-eligible
MN	**M**ember (Pensioner) is **N**ot Medicare-eligible; no Eligible Dependent is covered under the Plan
MNSM	**M**ember (Pensioner) is **N**ot Medicare-eligible; covered Eligible Dependent is **M**edicare-eligible
MNSN	**M**ember (Pensioner) is **N**ot Medicare-eligible; covered Eligible Dependent is **N**ot Medicare-eligible

ii) Premium Score and Range Class

You are given a score under a combination point system called the "Rule of 100".

a) If you qualified under Option 1 in Section 4(A)

Your "Rule of 100" score is determined at the time of your initial retirement under the Southern California Pipe Trades Retirement Plan and is based on your age plus the number of Pension Credits you have accrued under the Retirement Plan at the time of your initial retirement. For example, if you retire at age 65 with 35 Pension Credits, you will have a score of 100. If you retire at age 60 with 25 Pension Credits, you will have a score of 85.

If you receive a disability pension at the time of your initial retirement, then, in determining your score, it will be assumed that you are age 65.

If you retire under a non-disability pension and later you are eligible to convert, and do convert, to a disability pension under the Retirement Plan, your premium score will be recalculated to assume that you were age 65 when you retired. Your recalculated score will be used to calculate the Premium you owe as of the first month following the date the Fund Office receives both your notice of entitlement to Social Security Disability Benefits, or to 100% disability from the U.S. Department of Veterans Affairs, and your election to convert your pension.

b) If you qualified under Option 2 in Section 4(A)

Your "Rule of 100" score is determined at the time of your initial retirement and is based upon your age plus the number of months you were covered under the Southern California Pipe Trades Health & Welfare Fund (Active Plan) divided by 12. For example, if you retire at age 65 with 420 months of Active Plan coverage, you will have a score of 100. If you retire at age 60 with 300 months of Active Plan coverage, you will have a score of 85.

If, at the time of your initial retirement, the Social Security Administration or the U.S. Department of Veterans Affairs has determined that you are disabled, then, in determining your score, it will be assumed that you are age 65.

If the Social Security Administration or the U.S. Department of Veterans Affairs has not made a disability determination at the time of your initial retirement but later makes such a determination and your "disability entitlement date" is on or before your initial retirement date, then your premium score will be recalculated to assume that you were age 65 when you retired. Your recalculated score will be used to calculate the Premium you owe as of the first month following the date the Fund Office receives your notice of entitlement to Social Security or VA Disability benefits.

In either case (Option 1 or Option 2), your premium score will be reduced by four points for every year (or portion of a year), after you first worked in the plumbing and pipefitting industry, for an Employer that is not signed to a United Association master labor agreement (non-Covered Employment). Years before you become a third year apprentice will not count for this purpose. However, if you return to work in Covered Employment, you can regain one point for every two points earned as a result of such work. This means that -in addition to earning one new point for each Pension Credit earned (for Option 1) or 12 months of eligibility (for Option 2), you will also have one previously lost point restored for every two points you earn after returning to Covered Employment. Years before a permanent break in service under the Retirement Plan cannot be restored.

NOTE	**Your premium score will be determined once, at the time of your initial retirement, and generally will not be revised later, except as otherwise provided herein.**

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

Range Class	Score From	Score To
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) Premium Rates

i) Premium amounts are set such that, on average, Pensioners pay 50% of the cost of their coverage; active Members pay the rest.
ii) As of the publication date of this SPD, the monthly Premium for eligible Survivors is $108 per month.
iii) The following chart shows the monthly Premium amounts for Pensioners and their Survivors effective from January 1, 2025, through December 31, 2025. For example:
   a) If you are Medicare-eligible, but your Eligible Dependent is not Medicare-eligible (MMSN), and you retire at age 65 with 25 Pension Credits (Range Class "C"), your monthly Premium would be $463.
   b) If you are unmarried (MM) and retire at age 65 with 35 Pension Credits years of service (range class "A"), your monthly Premium would be $182.

Classification	Range Class						
	A	B	C	D	E	F	G
	100 +	95 - 99	90 - 94	85 - 89	80 – 84	75 - 79	< 75
MM	$182	$182	$182	$182	$209	$242	$280
MMSM	$182	$182	$220	$270	$338	$394	$453
MMSN	$256	$359	$463	$566	$707	$822	$950
MN	$459	$459	$459	$492	$613	$715	$826
MNSM	$459	$459	$463	$566	$707	$822	$950
MNSN	$459	$459	$537	$658	$822	$956	$1,106

C) Changes to or Refunds of Premiums

i) Changes to Premiums

Premium amounts are subject to change. For example:

a) Premiums may be changed at any time at the discretion of the Board of Trustees.
b) Premiums for Pensioners, Eligible Dependents, and Survivors are normally reviewed annually and adjusted to reflect changes in the cost of coverage.
c) When a Pensioner or Eligible Dependent turns 65, the Fund Office will assume they have become eligible for Medicare and will reduce the Premium accordingly. The reduced monthly Premium amount will be effective on the first of the month in which the Pensioner or Eligible Dependent becomes Medicare-eligible.
d) In the case of Medicare eligibility based on a Social Security or VA disability award rather than age, the Premium reduction will begin in the month following the month in which the Pensioner or Eligible Dependent receives written notice of an award of a Social Security or VA disability benefit or in the Social Security or VA disability entitlement month, whichever is later.

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

ii) Refunds of Premiums

In some cases, the Fund will apply a change in Premium retroactively and refund overpaid amounts. For a refund to be considered, you must timely advise the Fund Office of any change that may affect your Premium rate, such as:

a) Death of the Pensioner, Spouse, Domestic Partner, or Survivor;
b) Pensioner's divorce or dissolution of domestic partnership;
c) Pensioner's Spouse's or Domestic Partner's Medicare eligibility; or
d) Survivor's remarriage or new domestic partnership.

Note that:

a) The Fund Office should be notified of a Pensioner's death within 60 days to preserve a Survivor's right to COBRA or Survivor Premium Program coverage.
b) If a death certificate is not provided within 12 months of the date of death, any applicable Premium adjustment will be prospective only, not retroactive to the date of death.
c) If notice of divorce, dissolution of domestic partnership, remarriage, or new domestic partnership of a Survivor, or Medicare eligibility, is not provided within 60 days of the event, any applicable Premium adjustment will be prospective only, not retroactive to the date of the event.
d) If the Fund Office determines that a refund is due, it will be offset against any overpaid claims.
e) No refunds will be made for partial months of coverage.

D) Making a Premium Payment

As discussed in Section 4 on page 9, to keep coverage under the Pensioners and Surviving Spouses Plan, you must:

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

Premiums are due by the 20th of the month before the month of coverage. 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 coverage is due no later than June 20. If payment is not received by July 30th, your coverage will be permanently terminated.**

E) Coverage for Pensioners Eligible for a Retroactive Disability Benefit

a) If you qualified under Option 1 in Section 4(A)

If you (1) are awarded a retroactive disability pension under the Southern California Pipe Trades Retirement Fund, (2) you qualify for and elect coverage in this Plan, and (3) you provide proof of Continuous Comparable Coverage since your most recent month of eligibility in the Southern California Pipe Trades Health & Welfare Fund, you will be eligible under, and pay monthly premiums to, this Plan as of your Annuity Starting Date, and not your earlier "disability entitlement date".

b) If you qualified under Option 2 in Section 4(A)

If (1) the Social Security Administration or the U.S. Department of Veterans Affairs determines that you are disabled, (2) you qualify for and elect coverage in this Plan, and (3) you provide proof of Continuous Comparable Coverage since your most recent month of eligibility in the Active Plan, you will be eligible under, and pay monthly premiums to, this Plan as of the first month following the date the Fund Office receives your notice of entitlement to Social Security or VA benefits.

In either case (Option 1 or Option 2):

- Absent proof of Continuous Comparable Coverage, your eligibility under this Plan will be retroactive to your "disability entitlement date", and you must pay monthly Premiums for the entire retroactive eligibility period.
- Your "disability entitlement date", not your retirement date or Annuity Starting Date, is used to determine whether or not you meet the requirements to be eligible for coverage from the Plan.
- Your "disability entitlement date" is usually six months after your Social Security or VA "disability onset date", which is the date the Social Security Administration or the U.S. Department of Veterans Affairs determines that you first become disabled.
- If you are a disabled Pensioner and you pay for COBRA continuation coverage after your Active Plan Eligibility Bank runs out, any retroactive coverage from this Plan will start after the end of the COBRA coverage period.

See also Section 12(B), page 39.

SECTION 7. PLAN BASICS

A) Lifetime Maximum Benefit (LMB)

You and your Eligible Dependent or your Survivor each have an LMB of $2,000,000.

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

B) Out-of-Pocket Maximum

You and/or your Eligible Dependent(s) are responsible for Out-of-Pocket costs under the Plan, such as your Calendar Year Deductible and Coinsurance for Covered Services, up to an Out-of-Pocket Maximum. The Out-of-Pocket Maximum does not apply to amounts over the Allowable Charge.

The individual Out-of-Pocket Maximum will change annually.

The in-network Out-of-Pocket Maximum will be based on the out-of-pocket limits determined by the Department of Health and Human Services for the purposes of the Affordable Care Act. The out-of-network Out-of-Pocket Maximum is two times the in-network amount.

For claims incurred during the 2025 Calendar Year, the in-network individual Out-of-Pocket Maximum is $9,200, and the out-of-network individual Out-of-Pocket Maximum is $18,400.

For claims incurred during the 2026 Calendar Year, the in-network individual Out-of-Pocket Maximum is $10,600, and the out-of-network individual Out-of-Pocket Maximum is $21,200.

EXAMPLE	**You have surgery on July 1, 2025, in an in-network Hospital. The billed amount is $5,000, the Blue Shield of California PPO Network Rate is $4,000, and you are responsible for the 15% Coinsurance amount of $600.** • **The $600 Coinsurance that you pay applies toward your individual in-network Out-of-Pocket Maximum for 2025.**

EXAMPLE	**You have surgery on November 4, 2025, in an out-of-network surgery center. The billed amount is $5,000, the Allowable Charge is $1,350, and you are responsible for the 20% Coinsurance amount of $270 plus the amount over the Allowable Charge of $3,650 ($5,000 - $1,350).** • **The $270 Coinsurance that you pay applies toward your individual out-of-network Out-of-Pocket Maximum for 2025.** • **The $3,650 does not apply toward your Out-of-Pocket Maximum.**

EXAMPLE	**You buy a hearing aid from an in-network Durable Medical Equipment supplier on December 28, 2025. The billed amount is $1,700, the Blue Shield of California PPO Network Rate is $1,500, the Allowable Charge is $800, and there is a $50 Deductible. Because the Allowable Charge is less than the Blue Shield of California PPO Network Rate, you are responsible for the remaining $700 ($1,500 - $800) and the Deductible.** • **The $50 Deductible you must pay applies toward your individual, in-network Out-of-Pocket Maximum for 2025.** • **Because the Fund Allowable Charge is $800 per hearing aid, the $700 does not apply toward your Out-of-Pocket Maximum.**

C) Calendar Year Deductible

You and/or your Eligible Dependent are responsible for the first $250 in amounts otherwise payable by the Plan in a Calendar Year. This is called the Calendar Year Deductible. The Calendar Year Deductible applies separately to you and your Eligible Dependent.

Effective January 1, 2026, if you transition between this Plan and the Southern California Pipe Trades Health & Welfare Fund (Active Plan) within the same year you will only need to meet one Deductible per covered individual.

The Calendar Year Deductible does not apply to the following:

i) Hearing aid benefit – There is a separate $50 per device Deductible.
ii) Prescription Drug Benefit – There is a separate $50 Calendar Year Deductible for Prescription Drugs.
iii) Dental benefit – The MetLife PPO option has a separate $50 Deductible; the DeltaCare USA option has no Deductible.
iv) Vision benefit – There is no Deductible for vision services.

Non-covered charges do not count toward the Deductibles. Charges payable by the Plan, non-covered charges, or the portion of covered charges that the Patient must pay above the Blue Shield of California PPO Network Rate or Allowable Charge cannot be used to satisfy the Deductible.

D) Preferred Provider Organization (PPO) Network

The best value and lowest costs to you will generally be realized when you go to an in-network provider.

Blue Shield of California (BSC) is a non-profit organization that provides you with an expansive network of doctors, Hospitals, and other healthcare 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 healthcare services at a reasonable cost.

Blue Shield of California is a voluntary program. You may continue to choose any healthcare provider you wish. However, there is a financial advantage to you and the Plan if you choose health care providers from the Blue Shield of California PPO network.

When you seek medical care, select a provider from the Blue Shield of California PPO network to receive the maximum benefit under this Plan at the lowest cost to you. A list of Blue Shield of California PPO network providers can be found at www.blueshieldca.com or contact the Fund Office at (213) 385-6161 or (800) 595-7473.

Blue Shield of California, an independent member of the Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Obtaining services from a Blue Shield of California PPO network provider does not guarantee that the services will be covered. Services not covered by the Plan are excluded, regardless of where or by whom the services are provided.

IMPORTANT	**To verify that your healthcare provider is in the Blue Shield of California PPO network, go to www.blueshieldca.com or call the Fund Office at (213) 385-6161 or (800) 595-7473. When you make your appointment, and at the time of your appointment, confirm that your provider is participating in this network.**

IMPORTANT	**Many emergency room Physicians and anesthesiologists working in a Blue Shield of California PPO Hospital are not part of the Blue Shield of California PPO 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 any out-of-network service.**

IMPORTANT	**When seeking medical care, notify the provider's staff that benefits are provided through the Blue Shield of California PPO network. If you are referred to a specialist or a Hospital, or if laboratory work is needed, remind the doctor that Blue Shield of California PPO network providers, laboratories, and Hospitals are to be used. If you use Blue Shield of California PPO network providers, your Out-of-Pocket cost will be less than if an out-of-network provider is used. Using Blue Shield of California PPO network providers saves you and the Fund money.**

E) When Claims are Paid

Every effort will be made to pay a claim within a reasonable time after it has been submitted with all necessary information. The Plan rules described or referred to in this document control whether a claim will be paid, in whole or in part, or whether it will be denied. In addition, claims submitted more than 12 months after the date of service will be automatically denied except when the Plan is not the primary payer, the deadline for filing a claim is 12 months after the primary insurance has adjudicated the claim.

Because it becomes increasingly difficult over time to determine if a benefit payment has been cashed or negotiated and to establish certainty as to the benefits owed by the Fund, it is the Fund's policy not to:

i) Allow a check to be deposited or cashed more than 180 days after it was issued; or
ii) Reissue any benefit payment more than two years after it was first issued.

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

F) What the Plan Will Pay

After your Calendar Year Deductible is satisfied, the Plan will pay for any further Medically Necessary Covered Services based on either the Blue Shield of California PPO Network Rate or based on the Allowable Charge, whichever is applicable.

i) Blue Shield of California PPO Network Providers

If you use a Blue Shield of California PPO network provider, in most circumstances, the Plan will pay a percentage of the Blue Shield of California PPO Network Rate so long as the services are determined by the treating Physician or other recognized provider and by the Plan to be Medically Necessary for the care and treatment of an Injury or Illness. However, even if a service is considered Medically Necessary, it may not be covered by the Plan. If you or your doctor have a question about coverage for a service, you can contact the Fund Office.

The Blue Shield of California PPO Network Rate is the amount a participating provider has agreed to accept in payment for specific services. The participating provider cannot charge above the Blue Shield of California PPO Network Rate. In most cases, but not all, the Plan pays 80% of the Blue Shield of California PPO Network Rates.

In some cases, such as orthotics, Adult Day Health Care, pain management, tens unit, and hearing aids, the Plan will pay an Allowable Charge instead of the Blue Shield of California PPO Network Rate.

ii) Out-of-Network Providers

If you use an out-of-network provider, the Fund's payment of benefits for Medically Necessary Covered Services will be based on a percentage of an Allowable Charge.

The Allowable Charge is determined based on several factors applied when the claim is submitted. Any charges that exceed the Allowable Charge are Out-of-Pocket expenses to you. If you want to know what the Allowable Charge will be before you schedule your treatment, you may contact the Fund Office and request this information.

IMPORTANT	**No healthcare provider is an agent or representative of the Plan or the Board of Trustees. The Fund does not provide medical services itself, nor does it control or direct the provision of health care services or supplies 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 healthcare providers, including both Blue Shield of California PPO network providers and out-of-network providers under the terms of the Plan, and all entities (and their agents, employees, and representatives) that contract with the Fund to offer health-related services or supplies. Nothing in this Plan restricts the ability of a provider to disclose alternative treatment options.**

G) Out-of-Area Services

Benefits will be provided for Covered Services received outside of California within the United States, Puerto Rico, and U.S. Virgin Islands. The Southern California Pipe Trades Health and Welfare Fund, the "Fund", calculates the Participant's copayment either as a percentage of the allowable amount or a dollar copayment, as defined in this SPD. 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 SPD.

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 SPD.

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

When you require Covered Services while traveling outside of California:

1. Call BlueCard Access® at 1-800-810-BLUE (2583) to locate Physicians and Hospitals that participate with the local Blue Cross and/or Blue Shield plan, or go on-line at www.bcbs.com

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 the Southern California Pipe Trades Health and Welfare Fund, the out-of-area provider should call the customer service number noted on the back of your identification card.

i) BlueCard Program

Under the BlueCard® Program, when you obtain Covered Services within the geographic area served by a Host Plan, the Plan will remain responsible for any payment due, excluding the Participant's liability (e.g., Copayment and Plan Deductible amounts shown in the Benefits SPD). However, the Host Blue 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 SPD.

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, 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 SPD.

ii) Non-Preferred Provider

If you do not see 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 pay you at the Non-preferred provider benefit level. Remember, your copayment is higher when you see a non-preferred provider. You will be responsible for paying the entire difference between the amount paid by the Southern California Pipe Trades Health and Welfare 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.

iii) Care for Emergency Care or Urgent Care 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 the Fund at the customer service 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 your local Customer Service office for the most current listing of providers world-wide or you can go on-line at www.bcbs.com.

SECTION 8. MEDICAL BENEFITS

Benefits are listed in alphabetical order.

Acupuncture

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, not to exceed 20 visits per Calendar Year.

Allergy Testing

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable.

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 three-month supply of antigens but will do so no more than four times in any 12-month period.

Ambulance/Air Ambulance

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, for professional ground ambulance or air ambulance services deemed Medically Necessary.

A) The Plan will pay for the following:
   i) Ground ambulance transportation to a Hospital in the area of an emergency;
   ii) Ground ambulance service between a Hospital or Extended Care Facility in connection with a confinement;
   iii) Ground ambulance service to the air ambulance;
   iv) Transportation from one Hospital to another for Medically Necessary specialized care (i.e., to a pediatric facility required for patient's condition); and
   v) Air ambulance service to a medical facility.

B) The Plan will not pay for the following:
   i) The use of a ground ambulance or air ambulance due to lack of other transportation or for personal preference, such as your desire to use your own Physician, your desire to be near home and family, or your desire to be treated at a different facility; or
   ii) Stand-by time charged by any ambulance; or
   iii) Chartered aircraft instead of air ambulance unless a bona fide air ambulance is not available; or
   iv) More than one air ambulance charge per Illness or Injury; or
   v) Transportation from a nursing facility to a Hospital or vice versa for tests, X-rays, scans, etc.; or
   vi) EMS (Emergency Medical Service) with no transport.

Anesthesia

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable. For pain management benefits, see this section, page 30.

IMPORTANT	**Many emergency room anesthesiologists working in a Blue Shield of California PPO Hospital are not part of the Blue Shield of California PPO network. Most emergency room 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 any out-of-network service.**

NOTE	For pain management services, see this section, page 30.

Bariatric Surgery
Bariatric Surgery is not a covered benefit under this Plan.

Cardiac Rehabilitation
For cardiac rehabilitation provided by a Blue Shield of California PPO network provider, the Plan will pay 80% of the Blue Shield of California PPO Network Rate.

For cardiac rehabilitation provided by an out-of-network provider, the Plan will pay 80% of the Allowable Charge up to a maximum of $20 per visit.

Cardiac rehabilitation services rendered in an inpatient hospital will be paid under the Hospital benefit.

Chemotherapy
The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% Allowable Charge, whichever is applicable.

Chiropractic Care
The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, up to 3 visits per week, with a maximum of $600 per Calendar Year.

Massage therapy is not a Covered Service unless performed by a Chiropractor in conjunction with a manipulation.

Colonoscopy/Sigmoidoscopy (Screening)
The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, for a screening colonoscopy or sigmoidoscopy once every five years for Patients age 45 and older.

A colonoscopy/sigmoidoscopy rendered in a Hospital or Outpatient facility setting will be paid under the Hospital benefit.

Dialysis (Renal)
A) Physician's office
The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, for services rendered in a professional office.

B) Hospital or facility
For renal dialysis provided by a Blue Shield of California PPO network provider, the Plan will pay 80% of the Blue Shield of California PPO Network Rate per visit.

For renal dialysis provided by an out-of-network provider, the Plan will pay 80% of the Allowable Charge up to a maximum of $200 per visit.

Durable Medical Equipment
The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, for the Durable Medical Equipment listed below, if Medically Necessary and authorized by a licensed Physician or Podiatrist:

A) Rental of a wheelchair, 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 wheelchairs, electric scooters, or electric hospital beds.)
B) Prosthetic devices that improve or maintain the function of an impaired body part.
C) Insulin Pumps.
(Note: The Plan pays for up to $160 per month for supplies.)
D) C-pap devices.
(Note: The Plan pays up to $150 per 12-month period for supplies.)
E) Foot Orthotics, subject to a $200 Lifetime Maximum Benefit.

Benefits are paid on a rental-to-purchase basis based on the Patient's monthly eligibility.

Replacement or repair of Durable Medical Equipment is permitted no more often than once every 36 months.

See Section 16, page 45, for further Exclusions and Limitations for Durable Medical Equipment.

Emergency Services by Out-of-Network Providers

When a claim for Medically Necessary Emergency Services by an out-of-network provider is received, and the Plan determines that the services rendered are due to an Emergency Medical Condition, the Plan will pay an amount that is reasonable, as determined by the Plan. This amount is calculated using Medicare rates, UCR (usual, customary, and reasonable), or negotiation with the provider.

An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention could reasonably result in one or more of the following: (1) placing the health of the individual in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Emergency Services means a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such and Emergency Medical Condition, and within the capabilities of the staff and facilities available at the Hospital and such further medical examination and treatment as are required to stabilize the patient.

Genetic Testing

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, for genetic testing or screening deemed Medically Necessary.

Medical Necessity is as determined by the Plan and generally must meet all of the following three criteria:

A) One of the following:
   i) Family history suggestive of a heritable condition;
   ii) Specific symptoms suggestive of a heritable condition; or
   iii) Medical management requires consideration of genetic variants; and
B) Testing will impact treatment or heighten monitoring for early detection of disease; and
C) Evidence-based data supports the validity and utility of the test.

Hearing Aid Benefit

The Plan will pay 80% of the charge after a separate $50 Deductible per device up to a maximum of $800 per device for replacement or repair, not to exceed one device per ear in a 36-month period. Replacements or repairs will not be covered until 36 months have elapsed from the date the expense was incurred for the existing device.

EXAMPLE	**If a right ear device was dispensed on March 21, 2024, no additional benefits will be allowed until March 22, 2027 for the right ear. If a left ear device was dispensed on October 14, 2024, no additional benefits will be allowed until October 15, 2027 for the left ear.**

Home Health Nursing

For home health nursing provided by a Blue Shield of California PPO network registered nurse, nurse practitioner, licensed vocational nurse, or skilled practical nurse, the Plan will pay 80% of the Blue Shield of California PPO Network Rate.

For home health nursing provided by an out-of-network registered nurse, nurse practitioner, licensed vocational nurse, or skilled practical nurse, the Plan will pay 80% of the Allowable Charge up to a maximum of $60 per day.

The Plan limits home health care benefits to no more than 120 visits per Calendar Year. The 120 visits can be a combination of home health care and Extended Care Facility/Convalescent Care Facility or skilled nursing facility services.

Home Intravenous (IV) Therapy

The Plan will pay 85% of the Blue Shield of California PPO Network Rate or 85% of the Allowable Charge, whichever is applicable.

Hospice

The Plan will pay 85% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, if you have been diagnosed as Terminally Ill and elect, with the approval of a Physician, to be treated by a Hospice Care Program at a Hospice facility or at home.

Covered Services include those provided by a registered nurse, nurse practitioner, licensed vocational nurse, skilled practical nurse, or home health aide.

Hospital

A) Introduction

The Plan will pay for room and board and Medically Necessary services and supplies billed by a Hospital. For other services, such as Physician visits, see the relevant part of this alphabetical listing.

You are responsible for the Coinsurance percentage indicated below and for any non-covered services, which may include, but are not limited to:

i) Guest expenses;
ii) Telephone charges;
iii) Charges by a Hospital for any standby services, including the availability of a "trauma team".

See also Exclusions and Limitations, Section 16, page 45.

B) Inpatient

i) Blue Shield of California PPO Network Hospital
The Plan will pay 85% of the Blue Shield of California PPO Network Rate.

ii) Out-of-Network Hospital
The Plan will pay 80% of the Allowable Charge, up to a maximum of $1,080 per day, except where the Plan determines that the services rendered are due to an Emergency Medical Condition. (See this section, page 27.)

NOTE	A fully itemized bill is required from the facility.

C) Outpatient

The Plan covers expenses that you incur for Medically Necessary facility services and supplies received in the Outpatient department of a Hospital as follows:

i) Blue Shield of California PPO Network Hospital
The Plan will pay 85% of the Blue Shield of California PPO Network Rate.

ii) Out-of-Network Hospital
The Plan will pay 80% of the Allowable Charge, up to a maximum of $1,080 per day, except where the Plan determines that the services rendered are due to an Emergency Medical Condition. (See this section, page 27.)

NOTE	For pain management services, see this section, page 30.

Immunizations

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, based on Blue Shield of California's recommended schedule.

Laboratory

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable.

Laboratory services rendered in a Hospital or Outpatient facility will be paid under the Hospital benefit.

Medical Supplies

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, for the items listed below if Medically Necessary and authorized by a licensed Physician or Podiatrist:

A) Blood and blood plasma;
B) Surgical dressings, splints, casts, and other devices for the reduction of fractures and dislocations;
C) Oxygen and rental of equipment for its administration;
D) Trusses, braces, or crutches; or
E) Diabetic supplies, including glucose monitors, test strips, and other self-testing supplies.

Mental Health

A) Introduction

Hospital or office visits for mental health care are Covered Services when provided by a practitioner acting within the scope of their license in the state where they practice.

You are responsible for the Coinsurance percentage listed below and for any non-covered services, which may include, but are not limited to:

i) Guest expenses;
ii) Telephone charges;
iii) Charges by a Hospital or any standby services, including the availability of a "trauma team".

See also Exclusions & Limitations, Section 16, page 45.

B) Adult Day Health Care Center (ADHC)
Placement in an ADHC or "Community-Based Adult Services" facility requires certification by a Physician or Psychiatrist. Custodial care, transportation to and from the facility, and meals are not covered under this benefit.

i) Blue Shield of California PPO Network Facility
The Plan will pay 85% of the Blue Shield of California PPO Network Rate, up to a maximum of $27 per day.
ii) Out-of-Network Facility
The Plan will pay 80% of the Allowable Charge, up to a maximum of $27 per day.

C) Inpatient Hospital

i) Blue Shield of California PPO Network Hospital
The Plan will pay 85% of the Blue Shield of California PPO Network Rate.
ii) Out-of-Network Hospital
The Plan will pay 80% of the Allowable Charge, up to a maximum of $1,080 per day, except where the Plan determines that the services rendered are due to an Emergency Medical Condition. (See this section, page 27.)

D) Outpatient – Office

i) Blue Shield of California PPO Network Provider
The Plan will pay 80% of the Blue Shield of California PPO Network Rate.
ii) Out-of-Network Provider
The Plan will pay 80% of the Allowable Charge.

E) Partial Hospitalization
Partial hospitalization requires a referral by a Physician or Psychiatrist. Custodial care and meals are not covered under this benefit.

i) Blue Shield of California PPO Network Facility
The Plan will pay 85% of the Blue Shield of California PPO Network Rate.
ii) Out-of-Network Facility
The Plan will pay 80% of the Allowable Charge, up to a maximum of $1,080 per day.

F) Residential Treatment Center
Placement in a Residential Treatment Center requires either a (1) court order or (2) certification by a Physician or Psychiatrist. Custodial care is not covered under this benefit.

i) Blue Shield of California PPO Network Facility
The Plan will pay 85% of the Blue Shield of California PPO Network Rate.
ii) Out-of-Network Facility
The Plan will pay 80% of the Allowable Charge, up to a maximum of $1,080 per day.

Non-prescription and Over-the-Counter Drugs

Non-prescription and over-the-counter drugs are not a covered benefit under this Plan. Reimbursement may be available from your Active Plan Health Reimbursement Arrangement Allowance.

Nutritional Counseling

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, for Medically Necessary nutritional counseling when rendered by a Physician or registered dietician. The Plan will pay up to eight visits per Calendar Year.

Occupational Therapy

For occupational therapy, the Plan will pay 80% of the Blue Shield of California PPO Network Rate per visit, or 80% of the Allowable Charge, whichever is applicable, up to a maximum of $1,200 per Calendar Year. The yearly maximum is combined with Physical Therapy.

These services require a prescription from your Physician. Services must be rendered by a licensed occupational therapist.

Occupational therapy rendered in an Inpatient Hospital will be paid under the Hospital benefit.

Opioid Drug Testing

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable.

The Plan will cover opioid drug testing, per Medicare guidelines, except that the Plan will cover opioid drug testing no more than once every three months. This limitation does not apply to substance use disorder treatment.

Pain Management

The Plan will pay 80% of the Blue Shield of California PPO Network Rate for all services rendered in a Physician's office or surgical suite or 85% of the Blue Shield of California PPO Network Rate for all services rendered in a surgery center or Hospital, for pain management expenses, with a maximum of three injections per day.

The Plan will pay 80% of the Allowable Charge for all services, not to exceed $1,080 for surgery center or Hospital fees, for pain management expenses, with a maximum of three injections per day.

There is a $10,000 Lifetime Maximum Benefit for all pain management expenses.

Physical Examinations

If you incur any of the preventive 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 PPO Network Rate or 80% of the Allowable Charge, whichever is applicable. The Plan covers only one routine physical examination per Calendar Year per person. However, an additional examination will be permitted if a Pap Smear was not performed during a routine physical examination earlier in the Calendar Year.

A physical examination includes, but is not limited to:

- Physician's Examination
- Urine Analysis
- Complete Blood Count (CBC)
- General Health Blood Panel
- Electrocardiogram (EKG)
- Chest X-ray
- Occult Blood
- Proctosigmoidoscopy (office only)
- Prostate Specific Antigen (PSA)
- Pap Smear; Mammography – Screening

Physical Therapy

For physical therapy the Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, up to a maximum of $1,200 per Calendar Year. The yearly maximum is combined with Occupational Therapy.

These services require a prescription from your Physician. Services must be rendered by a Registered Physical Therapist or Registered Physical Therapist Assistant under the supervision of a Registered Physical Therapist.

Physical therapy rendered in an Inpatient Hospital will be paid under the Hospital benefit.

Physician or Psychiatrist Visits/Professional Services

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable.

The Plan does not cover "standby" charges. These are charges by a Physician or Psychiatrist who is not providing any care for treatment. Physician or Psychiatrist 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.

Radiation Therapy

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable.

Radiation Therapy rendered in a Hospital or Outpatient facility will be paid under the Hospital benefit.

Radiology

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable.

Radiology services rendered in a Hospital or Outpatient facility will be paid under the Hospital benefit.

Skilled Nursing Facility or Convalescent Care Facility/Extended Care Facility/Adult Day Health Care

The Plan will pay 85% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, for a maximum of 120 days per Calendar Year. Extended Care Benefits follow Medicare Guidelines, which require care to be provided within three days of a four-day inpatient Hospital confinement.

The Plan limits Extended Care Facility/Convalescent Care Facility or skilled nursing facility benefits to no more than 120 visits per Calendar Year. The 120 visits can be a combination of home health care and a Skilled Nursing Facility, also called an Extended Care Facility/Convalescent Care Facility.

The Plan will pay a maximum of $27 per day if you are confined in a Convalescent Care, Extended Care, or Adult Day Health Care Facility.

This benefit does not include Custodial Care, companion care, etc.

Sleep Study

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable.

A sleep study rendered in a Hospital will be paid under the Hospital benefit.

Specialty Medication

A Prescription Drug is covered as a Specialty Medication when the Fund determines that the medication:

A) Requires special delivery, preparation, or handling; or
B) Requires special administration or monitoring; or
C) Treats a complex condition; or
D) Costs $1,000 or more for a 30-day supply.

The Plan will pay 80% of either (1) the cost or (2) the "Red Book" average wholesale price of the Specialty Medication, whichever is lower. A Specialty Medication requires prior authorization from the Fund Office. Generic or other lower-cost drug substitutes may be required. A maintenance medication for a chronic or long-term condition (such as diabetes), other than one that costs $1,000 or more for a 30-day supply, is not considered a Specialty Medication.

The Plan requires a Physician's letter of Medical Necessity and medical records annually.

Speech Therapy

For speech therapy the Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge up to a maximum of $18.00 per visit, whichever is applicable.

These services require a prescription from your Physician. Services must be rendered by a qualified speech pathologist.

Speech therapy rendered in an Inpatient Hospital will be paid under the Hospital benefit.

Substance Use Disorder

A) Introduction

Hospital or office visits for substance use disorder treatment are Covered Services when provided by a practitioner acting within the scope of their license in the state where they practice.

You are responsible for the Coinsurance percentage listed below and for any non-covered services which may include, but are not limited to:

i) Guest expenses;
ii) Telephone charges;
iii) Charges by a Hospital or any standby services, including the availability of a "trauma team".

See also Exclusions & Limitations, Section 16, page 45.

B) Inpatient Hospital

i) Blue Shield of California PPO Network Hospital
The Plan will pay 85% of the Blue Shield of California PPO Network Rate.
ii) Out-of-Network Hospital
The Plan will pay 80% of the Allowable Charge, up to a maximum of $1,080 per day, except where the Plan determines that the services rendered are due to an Emergency Medical Condition. (See this section, page 27.)

C) Outpatient – Office

i) Blue Shield of California PPO Network Provider
The Plan will pay 80% of the Blue Shield of California PPO Network Rate.
ii) Out-of-Network Provider
The Plan will pay 80% of the Allowable Charge.

D) Partial Hospitalization
Partial hospitalization requires a referral by a Physician or Psychiatrist. Custodial care and meals are not covered under this benefit.

i) Blue Shield of California PPO Network Facility
The Plan will pay 85% of the Blue Shield of California PPO Network Rate.
ii) Out-of-Network Facility
The Plan will pay 80% of the Allowable Charge, up to a maximum of $1,080 per day.

E) Residential Treatment Center
Placement in a Residential Treatment Center requires either a (1) court order or (2) certification by a Physician or Psychiatrist. Custodial care is not covered under this benefit.

i) Blue Shield of California PPO Network Facility
The Plan will pay 85% of the Blue Shield of California PPO Network Rate.
ii) Out-of-Network Facility
The Plan will pay 80% of the Allowable Charge, up to a maximum of $1,080 per day.

F) Laboratory
Placement in a Residential Treatment Center requires either a (1) court order or (2) certification by a Physician or Psychiatrist. Custodial care is not covered under this benefit.

i) The Plan will pay 80% of the Blue Shield of California PPO Network or 80% of the Allowable Charge, whichever is applicable.
ii) Laboratory services rendered in a Hospital or Outpatient facility will be paid under the Hospital benefit.

Surgery

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable.

Temporomandibular Joint Dysfunction (TMJ)

Treatment for TMJ is not a covered medical benefit under this Plan, but may be covered as a dental benefit by the DeltaCare USA DHMO or the MetLife dental PPO.

Transplants

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

A) Natural organs and organ parts transplants are limited to:
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.

B) 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. This maximum benefit in connection with any one-organ transplant ($100,000) is included in your 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 PPO Network Rate or the out-of-network 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 Blue Shield of California PPO Network Rate or the Allowable Charge for an organ donor is included in the maximum payable for any organ transplant of $100,000 and is included in your Lifetime Maximum Benefit.

Additional benefits are provided for bone marrow transplants above the $100,000 maximum. The Plan will cover 60% in excess of $100,000 at the applicable percentage. The applicable percentage is 85% for facility charges and 80% for professional charges from Blue Shield of California PPO network providers. This benefit includes all pre- and post-transplant care including, but not limited to, chemotherapy, radiation therapy, laboratory services, X-rays, scans, and prescription medication.

Vision Services – After Cataract Surgery

After cataract surgery, the Plan will pay up to $100 per eye for glasses, contact lenses, or corrective intraocular lenses (IOLs). In addition, see Section 10 for other routine vision benefits.

SECTION 9. PRESCRIPTION DRUG BENEFITS

A) Benefit Limitations

The Plan's maximum Calendar Year Prescription Drug benefit is $1,200 per person, subject to a separate $50 Calendar Year Deductible.

Subject to the maximum annual benefit, the Plan will reimburse you for 100% of the amounts you pay for covered Prescription Drugs, net of any rebates or discounts you receive, except for the $50 Deductible.

EXAMPLE	**You paid $6,550 for covered Prescription Drugs in 2024. The first $50 you paid was applied to your Prescription Deductible. The next $1,200 you paid was reimbursed at $1,200 ($1,200 x 100%). The remaining $5,300 you paid exceeded the Prescription Drug benefit and was not reimbursed. In total, you received $1,200 in Prescription Drug reimbursements.**

The $50 Prescription Drug Deductible is not applied to the $250 medical Deductible. The $250 medical Deductible does not apply to the Prescription Drug benefit.

The Plan covers only Prescription Drugs that are lawfully prescribed and purchased from a licensed Pharmacy located in the United States. The Plan does not cover Prescription Drugs purchased out of the country unless proof of residency in the country where the services were rendered is submitted or in case of an Accident or life-threatening Emergency Medical Condition.

Prescription Drugs dispensed in a provider's office are not a covered benefit under the Plan. The Plan will cover off-label use if such use is supported by at least two peer-reviewed clinical studies, and/or recognized as industry standard by appropriate professional associations or recognized clinical guidelines.

Implantable devices that contain hormone medication may be covered under more than one benefit.

Certain specialty medications are covered as a medical benefit. See Section 8, page 311.

EXAMPLE	**The Patient receives services for implanting an intrauterine device containing progestin. Because the implant includes hormones, the cost of the device would be covered under the Prescription Drug benefit, and the implantation charges billed by the Physician or anesthesiologist would be covered under medical benefits. Implanted devices that do not contain Prescription medication, such as the copper IUD, would also be covered under medical benefits.**

Prescription Drugs include up to 30 pills annually to treat erectile dysfunction.

B) Claim Requirements

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

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

A printout from a licensed Pharmacy may be substituted for a receipt, but it must include all the above information.

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

C) Medicare Part D

The Pensioners & Surviving Spouses Health Plan Prescription Drug benefit is not "actuarially equivalent" to Medicare Part D and is, therefore, not "creditable coverage" under Medicare rules. This means that if you do not sign up for Medicare Part D when you first become eligible, you may have to pay a higher premium for your Medicare Part D coverage for as long as you are covered under Medicare Part D. You can avoid this increase in premium by not going more than 63 days without "creditable coverage".

Because Medicare Part D provides better benefits, on average, than this Plan does, and because you may therefore pay a penalty if you do not enroll in Medicare Part D when you are first eligible, you should seriously consider enrolling in a Medicare Part D Prescription Drug plan.

Detailed information about Medicare is available through the "Medicare & You" handbook from Medicare. You are strongly encouraged to study the Medicare handbook. If you have not received a copy, you can download it from www.medicare.gov/publications. You can also obtain more information about Medicare from:

i) www.medicare.gov;
ii) (800) MEDICARE (TTY users should call (877) 486-2048); or
iii) California Health Advocates at (800) 434-0222.

SECTION 10. VISION BENEFITS

A) Eligibility and Enrollment

Any Pensioner or Survivor who is eligible for benefits under the terms of the Plan may choose to purchase coverage in the Vision Service Plan (VSP) program when they first become eligible under the Plan and thereafter during annual open enrollment periods. An enrollment change can also be made at certain other times, such as when a Pensioner marries or divorces or when a Pensioner or Spouse dies.

An eligible Pensioner may also purchase VSP coverage for their Spouse or Domestic Partner. (However, coverage can only be purchased for a Pensioner's Spouse or Domestic Partner if coverage is purchased for the Pensioner.)

B) Premiums

Note that the premiums for the VSP program are in addition to the normal monthly premium that a Pensioner or Survivor pays for medical, prescription drug, and dental coverage under the Plan. Unlike the premiums for medical and prescription drug coverage, the premiums for the VSP program will not vary based on the number of Southern California Pipe Trades Retirement Fund Pension Credits the Pensioner had when they retired, the Pensioner's age at retirement, or the Pensioner's (or Spouse's or Domestic Partner's) Medicare status.

The monthly premiums for the VSP Vision option will be as follows:

i) Pensioner or Survivor Only: $4.76
ii) Pensioner and Spouse/Domestic Partner: $9.54

Monthly premium payments for the VSP program must be deducted from the Pensioner's or Survivor's Southern California Pipe Trades Retirement Fund pension benefit, if any. By signing a Vision Benefit Enrollment Form, the Pensioner or Survivor authorizes this deduction. If the Pensioner or Survivor is not receiving such a benefit, premium payments must be made by monthly electronic ACH transfer from a bank account, which must be authorized in writing. VSP program premiums will not be accepted by check, money order, cash, or any other method.

C) Cancelling Coverage

Once enrolled, a Pensioner or Survivor may not cancel VSP program coverage until the next open enrollment period. Any cancellation will apply both to the Pensioner and their Spouse/Domestic Partner, if applicable.

D) Benefit Limitations

The VSP program offers many vision services for a minimal co-pay. VSP pays benefits regardless of where you obtain vision services, but you will maximize your benefits by using VSP network providers.

E) Other Plan Rules

Generally, existing Plan rules continue to apply in the case of VSP program benefits, including rules related to commencement of eligibility, suspension or termination of eligibility, and COBRA benefits.

Note that the Pensioners & Surviving Spouses Health Plan's rules determine who is an Eligible Dependent for all benefits, including the VSP program. Some VSP program documents may imply that a broader range of persons qualify as Eligible Dependents. Only Spouses and Domestic Partners of Pensioners are covered as Eligible Dependents under the Plan.

F) Claims and Appeals Procedures

If a Participant or Eligible Dependent disagrees with a Fund Office decision, such as eligibility to participate in the VSP program or a disagreement over premium payments for this option, they may appeal the decision to the Board of Trustees under the Plan's normal claims and appeals procedure, as set forth in the Summary Plan Description. Other disagreements regarding VSP program benefits, including issues about network providers, covered procedures, and charges for procedures, should be appealed to VSP. A Participant who elects the VSP program will be given VSP's claims and appeals procedure. All appeals under VSP's purview will be decided finally by VSP with no additional appeal to the Board of Trustees.

SECTION 11. DENTAL BENEFITS

You may purchase coverage in one of two DeltaCare USA DHMO options or the MetLife PPO option when you first become eligible for Plan benefits and thereafter during annual open enrollment periods, as long as you remain eligible under this Plan. You may also purchase DeltaCare USA DHMO or MetLife PPO coverage for your Spouse/Domestic Partner. However, coverage can only be purchased for your Spouse/Domestic Partner if you purchase coverage.

A) Enrollment

To enroll, you must complete a Dental Enrollment Form. You may obtain a Dental Enrollment Form from any local Union office, the Fund Office, or the Fund website at www.scptac.org.

i) Initial Enrollment

You must enroll no later than 60 days from your initial eligibility date or during annual open enrollment periods.

ii) Changing Plans

Once enrolled, you can change your enrollment during annual open enrollment periods.

B) Benefit Options

i) The DeltaCare USA High DHMO option offers benefits without copayments for a higher monthly premium.
ii) The DeltaCare USA Medium DHMO option offers benefits with copayments for a lower monthly premium.
iii) The MetLife PPO option offers a wider range of providers for a higher monthly premium. A $50 per-Patient Calendar Year Deductible and coinsurance amounts may be payable, and an $1,800 annual maximum applies.

A more thorough description of these options is available by contacting DeltaCare USA for either of the DHMO options at (800) 422-4234 or MetLife at (800) 438-6388 for the PPO option.

C) Premiums

Premiums for dental coverage are in addition to the normal monthly Premium that you pay for medical and prescription drug coverage under the Plan. Also, unlike the Premiums for medical and prescription drug coverage, the premiums for dental coverage will not vary based on the number of Retirement Fund Pension Credits or Active Plan coverage months you had when you retired, your age at retirement, or your or your Spouse/Domestic Partner's Medicare status.

At the time of publication, monthly premiums for the two DeltaCare USA DHMO and the MetLife options were as follows:

Dental Plan	Pensioner or Survivor	Pensioner and Spouse/ Domestic Partner
DeltaCare USA DHMO High	$22.51	$44.93
DeltaCare USA DHMO Medium	$15.47	$30.74
MetLife PPO Dental	$65.56	$131.12

Monthly premiums for dental coverage must be deducted from your Southern California Pipe Trades Retirement Fund pension benefit unless you are not eligible for a pension benefit, in which case premium payments must be made by monthly electronic ACH transfer from a bank account, which must be authorized in writing by you. By signing a Dental Enrollment Form, you authorize this deduction. A Survivor must also have any dental premium deducted from their Southern California Pipe Trades Retirement Fund pension benefit unless the Survivor is not receiving such a benefit, in which case premium payments must be made by monthly electronic ACH transfer from a bank account, which must be authorized in writing by the Survivor. DeltaCare USA DHMO premiums will not be accepted by check, money order, cash, or any other method.

D) Cancelling Coverage

You may cancel dental coverage at any time. However, if you cancel coverage, you will not be permitted to re-enroll in dental coverage until the next open enrollment period. Any cancellation will apply both to you and your Spouse/Domestic Partner, if applicable.

E) Benefit Limitations

See the DeltaCare USA DHMO or MetLife Dental PPO materials for detailed information regarding dental rules and benefits.

Both DeltaCare USA options are DHMOs. You must live within the DHMO's service area to qualify for benefits. You must use only your assigned Dentist in the DeltaCare USA DHMO network. Before enrolling, you should check that the DeltaCare USA DHMO network operates where you live. You must contact DeltaCare USA to change your assigned Dentist.

The MetLife PPO option lets you visit any licensed Dentist, but you will save the most by using a MetLife PPO Dentist. You can change your Dentist at any time without contacting MetLife.

A benefit maximum does not apply for either DeltaCare USA option.

The Calendar Year benefit maximum for the MetLife PPO dental option is $1,800 per person. The separate benefit for orthodontia is $1,800 per lifetime per person, which does not count toward the $1,800 Calendar Year benefit maximum for each person.

The Plan's rules determine who is an Eligible Dependent for all benefits, including dental benefits. Some DeltaCare USA DHMO or MetLife Dental PPO documents may imply that a broader range of persons qualify as Eligible Dependents. Only Spouses and Domestic Partners are covered under the Plan.

F) Claims Procedures

Dental claims are processed by MetLife PPO or DeltaCare USA.

If you elected the MetLife PPO option, dental claims should be sent to: MetLife Dental Claims

P.O. Box 981282
El Paso, TX 79998-1282

If you elected the DeltaCare USA DHMO option, dental claims should be sent to:

DeltaCare USA
Claims Department
P.O. Box 1810
Alpharetta, CA 30023

G) Appeals Procedures

If you disagree with a Fund Office decision, such as eligibility to participate in a dental option or a disagreement over premium payments, you may appeal the decision to the Board of Trustees under the Plan's normal claims and appeals procedure, as set forth in this SPD.

Other disagreements regarding dental benefits, including issues about network providers, covered procedures, and charges for procedures, should be appealed to DeltaCare USA or MetLife. If you elect dental coverage, you will be given the appropriate claim and appeal procedure. All appeals under DeltaCare USA's or MetLife's purview will be decided finally by DeltaCare USA or MetLife with no additional appeal to the Board of Trustees.

H) Coverage Comparison

Question	MetLife PPO	DeltaCare USA DHMO
Can I go to any Dentist?	You can visit any licensed Dentist, but you'll save the most by visiting a MetLife PPO contracted Dentist. You can change your Dentist at any time without contacting us.	You must visit your assigned DeltaCare USA DHMO primary care Dentist to receive benefits. You can change your assigned Dentist online or by telephone, generally effective the following month.
What procedures are covered?	Your plan covers a wide range of services without any pre-existing condition limitations. Diagnostic, preventive, basic restorative, endodontic, and periodontic services; oral surgery; and orthodontia are covered at 100%, while major services like crowns, dentures, and bridges are covered at 90%, subject to the MetLife PPO contracted fee schedule.	Your plan covers over 300 procedures without any pre-existing condition limitations. Copayments may be due depending on the DeltaCare USA DHMO option you choose.
Are there Deductibles and maximums?	Yes, a $50 per Patient Deductible and $1,800 maximum plan benefit apply each Calendar Year. Orthodontia has a lifetime benefit of $1,800 and is not counted towards the $1,800 Calendar Year maximum.	There are no Calendar Year Deductibles or maximums.
What happens if I need to see a specialist?	You do not need a referral from your Dentist.	Contact your DeltaCare USA DHMO primary care Dentist to coordinate your referral.
What is my out-of-area coverage?	You can visit any licensed Dentist.	You have a limited benefit for out-of-network emergency care.

SECTION 12. PROCESSING CLAIMS FOR BENEFITS

A) How to File a Medical or Prescription Claim for Payment

For the Fund to pay a benefit, the Fund's claims procedures must be followed. A written claim form and an itemized billing must be filed with the Fund by you or the provider. Casual inquiries about benefits or the circumstances under which benefits might be paid, and requests for pre-authorizations, are not claims under these procedures.

Providers should send medical claims to:	**Blue Shield of California** **P.O. Box 272540** **Chico, CA 95927-2540**

You should send your prescription claims to:	**Southern California Pipe Trades** **Pensioners & Surviving Spouses Health Fund** **Claims Department** **501 Shatto Place, Suite 500** **Los Angeles, CA 90020**

Claims cannot be submitted by phone. Providers may file electronic claims via Electronic Data Interface ("EDI").
All forms required by the Fund must be completed in full before claims can be processed. Failure to provide all the information necessary to process a claim will result in the delay or denial of benefits.

Claims 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 will not be treated as a claim for benefits.

Disagreements or claims involving eligibility to participate in the Plan or to receive benefits under the Plan must be submitted in writing to the Fund Office. No particular form is required.

Claims will be considered submitted upon receipt.

When you receive medical care, follow these steps for prompt claims processing:

i) Obtain the Plan's Coordination of Benefits Form from any local Union office, the Fund Office, or the Fund Office website at www.scptac.org. A fully completed Plan Coordination of Benefits Form is required once every Calendar Year and for each Accident.

ii) Submit the provider's fully itemized bill, which must include the following:
   a) Participant's name and the last four digits of their Social Security Number or Blue Shield ID number;
   b) Patient's name, date of birth, and the last four digits of their 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) Charge for each service.

iii) Submit a prescription claim receipt from a Pharmacy which must include the following:
   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) Prescription number;
   g) National Drug Code (NDC) number; and
   h) Cost of Prescription Drug.

The Fund may require additional information to process the claim, such as:

i) Patient employment status;
ii) 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);
iii) Operative reports;
iv) Laboratory results;
v) X-ray results; or

vi) Detailed information when the claim may be related to an Accident, including but not limited to circumstances surrounding: tripping, slipping, falling, dog bites, foreign objects (in the eye, ear, etc.), being hit by a projectile or another person, automobile Accidents, and bicycle Accidents.

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

Dental claims should be sent to:	**DeltaCare USA** **Claims Department** **P.O. Box 1810** **Alpharetta, GA 30023**
	MetLife PPO **MetLife Dental Claims** **P.O. Box 981282** **El Paso, TX 79998-1282**

Vision claims should be sent to:	**Vision Service Plan** **Attention: Claims Services** **P.O. Box 495918** **Cincinnati, OH 45249-5918**

B) Timely Filing

Claims should be submitted 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 received after 12 months from the date of service will not be reviewed.

When the Plan is not the primary payer, the deadline for filing a claim is 12 months after the primary insurance has adjudicated the claim.

Replies to the Fund Office's request for information on claims should be submitted within 90 days of the request. Replies submitted more than 12 months from the date of request will not be accepted.

In case of retroactive coverage for Pensioners eligible for a retroactive Retirement Fund disability benefit, the 12-month limit for filing claims will be waived with respect to claims incurred during the retroactive eligibility period, and any claims incurred during the retroactive eligibility period, must be submitted within 90 days of the date of your Annuity Starting Date in the Retirement Fund, or 12 months from the date of the service, whichever is later. See also Section 6(E), page 20, above.

C) Processing Claims

The time limits for the Fund Office to respond to your claim depend on the type of claim filed.

i) Urgent Care Claim

An urgent care claim is a claim that involves emergency medical care needed immediately to avoid serious jeopardy to your life, health, or ability to regain maximum function, or which a physician with knowledge of your medical condition thinks would subject you to severe pain if your claim were not dealt with in the "urgent care" time frame, which is as follows. The Fund Office will notify you whether your urgent care claim is approved or denied as soon as possible but not later than 72 hours after it receives your claim unless your claim is incomplete. The Fund Office will notify you as soon as possible if your claim is incomplete, but not more than 24 hours after receiving your claim. The Fund Office may notify you orally unless you request written notification. You will then have 48 hours to provide the specified information. Upon receiving this additional information, the Fund Office will notify you of its determination as soon as possible, within the earlier of 48 hours after receiving the information or the end of the period within which you must provide the information.

ii) Pre-Service Claim

A pre-service claim is a claim that conditions receipt of a benefit, in whole or part, on pre-approval of the benefit. Hospital admission pre-certification is an example of a pre-service claim. The Fund Office will notify you whether your claim is approved or denied within a reasonable time, but not later than 15 days after receipt of your claim. This period may be extended by one 15-day period if special circumstances beyond the control of the Fund Office require that additional time is needed to process your claim. If an extension is needed, the Fund Office will notify you before the expiration of the initial 15-day period

of the circumstances requiring an extension and the date by which the Fund Office expects to reach a decision. If the Fund Office needs an extension because you have submitted an incomplete claim, the Fund Office will notify you of this within five days of receipt of your claim. The notice will describe the information needed to make a decision. If the Fund Office needs more information from you, its time to decide on your claim will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request.

iii) Post-Service Claim

A post-service claim is a claim submitted after the service or procedure has occurred. Most claims will fall under this category. The Fund Office will notify you of its determination within a reasonable time, but not later than 30 days after receipt of your claim. This period may be extended by one 15-day period if special circumstances beyond the control of the Fund Office require that additional time is needed to process your claim. If an extension is needed, the Fund Office will notify you before the expiration of the initial 15-day period of the circumstances requiring an extension and the date by which the Fund Office expects to reach a decision. If the Fund Office needs an extension because you have not submitted information necessary to decide the claim, the notice will also describe the information it needs to make a decision. You will have until 45 days after receiving this notice to provide the specified information. If the Fund Office needs more information from you, its time to decide on your claim will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request.

iv) Concurrent Care Claim

A concurrent care claim is any claim to extend the course of treatment beyond the period of time or number of treatments that the Plan has already approved as an ongoing course of treatment to be provided over a period of time or number of treatments. A concurrent care claim can be an urgent care claim, a pre-service claim, or a post-service claim. If the Fund Office has approved an ongoing course of treatment to be provided over a period of time, it will notify you in advance of any reduction in or termination of this course of treatment. If you submit a claim to extend a course of treatment, and that claim involves urgent care, the Fund Office will notify you of its determination within 24 hours after receiving your claim, provided that the Fund receives your claim at least 24 hours before the expiration of the course of treatment. If the claim does not involve urgent care, the request will be decided in the appropriate time frame, depending on whether it is a pre-service or post-service claim.

v) Disability Claim

A disability claim will be handled like post-service medical claims. However, there are some special time periods that apply to processing a disability claim. The Fund Office will notify you of its determination within a reasonable time, but not later than 45 days after receipt of your claim. This period may be extended for up to two additional 30-day periods for circumstances beyond the control of the Fund Office if the Fund Office notifies you of the extensions before the expirations of the initial 45 days and first 30-day extension period, respectively. Any notice of extension will identify the circumstances requiring an extension, the date by which the Fund Office expects to reach a decision, the standards upon which entitlement to a benefit is based, the unresolved issues that require an extension, and additional information needed, if any, to resolve those issues. If the Fund Office needs more information from you, its time to decide on your claim will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request.

You will be provided, free of charge and before an adverse benefit determination is issued, with (a) any new or additional evidence considered, generated, or used by the Plan with regard to the claim and (b) any new or additional rationale on which the adverse benefit determination will be based. The new or additional evidence or rationale must be provided as soon as possible and sufficiently before an adverse benefit determination is due in order to give you a reasonable opportunity to respond to the new information before the adverse benefit determination is issued.

D) Notice of Denial of Claim

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

If an internal rule, guideline, protocol, or similar criterion was relied on in making the adverse determination, the specific rule, guideline, protocol, or similar criterion will be provided, or you 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 the rule, guideline, protocol, or other standard 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.

SECTION 13. APPEALS PROCEDURE

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

A) Appealing a Benefit Denial

If your claim for benefits is denied, in whole or in part, you may request that the Board of Trustees review the benefit denial. The Board of Trustees has delegated the responsibility to decide appeals to its Appeals Committee. (In some cases, the Board of Trustees may decide to consider an appeal, and in other cases, the Appeals Committee may delegate the responsibility to consider an appeal to a subset of the Committee.) All appeals, except for urgent care appeals, must be in writing. An urgent care appeal may be oral or written and may be made by telephone, facsimile, or other available means. All appeals must be received by the Fund within 180 calendar days after you receive the written notice of the denial from the Fund Office. Failure to file a timely written appeal will constitute a complete waiver of the right to appeal, and the decision of the Fund will be final and binding.

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

Your appeal should state the specific reasons why you believe the denial of your claim was in error. You should also submit any documents or records that support your claim. This does not mean that you are required to cite all of the Plan provisions that apply or to make "legal" arguments; however, your appeal should state clearly why you believe you are entitled to the benefits or other relief you are claiming. The Appeals Committee can best consider your position if it clearly understands your 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 Office in its determination. The Appeals Committee will also not afford deference to the initial determination by the Fund Office.

The Fund Office 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.

In deciding an appeal of a Fund Office determination that was based, in whole or in part, on a medical judgment (including determinations about whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate), the Appeals Committee will, when appropriate, consult with a health care professional who has appropriate training and expertise in the particular field of medicine, and who was not consulted by the Fund Office in connection with its determination. You 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.

B) Timing of Appeals Committee Decisions

The Appeals Committee (or a subset thereof if authorized or the Board of Trustees if not delegated to the Committee) will decide all appeals.

Post-Service Claims Appeals. Most claims will be post-service claims appeals. 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 Office. 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 you before the beginning of the extension. Such an extension may only last until the third meeting following receipt of the appeal.

C) Notice of Decision on Appeal

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

Urgent Care Claims Appeals. An urgent care claim appeal will be decided as soon as possible but not later than 72 hours after it is received by the Fund.

Pre-Service Claims Appeals. A pre-service claims appeal will be decided within a reasonable period of time but not later than 15 days after it is received by the Fund.

Concurrent Claims Appeals. A concurrent claim appeal will be decided either in the time period of a post-service claim appeal or a pre-service claim appeal depending on the type of claim.

Disability Claims Appeals. If your claim pertains to Total Disability, it will be decided in the time period of a post-service claim appeal.

If your appeal is denied, in whole or in part, you will receive a written decision that will include: (1) the specific reason(s) for the denial; (2) the specific Plan provisions on which the denial is based; (3) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; and (4) a statement of your right to bring a lawsuit under Section 502(a) of ERISA.

If an internal rule, guideline, protocol, or similar standard was relied on in making the adverse determination, you will be provided with the specific rule, guideline, protocol, or similar standard 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 the rule, guideline, protocol, or other standard will be provided to you upon request.

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

If your appeal relates to a disability benefit and it is denied, you will be provided, if applicable, with: (1) any specific internal criteria, including any internal rules or guidelines used in making the determination, and (2) an explanation of any disagreement with any determination from a health care/vocational professional who treated or evaluated you, a medical/vocational expert whose advice was obtained by the Fund, or an SSA disability determination.

If in reviewing your appeal for a disability benefit, the Appeals Committee or Board of Trustees considers, relies upon, or generates any new or additional evidence, or if the Committee or Board is considering denying your appeal based on new or additional rationale, you will be provided with this information, free of charge, and provided a reasonable opportunity to respond before an adverse decision is made.

D) Decisions on Appeal are Final and Binding

The decision of the Appeals Committee is final and binding on all parties, including anyone claiming a benefit on your behalf.

Once a final decision is rendered, there is no right to re-file the same appeal or to request reconsideration. If such an appeal or request for reconsideration is filed, the Appeals Committee may refuse to consider it.

As a committee of the Trustees, the Appeals Committee has full discretion and authority to determine all matters relating to the benefits provided under this Plan, including, but not limited to, all questions of coverage, eligibility, and methods of providing or arranging for benefits. As a committee of the Trustees, the Appeals Committee also has full discretion and authority over the standard of proof required for any inquiry, claim, or appeal and over the application and interpretation of the Plan. The Board of Trustees has delegated its authority to make final decisions on appeals to the Appeals Committee. To the extent the Board of Trustees does not delegate this authority for an appeal, the Board of Trustees will be substituted for the Appeals Committee in this appeal procedure. It will have the full discretion in deciding an appeal as set forth in this paragraph.

If the Appeals Committee denies the appeal and you decide to seek judicial review, the Appeals Committee's decision will be subject to limited judicial review to determine only whether the decision was arbitrary and capricious. Generally, no lawsuit may be brought without first exhausting the above claims and appeals procedures. Nor may any evidence be used in court unless it was first submitted to the Appeals Committee before the decision on appeal. No legal action may be commenced 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, you may be represented by an authorized representative. If your representative is not an attorney or court-appointed guardian, you must designate the representative by a signed written statement. However, neither you nor your representative has a right to an in-person hearing or appearance before the Trustees or the Appeals Committee.

F) Other Appeals

If you receive any written correspondence from the Fund Office that could be interpreted as adversely affecting your interest, you 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 calendar days of receipt of the correspondence from the Fund Office. Such appeals will be processed in the same manner as appeals for claims for benefits.

SECTION 14. COORDINATION OF BENEFITS

A) General Rules

This Plan has been designed to assist with the cost of covered expenses. The Plan does not pay more than you would be required to pay for any services. Benefits under this Plan will be coordinated with the coverage you have under any other plan, including but not limited to the following:

i) Group insurance or any other arrangement of coverage in a group whether or not insured or self-insured; or
ii) Individual coverage from a private insurer, including PPOs, HMOs, a Covered California plan, or any other prepaid medical arrangement; or
iii) Medicare.

For any Covered Service under the Plan, you will receive up to the normal benefit.

B) Which Plan Pays First - Coordination of Benefits

Below are several examples of how the Plan's coordination of benefits provisions operates.

i) If you and your Spouse/Domestic Partner are both retired and have coverage:
   a) The plan covering the Patient as a participant/subscriber is the primary payer.
   b) The plan covering the Patient as a dependent is the secondary payer.

ii) If one of you is retired and the other is actively employed:
   a) The plan providing active coverage is the primary payer.
   b) The plan providing retiree coverage is the secondary payer.

iii) If you are retired but using your Active Plan Eligibility Bank, and your Spouse/Domestic Partner is actively employed:
   a) The plan providing coverage for your Spouse/Domestic Partner is the primary payer.
   b) This Plan is the secondary payer because you are retired.

C) Coordination of Benefits with Medicare

i) Overview

Detailed information about Medicare is available through the "Medicare & You" handbook from Medicare. You are strongly encouraged to study the Medicare handbook. If you have not received a copy, you can download it from www.medicare.gov/publications. You can also get more information about Medicare from:

a) www.medicare.gov;
b) (800) 633-4227 (TTY users should call (877) 486-2048); or
c) California Health Advocates at (800) 434-0222.

The following is only a general summary of Medicare benefits. It is NOT a substitute for your own research based on your particular circumstances. There are four Medicare programs:

- Part A – Hospital Insurance
- Part B – Medical Insurance
  - Part A and Part B constitute "Original Medicare". This is the default Medicare coverage.
  - You may add a Medigap policy (optional insurance to help pay your out-of-pocket costs) and/or Part D Prescription drug insurance to Original Medicare.
- Part C – Medicare Advantage Plans
  - These optional plans replace Original Medicare and are like HMOs or PPOs. They typically include Part A, Part B, and Part D coverage.
- Part D – Prescription Drug Insurance

Part A coverage is usually free. Premiums apply for Parts B, C, and D coverage. If you do not enroll when you are first eligible, there may be a penalty in the form of a higher premium.

If you retire at age 65, you can apply for Medicare as part of your application for Social Security retirement benefits. The Social Security Administration advises people to apply 90 days before their 65th birthday. If your application is approved, Medicare will become effective on the first of the month in which you attain age 65.

ii) Which Plan Pays First

Below are some examples of how the Plan's coordination of benefits provisions apply with Medicare.

a) If you and your Spouse/Domestic Partner are both employed with medical coverage and eligible for Medicare:
   1) The plan providing coverage as an employee is the primary payer.
   2) The plan providing coverage as a dependent is the secondary payer.
   3) Medicare is the third payer.

b) If you are employed with medical coverage and your Spouse/Domestic Partner is retired with medical coverage, and both of you are eligible for Medicare:
   1) The plan providing coverage as an employee is the primary payer.
   2) Medicare is the secondary payer.
   3) The plan providing coverage as a retiree is the third payer.

c) If you are retired and using your Eligibility Bank to maintain coverage under the Active Plan and you are eligible for Medicare:
   1) The Active Plan is the primary payer.
   2) Medicare is the secondary payer because you have an Eligibility Bank.

IMPORTANT	**Medicare is the primary payer of your benefits from the date you deplete your Eligibility Bank. Medicare is considered by this Plan to be the primary payer of benefits for people eligible for Medicare whether or not they are enrolled in the Medicare program. This means that if you do not enroll in Medicare as soon as you are eligible, this Plan will not pay for benefits that Medicare would have paid for had you been enrolled in Medicare.** **To get full benefits under the Plan, Medicare Part A and Part B must be effective before your retirement effective date.**

D) Benefit Reduction – Failure to Comply with Coordination of Benefits Rules

If the other plan is an HMO or PPO plan and if you do not use that plan's contracted providers for services and supplies that would normally be covered under that plan, the benefits payable under this Plan will be reduced to 20% of the Blue Shield of California PPO Network Rate or the out-of-network provider Allowable Charge, whichever is applicable.

If your Spouse/Domestic Partner could have been covered as an employee under another plan, with no premium paid by the employee, but declined such coverage, the benefit payable will be reduced to 20% of the Blue Shield of California PPO Network Rate or the out-of-network provider Allowable Charge, whichever is applicable.

SECTION 15. 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 because of negligence, an intentional act, or a breach of any legal obligation on the part of that third party and against whom a Participant or Eligible Dependent has a claim. However, the Plan will conditionally pay for benefits for such Illness, Injury, or disease while the claim is being adjudicated, providing the Patient executes an agreement to reimburse the Fund, and will cover such benefits to the extent recovery against the third party is unsuccessful.

If any service is provided or medical claims paid in connection to any Illness or Injury caused by a third party, and you recover from a third party, insurance policy, or uninsured motorist coverage, you must reimburse the Plan from the recovered funds for medical claims paid in connection with the Illness or Injury. You 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, you will pay the Plan the recovered funds up to the full amount of medical claims paid on your 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 you 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. Without waiving its rights herein, the Plan

may, at its sole discretion, agree to reduce the full amount to which it is entitled under this provision to contribute to reasonable attorney's fees and costs incurred by you in collecting a recovery from the third party.

By making payments on your behalf, the Plan is granted a lien on such recovery. The Plan shall be entitled to enforce this requirement through any remedy permitted by equity. By accepting payments from the Plan, you 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.

You must complete and sign an agreement to reimburse the Fund in such a form as the Plan may require before any benefits are paid. If you refuse to sign an agreement to reimburse, or any other such agreement the Plan may require, you shall not be eligible for benefits under the Plan for medical claims related to this Illness or Injury. You may not assign any rights or cause of action that you may have against a third party to recover medical expenses without the express written consent of the Plan. You 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, as a condition of receiving benefits, you will be required to fully cooperate with the Plan to the extent the Plan pursues any subrogated claim.

If the Plan pays benefits on your behalf and you recover any proceeds from or on behalf of a third party, any insurance policy, or from uninsured motorists coverage, and you do not reimburse the Plan, you 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 16. EXCLUSIONS AND LIMITATIONS

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

A) Medical

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

1) A claim for a service or procedure not expressly covered by the Plan;
2) Any claim for treatment, services, or supplies, including any additional information requested, that is not filed within 12 months from the date the expense is incurred;
3) 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;
4) Any services or procedures that are Experimental Treatments or investigational 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, medical treatment, or procedure is considered experimental or investigational if:
    a) It is a drug or device that cannot be lawfully marketed without the 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, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis; or
    c) Reliable evidence shows that the consensus 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, safety, efficacy, or 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;
5) Services, prescriptions, medications, and supplies received outside of the United States and its territories unless:
    a) The services, medications, or supplies were the result of an Accident, urgent care requirement, or life-threatening Emergency Medical Condition or
    b) The Eligible Participant submits proof of residency in the country where the services were rendered;
6) Charges for missed or broken appointments;
7) Charges for completion of forms;
8) Charges for phone consultations other than telemedicine (e.g., reading of EKGs);

9) Hospital or Extended Care Facility charges for personal items such as charges for radio, television, telephone, guest expenses, and other similar items;
10) Charges for personal comfort, beautification, or convenience items or services;
11) Custodial Care as defined in this SPD;
12) Housekeeping services;
13) "Standby" charges (charges in which a Physician is present but is not providing care, treatment, or a diagnosis). This includes, but is not limited to, standby charges for an anesthesiologist, pediatrician, or trauma team;
14) Additional charges for "after-hours" and weekend services by a Physician;
15) Expenses for travel or transportation, except as provided under ambulance benefits;
16) EMS (Emergency Medical Service) with no transport;
17) Services by a provider who is a family member of the Patient;
18) Vitamins, including prenatal vitamins (prescription and over-the-counter);
19) Prescription Drugs dispensed in a Physician's office;
20) Over-the-counter medications and medical supplies, such as gauze, bandages, breast pumps, shoe inserts, and herbal medications;
21) Blood pressure monitors, thermometers, vaporizers;
22) 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 devices, humidifiers, and nasal pillows;
23) Replacement or repair of Durable Medical Equipment within 36 months unless otherwise specified not to exceed $150 annually;
24) Electric wheelchairs, electric hospital beds (allowance may be made for standard wheelchair or standard hospital bed);
25) Cosmetic Surgery, except for Medically Necessary treatment resulting from Accidental Injury, functional disorder, or congenital malformation or treatment related to Gender Identity Disorder. (It is suggested, but not required, that the eligible individual's Physician submit the proposed procedure to the Fund before the procedure to determine if benefits are available under the Plan);
26) Weight control, such as surgical procedures, medications, or exercise programs regardless of any medical condition, related or otherwise;
27) Goal-oriented behavior modification therapy for smoking cessation or weight loss;
28) Exercise equipment, tanning booths, whirlpools, swimming pools, saunas, spas, massage therapy, or gym membership;
29) Charges for obtaining, testing, and storing the Patient's blood before a medical procedure of any kind;
30) Family Planning (except Prescription Drug benefit for contraceptive drugs and devices);
31) Testing for or treatment of infertility, including artificial insemination and in-vitro fertilization, or any charges associated with the direct inducement of pregnancy, any testing during and related to the treatment of infertility or related conditions or complications of the treatment;
32) Care or treatment for pregnancy or related conditions or complications;
33) Reversal or attempted reversal of an elective sterilization procedure;
34) Acupuncture except as provided by a Physician or Licensed Acupuncturist;
35) Care by homeopathic practitioners, naturopathic practitioners, and doctors of oriental medicine (OMD);
36) Treatment for Temporomandibular joint dysfunction (TMJ) except if covered by DeltaCare USA or MetLife dental PPO;
37) Transplant and stem cell transfers (except as noted under Transplant Benefit);
38) Routine vision care, including eye examinations, eye glasses, or contact lenses;
39) Any refractive eye surgery (e.g., Lasik Surgery), regardless of the diagnosis.

B) Third-Party Liability

In addition to the Exclusions and Limitations listed elsewhere in this SPD, except as explicitly provided under Third Party Liability (see Section 15, page 44), the Plan will not provide benefits for:

40) Any charges or medical claims for which a third party may be liable or legally responsible, unless payable under the terms of the Plan's Third Party Liability recovery provisions;
41) Any charges paid for or payable by another plan or insurance;
42) Charges for services, treatments, or supplies for the care and treatment of an Injury or Illness that are more than the charges that would have been made in the absence of the benefits provided by the Plan;
43) Any Illness, Injury, or disability covered by any worker's compensation laws;
44) Care or treatment obtained in a federal or state facility, or a facility operated by a government agency, for which you are not required to pay except to the extent benefits are required by law to be paid by the Plan;
45) Conditions caused by an act of war, armed invasion, or insurrection;
46) Care or treatment in any penal institution.

C) Other

In addition to the Exclusions and Limitations listed elsewhere in this SPD, the Plan will not:

47) Pay interest on unpaid balance(s);
48) Reissue a benefit payment more than two years after it was first issued;

49) Pay for any charge by a financial institution, including but not limited to the deposit or cashing of:
   a) A check upon which a stop payment has been placed, or
   b) A stale-dated check.

IMPORTANT	**No healthcare provider is an agent or representative of the Plan or 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 or supplies to you 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 health care providers, including both Blue Shield of California PPO network providers and out-of-network providers under the terms of the Plan, and to all entities (and their agents, employees, and representatives) that contract with the Plan to offer contracting networks, or health-related services or supplies to you. Nothing in this Plan affects the ability of a provider to disclose alternative treatment options to you.**

SECTION 17. IMPORTANT NOTICES

A) No Assignment of Benefits

No one, including, but not limited to, a Participant or an Eligible Dependent, is permitted to assign any benefits, rights, or claims for benefits to any third party, including, but not limited to, a provider or a facility, without the express written consent of the Board of Trustees. Accordingly, unless written consent is provided, the Plan will not recognize or accept any assignment of benefits, rights, or claims for benefits or any appeal of a denied claim for benefits. "Benefits, rights or claims for benefits" includes, but is not limited to: (i) a claim, or an appeal of a denied claim, for payment of a benefit under the terms of the Summary Plan Description or other Plan document or communication; (ii) a claim for benefits or other relief under Section 502(a) of ERISA; (iii) a breach of fiduciary duty claim under ERISA or common law; (iv) a claim brought under state law; or (v) a claim for penalties assessable under any law or regulation.

A Participant or an Eligible Dependent may direct that benefits payable from this Plan to them be paid to a provider or a facility that delivered the related medical care to the Participant or Eligible Dependent. However, the Plan is not obligated to accept such direction. No payment made by the Plan to the provider or the facility, nor any communication about benefits or payments between representatives of the Plan and a provider or a facility, shall be considered an assignment of the benefit, an assignment of a claim, or an appeal, a waiver of this no assignment provision, or a contract with the provider or the facility to pay benefits.

B) Erroneous Payments

Every effort will be made to ensure accuracy in paying your benefits. If an error is discovered regardless of how long ago it occurred, and it is determined that the Fund has paid any benefits you are not entitled to, you are obligated to reimburse the Fund for the erroneous payments. The Trustees have the right to seek repayment from you through any legal means, including the right to reduce future benefit payments for you or your Eligible Dependent by the amount of the erroneous payment.

C) 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 erroneous amounts paid by the Fund, 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.

D) No Fund Liability

Using the services of any Hospital, Physician, or other health care provider, whether designated by the Fund or otherwise, is your voluntary act. Nothing in this SPD 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 or subcontractors of the Plan. The Trustees make no representation regarding the quality of service or treatment of any provider. They 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 because of negligence, failure to provide care or treatment, or otherwise.

SECTION 18. INFORMATION REQUIRED BY ERISA

The following additional information concerning the Plan is provided to you per the Employee Retirement Security Act of 1974 (ERISA). The terms in this section are generally as defined in ERISA unless capitalized.

A) Name and Type of Plan

The name of the Plan is the Southern California Pipe Trades Pensioners & Surviving Spouses Health Plan. It is a multi-Employer health and welfare benefit plan. It provides medical, Prescription Drug, dental, hearing aid, and other benefits.

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

B) Identification Numbers

The Fund's Internal Revenue Service tax identification number is 27-4271742. The Plan number is 501.

C) Plan Year

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

D) Plan Sponsor, Named Fiduciary, and Administrator

The Plan is maintained under a collectively bargained, jointly trusteed labor-management trust. The Board of Trustees is the plan sponsor, the plan administrator, and the named fiduciary under ERISA.

E) Board of Trustees

The Board of Trustees consists of Employer and Union representatives, selected by the Employers and Unions per 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	(800) 595-7473
Southern California Pipe Trades	(213) 385-6161
Pensioners & Surviving Spouses Health Fund	www.scptac.org
501 Shatto Place, Suite 500	info@scptac.org
Los Angeles, CA 90020	

F) Fund Office

The Board of Trustees has designated the Southern California Pipe Trades Administrative Corporation to perform the daily business functions of the Plan. You may contact the Fund Office at:

Southern California Pipe Trades Administrative Corporation	(800) 595-7473
Attention: CEO/Administrator	(213) 385-6161
501 Shatto Place, Suite 500	www.scptac.org
Los Angeles, CA 90020	info@scptac.org

G) Agent for Service of Legal Process

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

Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund
Attention: CEO/Administrator
501 Shatto Place, Suite 500
Los Angeles, CA 90020

H) Source of Contributions and Identity of any Organization Through Which Benefits are Provided

Contributions to the Fund are made by:

i) Employers per their Collective Bargaining Agreements or per the terms of a Participation Agreement, which require that contributions be made to the Fund at fixed rates per hour of work; and
ii) Self-payment as described in Section 5, page 13, and Section 6, page 17.

The Fund Office will provide you, upon written request, a complete list of Employers and Unions that are parties to a Collective Bargaining Agreement and their addresses. The Fund Office will also provide information about whether a particular employer is obligated to contribute to the Fund on behalf of Employees working under a Collective Bargaining Agreement or Participation Agreement and the address of any such employer.

The Fund's assets are held in trust by the Board of Trustees. Custody of the Fund's assets is with U.S. Bank, N.A. Benefits are provided directly from the Fund's assets, which are accumulated under the provisions of the Trust Agreement, except for certain insured dental benefits. The assets are used exclusively for providing benefits to participants and beneficiaries per the provisions of the Plan and for paying the reasonable administrative expenses of the Fund.

All types of benefits provided by the Plan for Pensioners & Survivors are set forth in this SPD. There is a separate Plan with its own SPD covering benefits for active Employees.

I) Collective Bargaining Agreement

Contributions to the Fund are made per Collective Bargaining Agreements between Employers and District Council No. 16 of the United Association or affiliated local Unions of District Council No. 16 or of the United Association. The United Association local Unions affiliated with District Council No. 16 are 78, 114, 230, 250, 345, 364, 398, 403, 460, 484, 582, and 761. The Fund Office will provide you, upon written request, a copy of the applicable Collective Bargaining Agreement. The Collective Bargaining Agreement is also available for examination at the Fund Office. The following are the employer associations with which District Council No. 16 has a bargaining relationship that requires contributions to this Fund:

i) California Plumbing & Mechanical Contractors Association (CPMCA);
ii) Airconditioning, 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 this Plan will continue indefinitely, but the Board of Trustees reserves the right to change or discontinue the Plan at any time. Assets may also be transferred to a successor fund providing health care benefits. The Trustees may terminate the Plan 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 Plan may also be terminated if no individuals living can qualify as participants or beneficiaries or if there are no longer any Collective Bargaining Agreements requiring contributions to the Fund. The Trustees have the complete discretion to determine when and if the Fund should be terminated.

If the Plan is terminated, the Trustees will: (i) pay the expenses of the Fund incurred up to the date of termination as well as the expenses in connection with the termination; (ii) arrange for a final audit of the Fund; (iii) give any notice and prepare and file any reports required by law; and (iv) apply the assets of the Fund per the law and the Plan, including amendments adopted as part of the termination, until the assets are distributed. Under no circumstances will any portion of the Fund revert to the benefit of an Employer, any employer association, or the Unions.

Upon termination of the Plan and Fund, the Trustees will promptly notify the Union, any employer association, Employers, and all other interested parties. The Trustees will continue as Trustees to wind up the affairs of the Plan.

K) Actions of Trustees

The Trustees have full discretion and authority over the standard of proof for any inquiry, claim, or appeal and over the application and interpretation of the Plan and trust. No legal proceeding may be filed in any court or before an administrative agency against the Plan or its Trustees unless all review procedures with the Trustees have been exhausted. No legal action may be commenced against the trust, the Plan, or the Trustees more than two years after a claim has been denied.

L) Right to Amend

The Trustees have complete discretion to amend or modify the Plan or trust and any of their provisions, 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 Participants, Eligible Dependents, and Beneficiaries. The Trustees may also modify any eligibility requirements for coverage.

M) 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

a) Examine, without charge, at the plan administrator's office and 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 Employee Benefits Security Administration.

b) 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 an updated summary plan description. The administrator may make a reasonable charge for the copies.

c) Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

ii) Continue Group Health Plan Coverage for a Spouse

Your former Spouse may continue health care coverage if coverage is lost under the Plan due to a Qualifying Event. Your former Spouse will 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.

iii) Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, must 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.

iv) Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits 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 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.

v) Assistance with Your Questions

If you have any questions about your Plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the 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.

N) Preferred Providers and Pre-paid Plans

The Board of Trustees may, from time to time, in its sole discretion, enter into written agreements with preferred provider (PPO) organizations or prepaid plans, such as health maintenance organizations (HMO). The use of such preferred providers is wholly at your option.

The current PPO network for medical services is:

Blue Shield of California
P.O. Box 272540
Chico, CA 95927
(800) 541-6652

The current PPO network for dental services is:	MetLife PPO P.O. Box 981282 El Paso, TX 79998-1282 (800) 942-0854
The current DHMO network for dental services is:	DeltaCare USA P.O. Box 1810 Alpharetta, GA 30023 (800) 422-4234
The current network for vision services is:	VSP P.O. Box 495918 Cincinnati, OH 45249-5918 (800) 877-7195

The existence of any preferred provider or pre-paid plan agreement shall not, in any manner, imply an endorsement of any specific provider, nor shall it constitute any guarantee of the services rendered.

SECTION 19. OTHER FEDERAL LAWS

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

i) Protected Health Information

The U.S. Department of Health & Human Services issued the Standards for the Privacy of Individually Identifiable Health Information. Under HIPAA, these rules give you greater control over who may access the information in your medical records. Health plans, such as this Plan, cannot share Protected Health Information ("PHI") under many circumstances without written authorization.

ii) 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, fulfill its coverage responsibilities, and 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 the Fund 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 a 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.

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 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 law enforcement purposes 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 to identify or locate 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 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 their 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 Uniformed 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.

Notwithstanding the foregoing, neither the Fund nor any of its business associates, may use or disclose your PHI for the following purposes:

a) To conduct a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating lawful reproductive health care.
b) To impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating lawful reproductive health care.
c) To identify any person for any purpose described in a) or b).

The prohibition on the use or disclosure of PHI related to reproductive health care applies when the reproductive health care at issue (1) is lawful under the law of the state in which such health care is provided; (2) is protected, required, or authorized by Federal law, including the United States Constitution, under the circumstances in which such health care s provided, regardless of the state in which it is provided; or (3) is provided by another person and presumed lawful.

The Fund may use or disclose your PHI to you, to your personal representative, to a third party (such as your Spouse or Domestic Partner) 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 and permissible under applicable law:

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 complete and sign an Authorization to Disclose Confidential Information form. You can revoke an Authorization to Disclose form at any time by submitting a Cancellation of Authorization to Disclose Confidential Information 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 per the provisions of the Fund's Privacy Policy and the provisions of the Plan.

iii) Individual Rights

You have certain important rights concerning 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 the 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.

iv) 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 concerning 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 you a paper copy of the notice currently in effect upon request.
d) If a breach of your PHI is discovered, the Fund has certain obligations to provide a notice to you.

v) 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 before issuing the revised notice.

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

vi) 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:

Southern California Pipe Trades
Pensioners & Surviving Spouses Health Fund
Attention: Privacy Officer
501 Shatto Place, Suite 500
Los Angeles, CA 90020

(800) 595-7473
(213) 385-6161
www.scptac.org
info@scptac.org

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 anyone for filing a complaint.

vii) For More Information About Privacy

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

B) Women's Health and Cancer Rights

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

The Plan also provides benefits for the following procedures:

i) All stages of reconstruction of the breast on which the mastectomy was performed;
ii) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
iii) Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the Physician and the Patient.

Benefits are determined based on the nature of the treatment and whether or not you choose a Blue Shield of California PPO network provider, and per Plan limits.

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.

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

Active Plan
Southern California Pipe Trades Health & Welfare Plan.

Allowable Charge
The dollar amounts for services that the Plan uses to determine how much it will pay, and how much your out-of-pocket cost will be, when you use an out-of-network provider. These dollar amounts are generally less than the amount the provider bills and less than the Blue Shield of California PPO Network Rate for in-network providers. For a few types of benefits (orthotics, pain management, home health care, allergy treatment, and hearing aids), an Allowable Charge also applies to Blue Shield in-network providers instead of the Blue Shield of California PPO Network Rate. Any amount that exceeds the Allowable Charge is not considered by the Plan. You are responsible for the Coinsurance amount, if any, and for any charges that exceed the Allowable Charge, but such amounts may be eligible for reimbursement from your HRA Allowance. When the Plan determines that the services rendered by an out-of-network provider are due to an Emergency Medical Condition, the Plan will pay an amount that is reasonable, as determined by the Plan, that may be more than the Allowable Charge. This amount is calculated using Medicare rates, UCR (usual, customary, and reasonable), or negotiation with the provider.

Annuity Starting Date
The date you are first entitled to receive a benefit from the Southern California Pipe Trades Retirement Plan, although the actual payment may be made later. Usually, your Annuity Starting Date is the first of the month after you have met the Retirement Plan's eligibility requirements and have submitted a pension application.

Appeals Committee
A subset of the Board of Trustees empowered to review any claims as described in Section 12.

Blue Shield of California
Blue Shield of California is a non-profit organization created to contract with healthcare providers to offer you quality healthcare services with lower Out-of-Pocket expenses.

Blue Shield of California PPO Network Rate
The fee charged for services rendered by participating providers with Blue Shield of California.

Board of Trustees
All of the Trustees established as one body according 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 their license, holding the degree of Doctor of Chiropractic (DC), and who is legally entitled to provide chiropractic care in all its branches under applicable laws where the services are rendered.

COBRA
The Consolidated Omnibus Budget Reconciliation Act of 1985 that may provide for continuation coverage when a Spouse loses coverage under the Plan.

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

Collective Bargaining Agreement
Any negotiated labor agreements between a Contributing Employer, or employer association acting on behalf of Employers, and Southern California Pipe Trades District Council No. 16 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada ("United Association"), or any local Union affiliate of the District Council that requires contributions to the Southern California Pipe Trades Pensioners and Surviving Spouses Health Fund. It also refers to an agreement to which the United Association is a party, requiring contributions to the Fund.

Continuous Comparable Coverage
Enrollment that has not lapsed for more than 60 days in a plan offering minimum essential coverage under the Affordable Care Act, a Medicare Advantage Plan (HMO, PPO, or Private Fee-For-Service plan), or a Medicare Supplemental (Medigap) Plan.

Contributing Employer
An Employer signed to a Collective Bargaining Agreement or Participation Agreement, or an Employer that assigns its bargaining rights to an employer association signed to a Collective Bargaining Agreement, that requires contributions to the Fund.

Coordination of Benefits Form
The form required by the Fund to provide information necessary to process claims. One complete routine Coordination of Benefits Form is required per Patient per Calendar Year. An Injury and Third Party Liability Form is required for any Injury.

Covered Employment
Work by an Employee under a Collective Bargaining Agreement.

Covered Services
Services that are expressly listed as covered by the Plan.

Custodial Care
Care that is primarily to meet personal needs which could be provided by persons without professional skills or training. This includes, but is not limited to, help with 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 considers expenses for reimbursement. 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 their license, holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD), 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.

Domestic Partner
A person with whom a Pensioner has established and registered a domestic partnership with the State of California or who has validly established and registered a domestic partnership, or similar union, in another state substantially similar to a domestic partnership recognized in California.

Durable Medical Equipment
Equipment that meets the following criteria:

A) Can withstand repeated use;
B) Is primarily and customarily used for a medical purpose and is not generally useful in the absence of Injury or Illness;

C) Is not primarily used for exercise;
D) Is not disposable or non-durable; and
E) Is used by the Patient only.

Eligibility Bank

The Active Plan Eligibility Bank is funded by contributions from Contributing Employers on an Employee's behalf. Active Plan eligibility is determined by the contributions credited and debited to and from the Eligibility Bank.

Eligible Dependent

The Pensioner's lawful Spouse or Domestic Partner if timely enrolled.

Emergency Medical Condition

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention could reasonably result in one or more of the following:

A) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
B) Serious impairment to bodily functions; or
C) Serious dysfunction of any bodily organ or part.

Emergency Services

A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and, within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required to stabilize the Patient.

Employee

An Employee is anyone employed by a Contributing Employer in a position for which the Employer contributes to the Fund under a Collective Bargaining Agreement. Employees may also include an Employer or someone employed by an organization signatory to a Participation Agreement.

Employer

See Contributing Employer.

ERISA

Employee Retirement Income Security Act of 1974, as amended.

Exclusion or Limitation

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

A) It is a drug or device that cannot be lawfully marketed without the 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 ongoing 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 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.

Explanation of Benefits
An Explanation of Benefits (commonly referred to as an EOB) is a statement sent by the Plan to you explaining what treatments or services were processed on your behalf.

Extended Care Facility
An institution, or a distinct part thereof, that is licensed under applicable laws and is operated primarily to provide skilled nursing care and treatment for a Participant or Eligible Dependent convalescing from Injury or Illness and:

A) Is approved by and is a participating extended care facility of Medicare;
B) Has organized facilities for medical treatment and provides 24-hour nursing services under the full-time supervision of a Physician or Registered Nurse;
C) Maintains daily clinical records on each Patient and has available the services of a Physician under the established agreements;
D) Provides appropriate methods for dispensing and administering Prescription Drugs;
E) 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
F) Is not an institution that is primarily a place for rest, a place for Custodial Care, a place for the aged, a hotel, or a similar institution.

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, Suite 500
Los Angeles, CA 90020

(800) 595-7473
(213) 385-6161
www.scptac.org
info@scptac.org

Hospice
A facility that provides a Hospice Care Program and operates under applicable law is a Hospice. It serves 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 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 Disorder treatment facilities 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 hotel, or a similar institution.

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.

Injury and Third-Party Liability Form
A form required by the Fund to provide information necessary to process claims related to an accident or injury. One complete Injury and Third-Party Liability form is required per Injury to determine third-party liability for claims reimbursement purposes.

Inpatient
Treatment or services received after you have been admitted to the Hospital with a Physician's order.

Lifetime Maximum Benefit (LMB)
The total dollar amount payable during your life for benefits issued by the Fund.

Medically Necessary/Medical Necessity

Appropriate for the condition being treated, per 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.

Medical Necessity, when used concerning genetic testing, generally must meet all of the following three criteria:

A) One of the following:
   i) Family history suggestive of a heritable condition;
   ii) Specific symptoms suggestive of a heritable condition;
   iii) Medical management requires consideration of genetic variants; and
B) Testing will impact treatment or heighten monitoring for early detection of disease; and
C) Evidence-based data supports the validity and utility of the test.

Medicare

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

Mental Disorder

A condition, Illness, disease, or disorder listed in the most recent edition of the International Classification of Diseases (ICD) as a psychosis, neurotic disorder, or personality disorder; and other non-psychotic disorders listed in the ICD.

Nurse

A person acting within the scope of their license and holding a degree/licensure of a Registered Nurse (RN), Certified Nurse Midwife (CNM), Licensed Vocational Nurse (LVN), or Licensed Practical Nurse (LPN).

Out-of-Pocket (OOP)

The amount the Patient may owe over what the Fund has paid. This includes Deductibles, Coinsurance, and non-covered charges. This is also called the "amount you may owe" on your Explanation of Benefits statement.

Out-of-Pocket Maximum

The most you have to pay for Covered Services in a Calendar Year. After you spend this amount on your Deductibles, as well as Prescription Drug and medical Coinsurance for Covered Services, the Plan pays 100% of the costs for Covered Services. This does not include amounts that are above the Allowable Charge.

Outpatient

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

Participant

Someone who has satisfied the rules to become eligible for benefits under the terms of the Plan.

Partial Hospitalization (for Mental Health and Substance Use Disorders)

Medically directed intensive, or intermediate short-term, mental health and substance use disorder treatment, for a period of less than 24 hours but more than four hours in a day in a licensed or certified freestanding or hospital-based facility or program.

Participation Agreement

An agreement approved by the Board of Trustees permitting a Contributing 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 not covered by a Collective Bargaining Agreement.

Patient

The Participant or Eligible Dependent receiving care, equipment, or Prescription Drugs.

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 their license and holding the degree of Doctor of Medicine (MD) or Doctor of Osteopathy (DO) who is legally entitled to practice medicine in all its branches under applicable laws. Providers such as Homeopathic Practitioners, Naturopaths (NP), and Doctors of Oriental Medicine (OMD) are not included.

Plan
The benefits, rules, Exclusions or Limitations, and other provisions described in this SPD.

Plan Year
January 1 through December 31 of each year.

Podiatrist
A Podiatrist or chiropodist licensed to practice podiatry or chiropody within the meaning of the license granted by the state in which the podiatrist or chiropodist is practicing.

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

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

Psychiatrist
A Physician who provides care and treatment for a Mental Disorder who is licensed to practice as a psychiatrist in the jurisdiction where the services are provided.

Qualified Beneficiary
Qualified Beneficiary means the Pensioner or Spouse who is entitled to elect COBRA coverage after the loss of coverage under the Plan due to a Qualifying Event.

Qualifying Event
A circumstance that permits a Pensioner or Spouse to elect COBRA coverage. Qualifying Events may include, but are not limited to, divorce from the Pensioner or death of the Pensioner.

SPD
Summary Plan Description. This document. A description of the provisions of, and benefits available under, the Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund.

Special Extension Period
In this Plan, the three-month period after the Pensioner's death during which free coverage is offered to a Survivor. In the Active Plan, a period of zero to three months of coverage in this Plan in the event of the Active Participant's death.

Spouse
Any person to whom a Pensioner is legally married.

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

Survivor
A Spouse or Domestic Partner of a deceased Participant who was covered under this Plan or the Active Plan on the Participant's date of death.

Survivor Premium Program
A continuing coverage option offered by this Plan for Survivors at a monthly Premium.

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

Totally Disabled
Wholly prevented by bodily Injury or Illness from engaging in any occupation or employment.

Trust Agreement
The written document titled "Agreement and Declaration of Trust Establishing the Southern California Pipe Trades Pensioners and Surviving Spouses Health Fund" under which the Fund has been established and maintained and to which this Plan has been adopted and any amendments to it.

Trustees
Employer and Union representatives who oversee the Fund.

Union(s)
Southern California Pipe Trades District Council No. 16 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada, AFL-CIO ("United Association"), and its affiliated local Unions, and such other unions which have or may in the future 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

The following is a list of the Trustees as of the publication date of this SPD. The members of the Board of Trustees may change from time to time. If you want a current listing of the Trustees, contact the Fund Office.

A) Employer Trustees

RYAN CAVANAUGH
Murray Company
5995 Plaza Drive
Cypress, CA 90630

ROBERT FELIX
All Area Plumbing/ACCO Engineered Systems, Inc.
6446 E. Washington Blvd.
Commerce, CA 90040

JASON GORDON
Prime SC Mechanical, Inc.
7392 Earl Circle
Huntington Beach, CA 92647

JEFF HACHEY
H.L. Moe Company, Inc.
526 Commercial Street
Glendale, CA 91203

ADAM KAPLAN
Sierra Commercial Plumbing, Inc.
4645 Industrial Street, Unit C
Simi Valley, CA 93063

CHIP MARTIN
CPMCA
1735 Flight Way, Suite 204
Tustin, CA 92782

JOHN MODJESKI
University Mechanical & Engineering Contractors
1168 Fesler Street
El Cajon, CA 92020

JEFF STEVANUS
Southland Industries
12131 Western Avenue
Garden Grove, CA 92841

BRYAN SUTTLES
Suttles Plumbing
2267 Agate Court
Simi Valley, CA 93065

STEVE VALOT
Pan-Pacific Mechanical
18250 Euclid Street
Fountain Valley, CA 92708

LAWRENCE VERNE
Verne's Plumbing, Inc.
8561 Whitaker Street
Buena Park, CA 90621

PIP ZAIDE
Allegiant Mechanical, Inc.
7776 Westminster Blvd.
Westminster, CA 92683

B) Union Trustees

DAVID BALDWIN
U.A. Local No. 403
3710 Broad Street
San Luis Obispo, CA 93401

STEVEN BERINGER
U.A. Local No. 230
6313 Nancy Ridge Drive
San Diego, CA 92121

SHANE BOSTON
U.A. Local No. 484
1955 N. Ventura Avenue
Ventura, CA 93001

BEN CLAYTON
U.A. Local No. 250
18355 South Figueroa Street
Gardena, CA 90248

RODNEY COBOS
District Council No. 16
501 Shatto Place, Suite 400
Los Angeles, CA 90020

JEREMY DIAZ
U.A. Local No. 78
1111 W. James M. Wood Blvd.
Los Angeles, CA 90015

STEVEN GOMEZ
U.A. Local No. 460
6718 Meany Avenue
Bakersfield, CA 93308

ROBERT JAMES
U.A. Local No. 582
1916 W. Chapman Avenue
Orange, CA 92868

GREG LEWIS
U.A. Local No. 761
1305 North Niagara Street
Burbank, CA 91505

RICARDO PEREZ
U.A. Local No. 345
1430 Huntington Drive
Duarte, CA 91010

JOE RAYMOND
U.A. Local No. 364
223 S. Rancho Avenue
Colton, CA 92324

BILL STEINER
U.A. Local No. 398
8590 Utica Avenue, Suite 200
Rancho Cucamonga, CA 91730

SASHA STEVENS
U.A. Local No. 114
93 Thomas Road
Buellton, CA 93427

APPENDIX 1 - SCPT RETIREMENT FUND SUSPENSION OF BENEFIT RULES

The following are excerpts from the Southern California Pipe Trades Retirement Fund Summary Plan Description that relate to when your Pensioners & Surviving Spouses Health Fund coverage may be suspended and reinstated. See Section 4(E) of this Pensioners & Surviving Spouses Health Fund SPD.

Southern California Pipe Trades Retirement Fund Summary Plan Description

SECTION 12. RETIREMENT AND SUSPENSION

A) Retirement-Severance from Employment

i) Before Age 65

If you have not reached Normal Retirement Age (generally age 65), then to be considered retired and eligible to apply for and receive an early or service pension benefit from the Plan, you must retire and refrain from any and all employment with Employers participating in the Retirement Fund and must sever any and all employment with Employers participating in the Retirement Fund before your Annuity Starting Date.

ii) Age 65 and Older

If you have reached Normal Retirement Age or older, you will be considered retired and eligible to apply for and receive benefits if you refrain from employment prohibited by the Plan and from all employment or work in the State of California in the plumbing and pipefitting industry in the same trade or craft in which you earned Pension Credits, with any Employer (whether or not signatory to a Collective Bargaining Agreement) or self-employed. However, you may work up to 39 hours per month in this type of employment without affecting your eligibility to retire.

B) Suspension of Benefits Upon Return to Employment

If you retire but subsequently return to work and work in what the Plan defines as "disqualified employment", your benefit may be suspended as explained below.

i) Disqualified Employment Before Age 65

If you retire before age 65 and later return to work, your benefit will be suspended from payment if you accept employment or activity in the plumbing or pipefitting industry. Employment or activity in the plumbing and pipefitting industry means the industry in which Employees covered by this Plan are employed and related businesses and any industry that falls under the trade jurisdiction of the United Association or any of its local unions. Disqualified Employment in this industry includes all job site and offsite construction, prefabrication, pre-cutting, supervisorial, design, labor relations, expediting and maintenance work, employment as an Employer or for a labor organization. The scope of this prohibition includes work for another person or company or through self-employment even if the pensioner is not doing the work directly but is supervising, directing or assigning work, or subcontracting.

Certain work in the industry is acceptable and will not be considered "disqualified employment".

a) It is acceptable for you to return to work and perform design, estimating, or consulting work in the plumbing and pipefitting industry so long as all of the following requirements are met:

1. The work is for an Employer that is a signatory to a Collective Bargaining Agreement with the United Association or an affiliated local union; and
2. The work is not performed on a job site; and
3. The work is performed as an actual employee of an Employer, not as an independent employer or sub-employer; and
4. The product of your work is supplied only to an entity that is a signatory to a Collective Bargaining Agreement with the United Association or an affiliated local union.

b) It will not be considered "disqualified employment" if you return to work as a corporate officer and hold a contractor's license or serve as an officer of the corporation or perform managerial, design, estimating, or consulting work for a corporation signatory to Collective Bargaining Agreement requiring contributions to the Fund.

The following are excerpts from the Southern California Pipe Trades Retirement Fund Summary Plan Description that relate to when your Pensioners & Surviving Spouses Health Fund coverage may be suspended and reinstated. See Section 4(E) of this Pensioners & Surviving Spouses Health Fund SPD.

Southern California Pipe Trades Retirement Fund Summary Plan Description

SECTION 12 (continued)

c) In addition, it will not be considered "disqualified employment" if you return to work with the United Association or any of its affiliates outside District Council No. 16. Employment by the United Association is also acceptable.

d) Public and private employment as an instructor teaching skills related to the plumbing and pipefitting industry is permissible, but only if such instruction is related to and approved by an apprenticeship or journeymen training program sponsored by the United Association or an affiliated local union.

e) For credit earned before January 1, 2006, work as a Civil Servant will not be considered "disqualified employment." You may return to work in the plumbing and pipefitting industry as a Civil Servant for a federal, state, local, or quasi-governmental entity pursuant to applicable laws governing Civil Servants. However, with respect to all credit earned in excess of 7.05 cents per hour after January 1, 2006, and prior to January 1, 2025, governmental employment as a Civil Servant in the plumbing and pipefitting industry was considered "disqualified employment." Beginning January 1, 2025, employment as a Civil Servant in the plumbing and pipefitting industry will not be considered "disqualified employment," unless such employment is covered under the scope of work of any collective bargaining agreement covering District Council No. 16 of the United Association.

   If you worked your first Hour of Service under the Plan on or after July 1, 2006, work in the plumbing and pipefitting industry in governmental employment as a Civil Servant on or after January 1, 2025, will not be considered "disqualified employment," unless such employment is covered under the scope of work of any collective bargaining agreement covering District Council No. 16 of the United Association. If you are a post-June 30, 2006 Participant who returns to work as a Civil Servant in the plumbing and pipefitting industry after January 1, 2025, you will not have your pension benefit suspended, unless the work is covered by such collective bargaining agreement.

ii) Disqualified Employment Between Age 65 and Age 70½

If you are between the ages of 65 and 70½ and you retire and later return to work, your benefit will be suspended from payment if you work, within the State of California, 40 or more hours per month in the same industry, trade, or craft in which you accrued pension benefits. This includes self-employment as well as work as an Employee.

It will not be considered disqualified employment, however, and your benefit will not be suspended if you return to work in any of the categories of jobs that constitute exceptions to "disqualified employment" for Pensioners returning to work before Normal Retirement Age, as set forth immediately above, either as an Employee or as an independent contractor.

iii) Employment Permitted After Age 70½

Starting when you reach age 70½, there are no restrictions on the type of work or the number of hours of work you may perform while receiving pension payments.

C) Suspension of Payments

If you become employed in "disqualified employment" as described above, your benefits from the Plan will be suspended for any month of such employment. If you are younger than 65, payments will be suspended for an additional six months following the end of the "disqualified employment", (18 months) if you fail to notify the Fund Office, but in no event beyond age 65.

If you are contemplating post-retirement employment, you should notify the Fund Office in writing before starting work.

If you are younger than age 70½ and receiving a pension from this Fund, you will be required to complete an Annual Statement by Pensioner form, which lists all employment performed by you or which certifies that you did not engage in "disqualified employment" during the preceding year. If this information is not provided by May 15, you will not receive your July pension payment, and payments will not resume until the Fund Office receives the information. You will be required to submit your tax returns if the Trustees request that you confirm the information you have provided in the Annual Statement by Pensioner or where no other appropriate evidence is available.

The Trustees will recover the amount of any previous payments that should have been suspended through offset against future monthly benefit payments or other lawful means. A pensioner who returns to work in disqualified employment without notifying the Fund Office, you will be deemed culpable for any resulting overpayment.

The following are excerpts from the Southern California Pipe Trades Retirement Fund Summary Plan Description that relate to when your Pensioners & Surviving Spouses Health Fund coverage may be suspended and reinstated. See Section 4(E) of this Pensioners & Surviving Spouses Health Fund SPD.

Southern California Pipe Trades Retirement Fund Summary Plan Description

SECTION 12 (continued)

If your benefits have been suspended, you must notify the Trustees, in writing, when the "disqualified employment" has ended. Benefit payments will not be re-started until such notice has been received. When the Trustees receive the notice, they will examine the circumstances of the employment and advise you on how the recovery of any improperly made payments will be scheduled.

If you have any questions as to whether a job you plan to take will cause a suspension, you should write to the Fund Office, giving the name of the Employer for whom you intend to work and a complete job description signed by the Employer describing the work you propose to perform. You will be advised if this work will cause a suspension of your benefits.

NOTE	**The Southern California Pipe Trades Pensioners and Surviving Spouses Health Fund says that a pensioner who engages in certain kinds of post-retirement employment must have his coverage suspended. Certain post-retirement employment may result in a permanent loss of eligibility to participate in the Pensioners Health Plan. In certain cases, you may instead be eligible for coverage under the Southern California Pipe Trades Health & Welfare Fund (active plan). You are strongly encouraged to study the Pensioners Health Fund SPD.**

APPENDIX 2 - SCPT RETIREMENT FUND TEMPORARY WAIVER RULES

The following are excerpts from the Southern California Pipe Trades Retirement Fund Summary Plan Description that relate to when your Pensioners & Surviving Spouses Health Fund coverage may be suspended and reinstated. See Section 4(E) of this Pensioners & Surviving Spouses Health Fund SPD.

Southern California Pipe Trades Retirement Fund Summary Plan Description

SECTION 13. TEMPORARY WAIVER PROGRAM FOR PENSIONERS TO RETURN TO WORK

Although employment in the plumbing and pipefitting industry is considered disqualified employment for which benefits may be suspended, the Trustees may temporarily permit employment in certain positions in the industry as they determine reasonable and appropriate given the needs of the industry. All such waivers of the disqualified employment rules set forth above shall be temporary and shall expire on a date set by the Trustees or upon revocation by the Trustees. The following categories of work, which may be expanded or contracted by the Trustees in their discretion as circumstances warrant, are subject to the temporary work waiver program:

A) Work as a Superintendent, Project Manager, or Labor Relations Representative in the Plumbing and Pipefitting Industry, Provided All of the Following Conditions are Met:

i) The work is for an Employer that is a signatory to a Collective Bargaining Agreement with the United Association or an affiliated local union;
ii) The work does not displace or take away any work from bargaining unit Employees under the applicable Collective Bargaining Agreement;
iii) The work does not involve employment for which contributions will be paid to the Southern California Pipe Trades Retirement Fund;
iv) The work must not include any of the duties of a foreman or a general foreman;
v) The duties of a position as a superintendent or project manager must include the supervision of general foremen and foremen and must not include the direct supervision of work crews;
vi) The employment must not be in the same position or involve substantially the same duties as the pensioner had with the Employer before he retired;
vii) The majority of the duties performed in a position as a labor relations representative must involve labor relations;
viii) If the pensioner is age 65 or older, the work may be performed either as an Employee, or as an independent contractor. If the pensioner is under age 65, the work must be performed as an actual Employee, not as an independent contractor or subcontractor; and
ix) The product of the work for the Employer may not be supplied to an entity that is not a signatory to a Collective Bargaining Agreement with the United Association or an affiliated local union.

B) Design or Estimating Work in the Plumbing and Pipefitting Industry, Performed Either On or Off a Jobsite, Provided All of the Following Conditions are Met:

i) The work is for an Employer that is a signatory to a Collective Bargaining Agreement with the United Association or an affiliated local union;
ii) The work does not displace or take away work from bargaining unit Employees under the applicable Collective Bargaining Agreement;
iii) If the pensioner is age 65 or older, the work may be performed either as an Employee, or as an independent contractor. If the pensioner is under age 65, the work must be performed as actual Employee, not as an independent contractor or subcontractor; and
iv) The product of the work may not be supplied to an entity that is not a signatory to a Collective Bargaining Agreement with the United Association or an affiliated local union.

C) Work in Covered Employment for an Employer Contributing to the Fund Under the Following Requirements and Conditions:

i) This program applies only to jobs for which a waiver has been granted. If there is a manpower shortage that working Participants cannot meet, District Council No. 16 may ask the Trustees for a temporary waiver. A special committee of the Trustees will then decide whether to grant a temporary waiver of the rules for the suspension of pension benefits.

The following are excerpts from the Southern California Pipe Trades Retirement Fund Summary Plan Description that relate to when your Pensioners & Surviving Spouses Health Fund coverage may be suspended and reinstated. See Section 4(E) of this Pensioners & Surviving Spouses Health Fund SPD.

Southern California Pipe Trades Retirement Fund Summary Plan Description

SECTION 13 (continued)

ii) The waivers will be limited to work at a specific job site or work of a specific skill type. The waivers will be temporary and subject to cancellation at any time. Work outside the scope of the waivers will still be subject to suspension of pension benefits.

iii) The program is only available to pensioners who have been receiving a pension for at least two years.

iv) If you are employed under this program, you will continue to receive your monthly pension benefit as long as you are working per the job site and other waiver limitations. You will also receive credit under the Plan for periods of such employment, and your pension amount will be adjusted annually to account for the increased credit. No adjustments will be made to the pension amount for any prior years. Any adjustment will be limited to the additional incremental amount earned for the year during the waiver employment.

v) If you are employed under this program, you will not lose your entitlement to the annual payment from the Southern California Pipe Trades Christmas Bonus Fund as long as you work per the job site or other limitations of the waiver.

vi) If you stay on the job after the waiver is canceled or if you work outside the limitations of the waiver, your pension benefits will be suspended, your coverage will terminate, and you will not be entitled to a benefit from the Southern California Pipe Trades Christmas Bonus Fund for the applicable year.

NOTE	**These waivers only apply to the Southern California Pipe Trades Retirement Fund. You should check with the Plumbers and Pipefitters National Pension Fund or other benefit funds to determine if benefits received from those plans will be affected by this type of employment.**

Summary Plan Description

of the

Southern California Pipe Trades

DEFINED CONTRIBUTION FUND

Contents

SECTION 1. INTRODUCTION

The Southern California Pipe Trades Defined Contribution Fund ("Fund" or "Plan") was established in 1991 through the negotiating efforts of District Council No. 16 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada ("United Association") and Employers in the plumbing and pipefitting industry in Southern California. The Landscape, Irrigation and Lawn Sprinkler Industry Defined Contribution Pension Plan (the "Landscape Plan") merged into the Fund as of January 1, 2025. The Fund is managed by Union and Employer Trustees.

A) This Summary Plan Description

This Summary Plan Description ("SPD") summarizes the provisions of the Southern California Pipe Trades Defined Contribution Plan. It applies on and after September 1, 2025. You must read this SPD carefully to understand how the Plan works. Please keep this SPD for future reference.

This summary is not meant to interpret, extend or change the Plan Document or the Trust Agreement in any way. If there is a conflict between this summary and the actual provisions of the Plan Document, your rights and benefits will be governed by the Plan Document. Plan rules may change from time to time, in which case a written notice explaining any important change will be sent to all covered households. Please read all Plan communications and keep them with this SPD.

B) Purpose of the Plan

The Plan was set up to provide retirement savings in addition to traditional pension and social security income. Employees working under a Collective Bargaining Agreement or Participation Agreement that permits participation may elect to contribute a portion of their hourly wage under the terms of the Defined Contribution Plan. The Collective Bargaining Agreement or Participation Agreement may also require Employers to make contributions on behalf of their Employees on a per-hour basis.

C) Role of the Board of Trustees

The Board of Trustees is authorized to interpret all Plan rules and documents, including the Plan Document, the Trust Agreement, and this SPD. The Board of Trustees has the discretion to decide all questions about the Plan, including, but not limited to, questions about eligibility for participation in the Plan, rights to benefits, the amount of benefits that are payable, the information and proof necessary to substantiate a claim for benefits, and the definition of any Plan term. The Board of Trustees also has the authority to make any factual determinations concerning claims. No individual Trustee, Employer, or Union representative has the authority to interpret any Plan document on behalf of the Board of Trustees or to act as an agent of the Board of Trustees. The Board of Trustees may delegate its authority to a subcommittee or other subset of the Board of Trustees.

The Trustees intend to continue the Fund indefinitely. However, the Board of Trustees has the authority to amend or terminate the Plan as they deem appropriate.

D) Role of the Fund Office

The Board of Trustees has authorized the Fund Office to respond in writing to your written questions. As a courtesy, the Fund Office may also respond informally to questions by telephone, email, or in person at the Fund Office. However, such information and answers are not binding upon the Board of Trustees and cannot be relied upon in any dispute. Remember 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 your entitlement to benefits.

NOTE	**If you have any questions regarding eligibility, benefits, or procedures, contact the Fund Office.** **Southern California Pipe Trades Administrative Corporation** **501 Shatto Place, Suite 500** **Los Angeles, CA 90020** **Toll-Free: (800) 595-7473 / Outside U.S.: (213) 385-6161** **Website: www.scptac.org / Email: definedcontribution@scptac.org** **Change of Address Form submission: coa@scptac.org**

NOTE	**Capitalized terms are defined in Section 17, on page 25.**

SECTION 2. ENROLLMENT

A) Qualifying to Participate in the Plan

You may participate in the Plan if you are working in a job covered under a Collective Bargaining Agreement or by some other written agreement that provides for coverage by the Plan. By law, you are not eligible to participate in the Plan if you are a sole proprietor or a partner in a partnership. Participation in the Plan is also available to Employees of District Council No. 16, its affiliated local Unions, and other organizations related to the Union, provided there is a Participation Agreement between the employing organization and the Plan. An Employer's non-bargaining unit employees may also be covered, provided there is a Participation Agreement between the Employer and the Plan. Coverage for any employees not working under a Collective Bargaining Agreement must be in accordance with the applicable Participation Agreement.

If you are a corporate officer or 50% or more shareholder of an Employer that is incorporated and is a signatory to a Collective Bargaining Agreement, you are permitted to participate in the Plan if:

i) All of the non-collectively bargained employees of the Employer are provided the option of making Employee 401(k) Contributions to the Plan; and
ii) Your Employer signs a Participation Agreement and fully complies with all of its terms.

B) Automatic Enrollment

You will be automatically enrolled in the Plan, and contributions will be deducted from your pay unless you opt out.

Under this "eligible automatic contribution arrangement", Employers must automatically deduct from your wages $0.50 per hour worked in Employee Pre-tax 401(k) Contributions and forward this amount to the Plan. These pre-tax contributions, and income earned, are not subject to income tax until they are withdrawn.

The $0.50 per-hour automatic Employee Pre-tax 401(k) Contributions will be made by all Employees working under a Collective Bargaining Agreement or Participation Agreement that provides for Employee contributions to the Plan.

See Section 5, page 9, for information on how your contributions are invested.

C) Alternatives to Automatic Enrollment

i) Opting-Out of Automatic Enrollment

You may opt-out of the $0.50 per-hour automatic Employee Pre-tax 401(k) Contribution by completing an Enrollment/Change/Opt-out Form and submitting it to your Employer. This form is available from the Fund Office or any local Union office. Any contributions made before the Fund Office receives and processes an opt-out form may not be refunded but will be retained in your Individual Account.

ii) Choosing a Different Amount or Type of Contribution

You may replace the $0.50 per-hour automatic Employee Pre-tax 401(k) Contribution with a larger or smaller amount and/or designate some or all of your contribution as an Employee After-tax Roth 401(k) Contribution by completing an Enrollment/Change/Opt-out Form and submitting it to your Employer. This form is available from the Fund Office or any local Union office. Any contributions made before the Fund Office receives and processes a change form will not be changed and will be retained in your Individual Account as originally contributed.

D) Changing Employers

You will be automatically enrolled with $0.50 per hour in Employee Pre-tax 401(k) Contributions each time you change Employers, even if you have previously opted-out. If you do not want to be enrolled, you must complete a new Enrollment/Change/Opt-out Form and give it to your new Employer. If you elect to make Employee 401(k) Contributions to the Plan other than the $0.50 per hour Employee Pre-tax 401(k) Contribution, and you want to continue your contributions at that rate when you change employers, you must also complete a new Enrollment/Change/Opt-out Form and give it to your new Employer.

E) Naming Beneficiaries

When you complete your Beneficiary Form, you will designate your Beneficiary or Beneficiaries to receive your Individual Account balance in the event of your death. You may change your Beneficiary designation at any time. The most recently dated of these Beneficiary designations will be honored in the event of death. If you are married, your Spouse is automatically your Beneficiary. This automatic designation will be revoked if you divorce. This means that your former Spouse will no longer be your Beneficiary unless you name your former Spouse as your Beneficiary on a new Beneficiary Form after the divorce.

This rule limits the chances of conflicting claims to death benefits if you forget to change your Beneficiary designation if you divorce.

You may name someone other than your Spouse as your Beneficiary. Your Spouse's consent is required, which must be in writing and witnessed by a notary.

You may obtain a Beneficiary Form from any local Union office, the Fund Office, or the Fund Office website at www.scptac.org.

If you fail to name a Beneficiary, your Individual Account will be paid as set forth in Section 11(B), page 18. For more details regarding Beneficiaries, see Section 11, page 18.

IMPORTANT	**To keep your former Spouse as your named Beneficiary after divorce, you must file a new Beneficiary Form with the Fund Office.**

F) Change of Address

You must complete a Change of Address Form to update your address so that any changes to the Plan, important notices, or account statements can be sent to you. The form may be obtained from any local Union office, the Fund Office, or at www.scptac.org.

G) Change in Marital Status

You must promptly notify the Fund Office if you marry or divorce by providing an original, official marriage certificate or documentation of divorce (church or souvenir marriage certificates are not acceptable). You should also complete a Beneficiary Form (available from any local Union office, the Fund Office, or the Fund Office web site at www.scptac.org).

IMPORTANT	**If there is a change in your family status, such as marriage, divorce, death, or a change in status of a Beneficiary, or if your address changes, notify the Fund Office as soon as possible, but no later than 90 days after the change.**

SECTION 3. CONTRIBUTIONS TO THE PLAN

All contributions made to the Plan on your behalf are placed in the Fund, where an Individual Account is established and maintained for each Participant. Contributions must be made per the requirements of the Internal Revenue Code.

A) Employee 401(k) Contributions

If you are eligible to participate in the Plan, you may choose to contribute a portion of your wages to the Fund.

The Plan also has an automatic enrollment feature that will automatically enroll you for Employee Pre-tax 401(k) Contributions when you first start working for a new Employer. You may opt out of automatic enrollment or contribute a different amount than the standard automatic enrollment amount. See Section 2(C), page 2.

You may choose the amount of Employee 401(k) Contributions that you wish to save through the Plan for your retirement. For instance, you may decide to save $2.00 for each hour that you work in employment covered by the Plan. Your Employer will withhold this amount from your wages and send it to the Fund Office.

The minimum Employee 401(k) Contribution you may make is $0.25 per hour. If you contribute more than the minimum, you may elect a higher contribution rate in $0.25 increments, up to the maximum amount permitted under law. (See Section 3(A)(iv), page 5, which discusses IRS limits.) The contribution rate you elect remains in effect until you change it by submitting an Enrollment/Change/Opt-Out Form or until you change Employers.

You may also elect to adjust the hourly deduction amount for your overtime hours so that when you receive overtime or double-time wages, your 401(k) deduction is also increased to 150% or 200% of your regular contribution rate.

EXAMPLE	**If your regular Employee 401(k) Contribution is $2.00 per hour, you may adjust your contribution to $3.00 per hour when you are paid time-and-a-half and $4.00 when you are paid double-time.**

If you elect to contribute a portion of your wages to the Plan, you must decide whether those contributions will be Employee Pre-tax 401(k) Contributions, Employee After-tax Roth 401(k) Contributions, or some combination of both.

i) Employee Pre-tax 401(k) Contributions

Employee Pre-tax 401(k) Contributions are deducted from your wages before income tax or income tax withholding is calculated. Employee Pre-tax 401(k) Contributions are not taxed in the year you earn them. The contributions, and any investment earnings, are taxed only at the time of distribution. Employee Pre-tax 401(k) Contributions and earnings may be paid as a Rollover Distribution to your account in another qualified plan, or into an IRA, etc. In most cases, if a distribution of Employee Pre-tax 401(k) Contributions is not rolled over into another qualified plan or an IRA, the amount not rolled over will be subject to income tax and may be subject to tax penalties for early withdrawal.

ii) Employee After-tax Roth 401(k) Contributions

Unlike Employee Pre-tax 401(k) Contributions, Employee After-tax Roth 401(k) Contributions are subject to income tax when the contribution is made and are not taxed when distributed. The earnings on Employee After-tax Roth 401(k) Contributions are also distributed tax-free so long as the distribution is "qualified". A distribution is qualified if it occurs after you turn age 59½ or because of your death or disability and if it occurs at least five years after the date of your first Employee After-tax Roth 401(k) Contribution. Employee After-tax Roth 401(k) Contributions and their earnings may be paid as a Rollover Distribution but only into a Roth contribution account in another qualified plan or a Roth IRA. In most cases, if a distribution of Employee After-tax Roth 401(k) Contributions is not qualified, the earnings will be subject to income tax and tax penalties.

Unlike Roth IRAs, you may make Employee After-tax Roth 401(k) Contributions to the Plan regardless of your annual income level.

iii) Designation of Pre-tax 401(k) or After-tax Roth 401(k) Contributions

It is your decision whether to designate your Employee 401(k) Contributions as Pre-tax 401(k) Contributions, After-tax Roth 401(k) Contributions, or some combination of both. In all cases, it will be presumed that a contribution is a Pre-tax 401(k) Contribution unless you explicitly designate in writing, on an Enrollment/Change/Opt-Out Form submitted to your Employer, that a contribution, or a portion thereof, should be made as an After-tax Roth 401(k) Contribution. You may change this designation at any time. However, once paid to the Fund, a Pre-tax 401(k) Contribution cannot be converted to an After-tax Roth 401(k) Contribution, and vice versa.

Regular Pre-Tax 401(k) Contributions	Roth After-Tax 401(k) Contributions
Made pre-tax	Made after-tax
Contributions and earnings are taxed when distributed	Contributions are taxed when made, and earnings are never taxed if distributions are "qualified" (See Section 3(A)(ii) above)
Immediate 100% vesting	Immediate 100% vesting
May be available for a hardship withdrawal (See Section 9(A), page 13)	May be available for a hardship withdrawal (See Section 9(A), page 13)
May be rolled over into a qualified plan or IRA	May be rolled over only into a qualified plan that has a Roth account or to a Roth IRA

How 401(k) Contributions Affect Your Taxable Income*		
Employee 401(k) Contribution Type:	Employee Pre-tax 401(k) Contributions	Employee After-tax Roth 401(k) Contributions
Your Gross Wages:	$1,664.00	$1,664.00
Wages Subject to Payroll Tax:	$1,664.00	$1,664.00
Subtract Pre-Tax Employee 401(k):	($140.00)	$0.00
Wages Subject to Income Tax:	$1,524.00	$1,664.00
Subtract Payroll Taxes:	($147.27)	($147.27)
Subtract Income Taxes:	($282.26)	($327.39)
Subtract After-Tax Employee 401(k):	$0.00	($140.00)
Net Pay:	**$1,094.47**	**$1,049.34**
Key Differences:	• Your current taxes are lower. • Your net pay is higher. • You will have to pay income taxes when you receive your benefit.	• Your current taxes are higher. • Your net pay is lower. • You will not have to pay any tax when you receive your benefit.
Key Question:	Will you be in a higher or lower tax bracket when you receive your benefit?	
*Tax rates used in the chart above are based on a filing status of Single (no dependents or other adjustments).		

iv) Employee 401(k) Contribution Limits

The Internal Revenue Service sets a dollar limit each year on the amount of Employee 401(k) Contributions you are allowed to contribute to this Plan. The IRS adjusts the limit periodically for cost of living changes. The Employee 401(k) Contribution limit for each year is announced annually by the IRS toward the end of the prior year. In addition, under the law, if you are at least 50 years of age by the end of the Calendar Year, you are entitled to make a "catch-up" contribution up to the limits established by law. The maximum amount of Employee 401(k) Contributions near the time of publication was as follows:

Employee 401(k) Contribution Limits			
Year	Maximum Contribution	Catch-up Contribution*	Total Contribution
2024	$23,000	$7,500	$30,500
2025	$23,500	$7,500	$31,000
2026	$24,500	$8,000	$32,500
* Catch-up contributions are permitted beginning in the year you turn age 50. Beginning in 2025, the catch-up contribution limit is increased to 150% of the standard catch-up contribution limit for individuals who are age 60-63 ($11,250 for 2025 and 2026).			

Employee Pre-tax 401(k) Contributions and Employee After-tax Roth 401(k) Contributions are combined for purposes of limits on the annual maximum amount that may be contributed to a 401(k) plan. For 2025, this limit is $23,500 (not including catch-up contributions for Participants age 50 or older). For 2026, this limit is $24,500 (not including catch-up contributions for Participants age 50 or older).

In addition to the limits on your Employee 401(k) Contributions, there is also an overall limit on the amount you and your Employer together may contribute to this Plan each year. In 2025, contributions may not exceed the lesser of $70,000 (before considering catch-up contributions if applicable) or 100% of your earnings for the year. In 2026, contributions may not exceed the lesser of $72,000 (before considering catch-up contributions if applicable) or 100% of your earnings for the year. This limit will change over time. In addition, the amount of contributions to this Plan may affect how much you and your Employer may contribute to another defined contribution plan of the Employer.

There is a further limitation for "highly compensated employees". The average deferral percentage of highly compensated employees must not exceed that of non-highly compensated employees by more than a certain amount. As a result, the maximum contribution for a highly compensated employee may be lower than the limits set above. For 2025, highly compensated employees include employees with annual wages exceeding $155,000 in 2024 or who own 5% or more of an Employer. For 2026, highly compensated employees will include employees with annual wages exceeding $160,000 in 2025 or who own 5% or more of an Employer.

Each year, as required by law, the Fund Office conducts tests to determine whether any of the limits on contributions have been exceeded. Any excess amounts, plus investment earnings, are refunded to you.

In case of a distribution to a highly compensated employee due to non-discrimination test failure, the employee may designate the extent to which the excess amount is composed of Employee Pre-tax 401(k) Contributions and Employee After-tax Roth 401(k) Contributions, but only to the extent such types of contributions were made for the year. If the highly compensated employee does not designate the type of Employee 401(k) Contributions to be distributed, the Plan will distribute Employee Pre-tax 401(k) Contributions first. In case of a distribution due to excess contributions (amounts exceeding $23,500 in 2025 or $24,500 in 2026, plus "catch-up" contributions if applicable), if the Employee contributed both Employee Pre-tax 401(k) and Employee After-tax Roth 401(k) Contributions, excess amounts will be withdrawn pro-rata in the same proportion as the original contributions made.

If you have any questions about the limitations on contributions, you should contact the Fund Office.

B) Employer 401(a) Contributions

Employers may also contribute to the Fund on your behalf if such contributions are required by a Collective Bargaining Agreement or Participation Agreement. These contributions will be accounted for separately from your Employee 401(k) Contributions.

C) Rollover Contributions

This Plan accepts Rollover Contributions from a variety of retirement accounts, including other qualified plans, tax-qualified annuities, qualified state and local government plans, and that portion of an IRA distribution that would otherwise be includable in gross income. This means that if you have money in such a retirement account and work for an Employer who participates in this Plan, you may roll over that retirement savings into this Plan. The amount you roll over will be placed in your Individual Account and will be accounted for separately from your Employee 401(k) Contributions and your Employer 401(a) Contributions.

D) Reciprocal Contributions

This Plan is a signatory to the United Association National Pension Fund Reciprocal Agreement, which provides for money-follows-the-Member reciprocity with all pension funds that have also signed the agreement and, in some cases, with the United Association National Pension Fund. Under this agreement, contributions are transferred to your home local pension fund(s) automatically. This Fund may also enter into other similar reciprocity agreements.

i) Incoming Reciprocity

If your home local is a District Council No. 16 local and you work outside of the jurisdiction of District Council No. 16, contributions made to another defined contribution fund that has signed an applicable reciprocal agreement will be transferred to this Fund according to the terms of the reciprocal agreement.

ii) Outgoing Reciprocity

If your home local is not a District Council No. 16 local and you work within the jurisdiction of District Council No. 16, contributions to this Fund will be transferred to your home local pension fund(s) if your home local pension fund has signed an applicable reciprocal agreement, according to the terms of the reciprocal agreement.

Contributions are reciprocated based on your home local as reflected in the United Association's records.

E) Qualified Uniformed Service

If you are engaged in Qualified Uniformed Service, the Plan will comply with the requirements of the law concerning contributions and benefits while you are serving. Your last Employer will be responsible for making any Employer 401(a) Contributions, to the extent required by law, while you are in the military. You may pay for missed Employee 401(k) Contributions in the manner and amount permitted by law.

If you return to Covered Employment following a period of service in the United States Armed Forces and meet the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), the period of Qualified Uniformed Service will be treated as Covered Employment under the Plan. This means that make-up contributions may be made for the time you were in Qualified Uniformed Service upon your return to Covered Employment. Contributions may be made as follows:

i) Employee 401(k) Contributions

Upon your return from Qualified Uniformed Service, you will be permitted, but not required, to make additional Employee 401(k) Contributions ("make-up contributions") to make up some or all of the contributions that would have been made during the period of Qualified Uniformed Service had you remained in Covered Employment. Any make-up contributions for a period of Qualified Uniformed Service must be made during a period not to exceed the lesser of three times the length of your immediate past period of Qualified Uniformed Service or five years from the date of your reemployment and not later than the termination of your reemployment with a Contributing Employer.

ii) Employer 401(a) Contributions

If you were entitled to have Employer 401(a) Contributions made to the Plan on your behalf while working in Covered Employment just before leaving for Qualified Uniformed Service, upon your return from Qualified Uniformed Service, your pre-service Employer will be responsible for making those Employer 401(a) Contributions that would have been required had you not entered Qualified Uniformed Service. Generally, these Employer 401(a) Contributions must be made within 90 days after you return to Covered Employment or when Plan contributions are normally due for the year in which the Qualified Uniformed Service is performed, whichever is later.

iii) Contribution Limits

The amount of Employee 401(k) Contributions and Employer 401(a) Contributions that may be made to the Plan is limited by the Internal Revenue Code. You are not permitted to make contributions or to have contributions made on your behalf in excess of the contributions that would have been made had your leave for Qualified Uniformed Service not occurred. Make-up contributions for periods in Qualified Uniformed Service are attributed to the year(s) during which Qualified Uniformed Service occurred and not the year(s) in which the contributions are made (unless the period of Qualified Uniformed Service and the period during which make-up contributions are made occur in the same year).

iv) No Interest or Investment Gains or Losses on Make-Up Contributions

Make-up contributions will not be subject to any earnings or losses experienced during your absence. Neither you nor your Employer is permitted or required to pay interest when making up missed contributions.

Notwithstanding the above, contributions will be permitted or required only to the extent and in the manner provided by USERRA and the regulations thereunder and per Section 414(u) of the Internal Revenue Code.

If you have questions about the effect of your Qualified Uniformed Service on your rights under the Plan, you should contact the Fund Office.

SECTION 4. YOUR ACCOUNT

A) Components of your Account

When contributions are first received on your behalf, an Individual Account will be established for you. Your Individual Account will consist of your:

i) Employee 401(k) Contributions; plus
ii) Employer 401(a) Contributions (if any); plus
iii) Rollover Contributions; plus
iv) Any money forwarded to this Fund from another fund under a reciprocal agreement; plus
v) Any investment gains; minus
vi) Any investment losses; minus
vii) Fees and expenses; minus
viii) Benefits paid.

B) Changing Your Contribution Amount

If you wish to change the amount you contribute to the Plan, you must complete the applicable section of the Enrollment/Change/Opt-out Form and submit it to your Employer. Your contributions must be in $0.25 increments. Government regulations limit the amount you can contribute. (See Section 3(A)(iv), page 5.)

C) Managing Your Account

Employee 401(k) Contributions, Employer 401(a) Contributions, Rollover Contributions, and any money received through reciprocity are deposited into your account with the Plan's recordkeeper, John Hancock Retirement Plan Services (John Hancock). The Plan provides a variety of investment funds in which you may invest your account. Please refer to Section 6, page 11, for a list of the investment options at the time of publication.

You may contact John Hancock online at myplan.johnhancock.com or by phone at (833) 388-6466 to manage your Plan account, including:

- Receiving retirement planning help
- Reviewing investment options
- Requesting account statements
- Changing investment elections
- Viewing existing balances
- Receiving investment advice from Morningstar®
- Other Plan features

You must contact John Hancock to make your initial investment elections and to make any changes to those elections. If you do not select your investment elections, your funds will be automatically invested in a default fund designated by the Trustees. See Section 5(C), page 9.

Self-service Internet or telephone access is available 24 hours a day, seven days a week. John Hancock service representatives are available by telephone from 8 a.m. to 10 p.m. Eastern Time on any business day the New York Stock Exchange is open.

More details about account access may be found in the Fund enrollment kit provided separately.

IMPORTANT	**To choose initial investment options, you must contact John Hancock at (833) 388-6466 or online at myplan.johnhancock.com. If you do not choose your investments, 100% of your contributions will be invested in a default fund selected by the Trustees. See Section 5(C), page 9.**

D) Valuing Your Account

Your Individual Account is valued daily. You may check the value of your Individual Account at any time through John Hancock.

E) Account Statements

John Hancock will mail you a quarterly statement if you have a balance in the Plan and provide a current address. The statements are sent in January, April, July, and October and show your account balances as of December 31, March 31, June 30, and September 30. Your December statement will include a lifetime income estimate. You may also obtain statements online or by calling John Hancock.

The statements will show separate balances for:
i) Employee Pre-tax 401(k) Contributions;
ii) Employee After-tax Roth 401(k) Contributions
iii) Employer 401(a) Contributions; and
iv) Rollover Contributions.

It will also show the current period:
i) Earnings;
ii) Fees and expenses; and
iii) Benefits paid.

You should promptly review your quarterly statements to check that all of the contributions made on your behalf have been properly reported. You should keep evidence of your contributions (such as pay records) as proof of how much was deducted by your Employer. If you believe that you have found an error in the records, you should file a written statement with the Fund Office within 60 days of the end of the calendar quarter. You should submit supporting evidence, such as copies of your pay records. You will be credited with any amounts properly due and subsequently collected from an Employer, and such amounts will be reflected on a future quarterly statement.

EXAMPLE

John Hancock Quarterly Statements & Conditions

Contributions for Hours Worked During…	… are Generally Received by John Hancock During…	… and Appear on the John Hancock Quarterly Statement Issued in…
September, October, November	October, November, December	January
December, January, February	January, February, March	April
March, April, May	April, May, June	July
June, July, August	July, August, September	October

Notes:
- This example assumes that the Employer remits contributions weekly. Some employers only send contributions after the end of each month, in which case, for example, no September contributions will appear on the quarterly statement issued in October.
- Contributions for work near the end of the quarter may not be received by John Hancock in time to appear on that quarter's statement.
- Only contributions actually paid by the Employer can appear on a quarterly statement.
- Incoming reciprocal contributions are credited at least one month later than contributions for work in District Council No. 16.

F) Vesting

You are always vested in (have the right to) 100% of the contributions you or your Employer made to the Plan, including any reciprocal contributions or Rollover Contributions:

i) Minus fees and expenses; and
ii) Plus or minus any investment earnings or losses.

However, the assets in your Individual Account are not available to you at any time you wish. You may only take a distribution from your Individual Account if permitted under the Plan's rules.

SECTION 5. YOUR INVESTMENT STRATEGY

The Trustees decide which investment options will be offered in the Plan. The Plan is designed to comply with Section 404(c) of the Employee Retirement Income Security Act ("ERISA") and Title 29 of the Code of Federal Regulations Section 2550.404c-1. Generally, this means you are provided with certain information about the Plan and the available investment alternatives, the opportunity to exercise control over the assets in your Individual Account, and the opportunity to choose from a broad range of investment alternatives. This also means the Plan fiduciary (the Board of Trustees) may be relieved of any liability for any losses that are the direct and necessary result of investment instructions given by you (or your Beneficiary).

The Trustees must ensure that the administrative procedures, policy guidelines, and selection of options are established and carried out prudently. The investment options at the time of printing are listed in Section 6, page 11. The Trustees may change the investment options at any time. When you enroll, you will be given information about the choice of professionally managed funds in which to invest your Plan contributions.

You have three options for determining your investment strategy:

A) Option 1 – Self-Direction

You may choose how your Individual Account will be allocated among the investment options offered in the Plan. After reviewing a description of each investment option, you may direct that all or a portion of your Individual Account be placed in one or more of the options. You may elect as often as daily to direct or redirect the investment of your Individual Account among the investment options (although some investment options prohibit frequent trading).

You must contact John Hancock at myplan.johnhancock.com or (833) 388-6466 to select your investment choices.

When deciding which investment mix is best for you, you will want to consider the following:

i) The amount of time you have to save for retirement;
ii) How inflation may affect the value of the balance in your account over time;
iii) The risks and returns of the available investment options;
iv) Your level of comfort with investment risk; and
v) Other assets you may own, such as other retirement plans.

You may request additional information about investments, investment strategies, and performance updates from John Hancock or the Fund Office.

B) Option 2 – Professional Investment Advice

John Hancock offers investment advice in partnership with Morningstar Investment Management, LLC, to help you decide about investing your retirement account. Morningstar Investment Management, LLC is a registered investment adviser, and through Morningstar® Retirement Manager℠, you can access free, automated, objective, personalized, independent retirement investment and savings advice.

You may access Morningstar® Retirement Manager℠ through the John Hancock website at myplan.johnhancock.com.

C) Option 3 – Default Options

If you do not direct the investment of your Individual Account, 100% of your balance, plus any future contributions, will be invested in the default option selected by the Trustees for all Individual Accounts for which no direction is received. This is also known as the "Qualified Default Investment Alternative" (QDIA). You will be provided with an annual notice regarding this alternative. The

QDIA consists of several "target date" common trust funds with different asset allocations among various asset classes. Your Individual Account will be invested in a target date fund based on your age.

However, each Participant has individual investment goals and risk tolerance, and only you can determine the best investments for you. Therefore, if you are placed in a default alternative, you are encouraged to review the investment and determine whether it is the best investment for you and, if not, self-direct the investment of your Individual Account through John Hancock at myplan.johnhancock.com or (833) 388-6466.

By establishing the QDIA, the Board of Trustees will not be liable for any losses or claims that the default investment alternative is inappropriate for you.

NOTE	**More detailed information about the investment options (such as fund fact sheets) is included in the enrollment package and is also available upon request from John Hancock or the Fund Office. Fund prospectuses are available from John Hancock.**

SECTION 6. INVESTMENT OPTIONS

The Southern California Pipe Trades Defined Contribution Plan is designed to comply with Section 404(c) of ERISA. Generally, this means that the Plan allows you to exercise control over the investments in your Individual Account and to choose from a broad range of investment alternatives.

After reviewing a description of each investment option, you may direct that all or a portion of your Individual Account be placed in one or more of the investment options. If you do not direct the investment of your Individual Account, 100% of your balance, plus any future contributions, will be invested in a default option chosen by the Trustees. In accordance with the Plan, the Trustees may change the options for investment in the future.

More details about account access may be found in the Fund enrollment kit provided separately. You must contact John Hancock Retirement Plan Services at (833) 388-6466 or myplan.johnhancock.com to select or change your investment options.

The investment options as of the publication date are as follows:

Fund Name (Share Class)	Objective	Category	Ticker Symbol
Invesco Stable Value Trust (Class A1)	Stable Value	Stable Value	N/A*
JPMorgan U.S. Government Money Market Fund (Class Capital)	Money Market		OGVXX
Baird Aggregate Bond Fund (Institutional Class)	Income	Intermediate-term Bonds	BAGIX
Vanguard Inflation-Protected Securities Fund (Admiral Shares)	Income	Inflation-protected Bonds	VAIPX
PIMCO All Asset Fund (Institutional Class)	Asset Allocation	U.S. & non-U.S. Large Value stocks & bonds	PAAIX
Great Lakes Large Cap Value CIT (Class 1)	Growth & Income	U.S. large value stocks	N/A*
Invesco Equity and Income Fund (Class R6)	Growth & Income	U.S. and non-U.S. stocks & bonds	IEIFX
Vanguard Institutional Index Fund (Institutional Shares)	Growth & Income	U.S. large blend stocks	VINIX
T. Rowe Price Blue Chip Growth Fund (Class I)	Growth	U.S. and non-U.S. large growth stocks	TBCIX
iShares Russell Small/Mid Cap Index Fund (Class K)	Growth	U.S. small blend stocks	BSMKX
American Funds - EuroPacific Growth Fund (Class R6)	Growth	Non-U.S. large growth stocks	RERGX
RBC Emerging Markets Equity Fund (Class R6)	Growth	Non-U.S. large growth stocks	RREMX
Qualified Default Investment Alternative (QDIA) / Target Date Funds:			
T. Rowe Price Retirement 2005 Trust (Class F)	Target Date	U.S. and non-U.S. large blend stocks & bonds	N/A*
T. Rowe Price Retirement 2010 Trust (Class F)	Target Date	U.S. and non-U.S. large blend stocks & bonds	N/A*
T. Rowe Price Retirement 2015 Trust (Class F)	Target Date	U.S. and non-U.S. large blend stocks & bonds	N/A*
T. Rowe Price Retirement 2020 Trust (Class F)	Target Date	U.S. and non-U.S. large blend stocks & bonds	N/A*
T. Rowe Price Retirement 2025 Trust (Class F)	Target Date	U.S. and non-U.S. large blend stocks & bonds	N/A*
T. Rowe Price Retirement 2030 Trust (Class F)	Target Date	U.S. and non-U.S. large blend stocks & bonds	N/A*
T. Rowe Price Retirement 2035 Trust (Class F)	Target Date	U.S. and non-U.S. large blend stocks & bonds	N/A*
T. Rowe Price Retirement 2040 Trust (Class F)	Target Date	U.S. and non-U.S. large blend stocks & bonds	N/A*
T. Rowe Price Retirement 2045 Trust (Class F)	Target Date	U.S. and non-U.S. large blend stocks & bonds	N/A*
T. Rowe Price Retirement 2050 Trust (Class F)	Target Date	U.S. and non-U.S. large blend stocks & bonds	N/A*
T. Rowe Price Retirement 2055 Trust (Class F)	Target Date	U.S. and non-U.S. large blend stocks & bonds	N/A*
T. Rowe Price Retirement 2060 Trust (Class F)	Target Date	U.S. and non-U.S. large blend stocks & bonds	N/A*
T. Rowe Price Retirement 2065 Trust (Class F)	Target Date	U.S. and non-U.S. large blend stocks & bonds	N/A*

* This option is a common trust fund, not a mutual fund, so it has no ticker symbol.

SECTION 7. QUALIFIED DOMESTIC RELATIONS ORDERS

A court may issue a "Qualified Domestic Relations Order" (QDRO) as part of legal proceedings such as divorce. A QDRO is an official court order that instructs the Trustees to pay all or part of your benefit to an Alternate Payee, most commonly your Spouse, in case of divorce. The Trustees are legally required to recognize and comply with a QDRO, provided the order is submitted to and approved by the Trustees. You may obtain a copy of the QDRO procedures and a sample QDRO from the Fund Office without charge.

Alternate Payees may include your Spouse, former Spouse, child, or other dependent. Payments to an Alternate Payee may not begin until the earlier of:

A) The date you reach age 50;
B) The date you become eligible for a distribution after terminating employment;
C) The date you are entitled to a distribution based on an approved application for a disability benefit; or
D) The date of your death.

NOTE	**Contact the Fund Office for more information about QDRO procedures.**

The processing of a QDRO results in special administrative costs to the Fund. These costs include the expense of corresponding about the order, the expense of setting up a separate account for the Alternate Payee, and the charges of the Fund's attorneys in assisting with the review of the QDRO. The Fund is permitted to charge these costs to the parties involved in the QDRO. Accordingly, the Fund will deduct from any affected account an administrative charge for processing a QDRO. At the time of publication, the charge was the lesser of $550.00 or 10% of the balance of the Individual Account. The charge will only be taken after any separate account is set up for the Alternate Payee, one-half from each account.

SECTION 8. FEES

You pay two types of fees:

A) Administrative Fees

i) To cover general expenses necessary to administer the Fund, such as recordkeeping, legal, and audit fees, you will be charged the following fees:

- $10.97 per quarter ($43.88 annually) if your Individual Account balance is $2,000 or less.
- $42.33 per quarter ($169.32 annually) if your Individual Account balance exceeds $2,000.

At the time of publication, these expenses totaled approximately 0.50% of assets annually.

ii) A fee of the lesser of $550, or 10% of the account balance, for processing a QDRO. See Section 7, page 12.

B) Fees Paid to Investment Funds

Each investment fund charges fees to manage the assets it holds. These are subtracted from the funds' assets before investment performance is calculated. The fees are disclosed in the fund's prospectus, which can be obtained from the Fund Office or from John Hancock. At the time of publication, the funds in the Plan charged annual fees between 0.04% and 1.95% of the investment fund market value.

Fees are subject to change at any time.

SECTION 9. BENEFITS BEFORE RETIREMENT

A) Payment Due to Hardship

If you qualify for a financial hardship distribution during your working years, you will be permitted to withdraw any money from your Individual Account, including your Employee 401(k) Contribution account, your Employer 401(a) Contribution account, any Rollover Contribution account, and investment earnings in all of the above. You must complete a special form to apply for a hardship distribution.

i) Qualifying for a Hardship Distribution

You may qualify for a hardship distribution if you have an immediate and heavy financial need and other funds are not available to meet that need. The following are the only financial needs considered "immediate and heavy":

a) Certain un-reimbursed medical expenses for you, your Spouse, child, dependent, or named Beneficiary that are not covered by insurance or otherwise and that are defined as medical expenses under Internal Revenue Code Section 213(d), meaning expenses that you would be allowed to take as itemized deductions on your income tax return (without regard to whether expenses exceed 7.5% of your Adjusted Gross Income).
b) Expenses to purchase your principal residence.
c) Expenses to stop your eviction from your principal residence.
d) Expenses to prevent foreclosure on the mortgage of your principal residence.
e) Payment of tuition, related educational fees, and room and board expenses for the next 12 months of post-secondary education for you or your Spouse, child, dependent, or named Beneficiary.
f) Expenses and losses (including loss of income) incurred by the Participant on account of a disaster declared by the Federal Emergency Management Agency (FEMA) under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, Public Law 100-107, provided that the Participant's principal residence or principal place of employment at the time of the disaster was located in an area designated by FEMA for individual assistance with respect to the disaster.
g) Expenses for repairing damage to your principal residence that would qualify for a deduction under Internal Revenue Code Section 165, without regard to whether the loss exceeds 10% of your Adjusted Gross Income.
h) Burial or funeral expenses for your deceased parent, Spouse, child, dependent, or named Beneficiary.

Hardship distributions related to natural disasters recognized by the federal government will be available to Participants under the conditions set forth above.

ii) Limitation on Hardship Withdrawals

You are eligible for a hardship withdrawal available under this Plan only if you have received all other withdrawals or nontaxable loans available to you under any other plan that your Employer maintains. (Note that this Plan does not permit loans.)

The amount of a hardship withdrawal is limited to the following:

a) The amount of your immediate and heavy financial need; plus
b) The amount needed to pay the income taxes and penalties resulting from the withdrawal.

Funds will be distributed from your Individual Account in the following order from your:

1) Employee Pre-tax 401(k) Contribution account
2) Employer 401(a) Contribution account
3) Pre-tax Rollover Contribution account
4) Employee After-tax Roth 401(k) Contribution account
5) Roth Rollover Contribution account

iii) Tax on Hardship Withdrawals

Income taxes and tax penalties generally apply to withdrawals paid to you before you are age 59½. The tax and penalties due may exceed 50% of the amount withdrawn.

B) Payment of Employer 401(a) Contribution Account

The portion of your Individual Account that is made up of Employer 401(a) Contributions may be paid to you if:

i) For Small Balances

a) The balance of your 401(a) Contribution Account is $2,000 or less; and
b) No Employer 401(a) Contributions have been made to your Individual Account for two consecutive Plan Years.

ii) After Termination of Employer 401(a) Contributions

a) You have participated in the Plan for at least 60 months following the date the first Employer 401(a) Contributions were made on your behalf; and
b) There have been no Employer 401(a) Contributions made to the Plan on your behalf, and no such contributions were required to be made to the Plan on your behalf for 12 consecutive months; and
c) Your Employer has not restarted Employer 401(a) Contributions to the Plan on your behalf.

C) Payment on Termination of Employment

You may withdraw the entire balance of your Individual Account if, during the 12 calendar months before the date the benefit is paid:

i) You have not been employed or self-employed in any capacity by a participating Employer; and
ii) You have not worked in the plumbing and piping industry within the geographic jurisdiction of District Council No. 16; and
iii) The Fund has received no reciprocal payments based on hours worked during those 12 months.

In addition, if you participated in the former Landscape Plan before January 1, 2025, you may withdraw the entire balance of your Individual Account accrued under that Plan prior to the merger as of the date on which at least two full Plan Years have elapsed since you were last employed or self-employed in any capacity by an Employer that was required to contribute to the Landscape Plan.

D) Payment Due to Disability

If you cannot work because you become permanently and totally disabled, you may receive a distribution of the value of your Individual Account in the Plan.

You are considered totally and permanently disabled only if you have received a Social Security disability "notice of award" from the Social Security Administration.

E) Automatic Payment of Small Individual Accounts

Your Individual Account may be paid to you automatically in a lump sum, regardless of whether or not you apply for benefits.

i) The Fund Office will send a notice to you if your Individual Account balance is $7,000 or less, and you have had no contributions added to your account for at least 12 consecutive months, and if the Fund Office has no record of your current employment in the industry.
ii) The notice will advise you that your Individual Account is subject to the automatic distribution provision. You may then choose to have the account balance paid out in a lump sum, rolled over into an IRA selected by the Plan, or rolled over into another IRA or qualified retirement plan selected by you.
iii) However, you may also provide information to the Fund Office showing that you are still working in the industry and should, therefore, not be required to take a distribution. For example, you might show that you are actively seeking work by registering on a local Union out-of-work list or are temporarily not working due to a disability or military service.
iv) If you fail to respond to the notice or cannot be located, the Plan will automatically distribute the balance in your Individual Account to an IRA for you, except that if your account is $1,000 or less, the Plan may issue a check directly to you instead of establishing an IRA.

Benefits Available Before Retirement		
Type of Withdrawal	**Amount Available**	**Key Limitations**
Hardship	100% of Individual Account	• Limited to certain hardship circumstances only
Qualified Disaster Recovery Distribution (QDRD)	Up to $22,000 (you may also be eligible for a hardship distribution for losses in excess of $22,000 resulting from the same disaster)	• Distribution must be made within 180 days of the first day of the Incident Period of the Qualified Disaster • Your principal residence must be located in the Qualified Disaster Area at any time during the Incident Period and you must have sustained an economic loss as a result of such Qualified Disaster
Employer 401(a) Contribution Account – Inactivity	Employer 401(a) Contribution account balance	• Employer 401(a) Contribution account balance must be $2,000 or less • Two Calendar Years with no Employer 401(a) Contributions
Employer 401(a) Contribution Account – In-service	Employer 401(a) Contribution account balance	• First Employer 401(a) Contribution received at least five years ago • 12 months with no contributions • Employer has not restarted Employer 401(a) Contributions
Termination of Employment	100% of Individual Account	• 12 months with no contributions • 12 months with no employment with a Contributing Employer • 12 months with no employment in the industry in D.C. No. 16
Special Termination of Employment Withdrawal for former Landscape Plan Participants	100% of Individual Account accrued prior to January 1, 2025	• Two full Plan Years with no Employer contributions from any Employer that contributed to the former Landscape Plan Participants
Disability	100% of Individual Account	• Must have Social Security disability "notice of award"
Automatic Payment of Small Individual Accounts	100% of Individual Account	• Individual Account balance must be $7,000 or less (not counting any Rollover Contribution account balance) • Must meet requirements for Termination of Employment above • Only at Trustees' discretion
Qualified Birth or Adoption	Up to $5,000	• Child must be: ◦ Under the age of 18; or ◦ 18 or older and physically or mentally incapable of self-support. • You must withdraw the amount within one year of the child's date of birth or within one year of when the legal adoption of the child is finalized.
Terminal Illness	100% of Individual Account	• Physician certification that death is expected within 84 months.

Notes:
- This is only a summary of the Plan's distribution rules. See Section 9, page 13 for further details.
- Federal and state income tax and tax penalties can total more than 50% of withdrawals taken before age 59½. See Section 13, page 19, for further details.
- Former Landscape, Irrigation and Lawn Sprinkler Industry Defined Contribution Plan Participants qualify for all available distributions under this SPD beginning January 1, 2025.

F) Qualified Birth or Adoption Distribution (QBOAD)

You may withdraw up to $5,000 from your Individual Account upon the birth of your child or following the adoption of a child.

An "adopted child" means anyone (other than your Spouse's child) who is legally adopted by you and who is:

i) Under the age of 18; or
ii) 18 or older and physically or mentally incapable of self-support.

You must withdraw the amount within one year of the child's date of birth or within one year of when the legal adoption of the child is finalized.

Funds will be distributed from your Individual Account in the following order:

i) Employee Pre-tax 401(k) Contribution account
ii) Employer 401(a) Contribution account
iii) Pre-tax Rollover Contribution account
iv) Employee After-tax Roth 401(k) Contribution account
v) Roth Rollover Contribution account

This withdraw is not subject to the 10% early distribution penalty for taking a withdrawal before age 59½, nor is it subject to the normal 20% mandatory withholding for taxes that applies to eligible rollover distributions. The Plan will withhold 10% for taxes unless you elect no withholding.

You have the option to repay to the Plan all or a portion of the amount you withdraw. All such withdrawals and repayments will be subject to federal law and any rules or regulations issued by the Internal Revenue Service.

G) Distribution or Transfer Due to a Change in Employment Status

If you move from Covered Employment to non-Covered Employment with an Employer, and you are no longer eligible to make Employee 401(k) Contributions to the Plan or entitled to Employer 401(a) Contributions to the Plan, you may continue to maintain your Individual Account in the Plan and direct your investments. However, if you do not want to continue to maintain your Individual Account in the Plan, the Plan offers two options:

i) In-Service Distribution

If you are age 59 ½ or older and have transferred to and are working in non-Covered Employment with an Employer, you may take a distribution of your Individual Account balance if you have served in the non-Covered Employment position for at least one year from the date you last worked in Covered Employment.

ii) Plan-to-Plan Transfer

If you have transferred to and are working in a non-Covered Employment position with an Employer, you may transfer your Individual Account balance to another eligible retirement plan maintained by that Employer if the Employer-maintained plan accepts the transfer and this Plan determines that all other requirements under the Internal Revenue Code for a plan-to-plan transfer are satisfied.

H) Advance Distribution to Terminally Ill Participants

If you become terminally ill, you may receive a distribution of the value of your Individual Account in the Plan, regardless of whether you qualify for another type of distribution under the Plan.

You are considered “terminally ill” if you have been certified by a physician as having illness or physical condition which can reasonably be expected to result in death in seven years or less.

In order to be eligible for an advance distribution due to terminal illness, you must submit a written certification from a physician that includes:

i) A statement that your illness or physical condition can be reasonably expected to result in death within 84 months of the certification;
ii) A narrative description of the evidence used to support the statement;
iii) The examining physician’s name and contact information;
iv) The date the physician examined you or reviewed evidence you provided;
v) Your physician’s signature with date; and
vi) An attestation that your physician composed the narrative description based on a physical examination of you or a review of evidence you provided.

This withdrawal is not subject to the 10% early distribution penalty for taking a withdrawal before age 59½, nor is it subject to the normal 20% mandatory withholding for taxes that applies to eligible rollover distributions. The Plan will withhold at the rate of 10% for taxes unless you elect no withholding.

You have the option to repay to the Plan all or a portion of the amount you withdraw. All such withdrawals and repayments will be subject to federal law and any rules or regulations issued by the Internal Revenue Service.

I) Qualified Disaster Recovery Distribution (QDRD)

If your principal residence is located within a Qualified Disaster Area during the Incident Period of a Qualified Disaster, you sustain economic loss as a result of such Qualified Disaster, and the distribution is made on or within 180 days of the first day of the Incident

Period, you may receive a Qualified Disaster Recovery Distribution (QDRD) of the value of your Individual Account in the Plan, up to a maximum of $22,000 per Qualified Disaster.

A Qualified Disaster is any event or occurrence that has been declared a major disaster by the President under Section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act. The Incident Period is the time period during which the major disaster occurred as determined by the Federal Emergency Management Agency (FEMA).

Funds will be distributed from your Individual Account in the following order:

i) Employee Pre-tax 401(k) Contribution account
ii) Employer 401(a) Contribution account (including only post-merger employer contributions for former Landscape Plan Participants)
iii) Pre-merger employer 401(a) Contribution account (for former Landscape Plan Participants)
iv) Pre-tax Rollover Contributions account
v) Employee After-tax Roth 401(k) Contribution account
vi) Roth Rollover Contribution account

This withdrawal is not subject to the 10% early distribution penalty for taking a withdrawal before age 59½. Unless you elect otherwise, income taxes will be assessed ratably over a three-year period.

You have the option to repay to the Plan all or a portion of the amount you withdraw. All such withdrawals and repayments will be subject to federal law and any rules or regulations issued by the Internal Revenue Service. Any amount of a QDRD that you repay to your Individual Account will be treated as a Rollover Contribution.

Taking a QDRD will not impact your eligibility for a hardship distribution as described in Section 9(A). If you take a QDRD and are also eligible for a hardship distribution due to expenses or losses incurred on account of the same disaster that gave rise to your eligibility for the QDRD, the $22,0000 QDRD limit will not impact the amount you can otherwise withdraw from your Individual Account pursuant to Section 9(A).

SECTION 10. BENEFITS AT RETIREMENT

A) When Benefits Are Available

The “normal retirement age” under the Plan is age 65. Benefits are payable at normal retirement age but may be paid before or after normal retirement age under the terms and conditions set forth herein.

You may withdraw the full balance in your Individual Account if you have:

i) Reached age 55; and
ii) Retired from active employment with any and all Employers participating in the Plan; and
iii) Completed an application form.

B) How Your Individual Account is Paid

You will receive your Individual Account balance in the form of a single lump-sum payment that will be paid no later than the 60th day after the end of the Plan Year in which you retire.

If you receive your distribution before you reach age 59½, it is usually subject to a federal penalty tax of 10%, in addition to ordinary income tax, plus state tax and penalties, if applicable.

C) Rollover of Distributions from the Plan

You may roll over eligible distributions made from the Plan into certain qualified retirement plans that accept rollovers, including IRAs, individual retirement annuities, annuity contracts, annuity plans, and eligible state or local government plans, as permitted by federal law.

It is your responsibility, not the Plan’s, to determine whether or not you are eligible to make a Rollover Distribution to a Roth IRA.

A Rollover Distribution may be made directly to an eligible retirement plan, annuity, or IRA. Payment may instead be made directly to you, in which case you will have 60 days to convert the payment into a Rollover Distribution by depositing the funds into an eligible retirement plan, annuity, IRA, etc., to avoid being taxed on the distributions that are eligible to be rolled over.

Distributions that are eligible to be rolled over that are paid directly to you are subject to a 20% mandatory federal tax withholding. However, Rollover Distributions transferred directly from this Plan to an eligible retirement plan, annuity, or IRA (including a Roth IRA) are not subject to mandatory withholding.

If the distribution you are to receive is eligible to be rolled over, the Plan will provide more detailed information at that time.

D) Required Minimum Distributions

You are not required to take a distribution when you retire, except that, generally, you may not postpone the payment of benefits beyond April 1 following the year in which you reach the applicable age for a required minimum distribution, known as the required beginning date. However, if you have not yet retired, you may continue to postpone the payment of benefits until April following the year in which you retire (even if you have reached the required beginning date). The Fund Office will make payments to any Participant, who can be located and who has reached these required beginning dates, even if an application has not been filed.

For purposes of determining your required beginning date, your "applicable age" is based on your date of birth as follows:

Birth Date	Applicable Age
Before July 1, 1949	70 ½
July 1, 1949 – December 31, 1950	72
January 1, 1951-December 31, 1959	73
January 1, 1960 or later	75

SECTION 11. DEATH BENEFITS

If you die before you receive your benefits and you are not married, your Beneficiary will receive a lump-sum payment of the value of your Individual Account as of the date it is paid out.

A) Naming your Beneficiaries

You may decide who your Beneficiary(ies) will be by filing a completed Beneficiary Form with the Fund Office. However, if you are married, your Spouse is automatically your Beneficiary. So, if you are married and wish to designate a Beneficiary other than your Spouse, your Spouse must consent in writing on the Beneficiary Form, and your Spouse's signature must be notarized.

B) When there is no Named Beneficiary

If you have no named Beneficiary or if your Beneficiary predeceases you, the Plan will pay survivor benefits to one or more of the following surviving relatives in the following order:

i) Surviving Spouse (not including a Domestic Partner);
ii) If none, to be divided equally among the surviving child(ren), including legally adopted child(ren);
iii) If none, to the surviving parent(s);
iv) If none, to be divided equally among the surviving sibling(s); or
v) If none, to your estate.

C) Automatic Revocation of Spouse Beneficiary

The designation of a Spouse as a Beneficiary of any death benefit will be automatically revoked if the marriage is later dissolved. Thus, a former Spouse will no longer be your designated Beneficiary unless named as such in a new Beneficiary Form, completed and submitted to the Fund Office after the marriage is dissolved. This rule limits the chance of conflicting claims to death benefits if you forget to change your Beneficiary designation from a former Spouse to a subsequent Spouse or other Beneficiary.

D) Minor Beneficiaries

If the benefits are payable to a minor, the Trustees may direct that the benefits be paid to a legally appointed guardian or conservator or to the person having custody or care of the minor, providing the benefits are used solely to support the minor. The Trustees may direct that the benefits be deposited in a federally insured savings account in the name of the minor.

E) Rollovers for Surviving Spouse Beneficiaries

Most distributions made to a surviving Spouse Beneficiary are eligible for rollover. A surviving Spouse Beneficiary will be provided with a notice at the time of the distribution which will provide complete information as to the Beneficiary's options and rights with

respect to an eligible rollover distribution. A surviving Spouse may not postpone the payment of benefits beyond when you would have reached the applicable age as defined under Internal Revenue Code Section 401(a)(9)(C)(v) or, if later, the end of the Calendar Year immediately following the Calendar Year in which you died. The Fund Office will make payments to any surviving Spouse Beneficiary, who can be located and who has reached these required beginning dates, even if an application has not been filed.

F) Non-Spouse Beneficiaries

Payments to non-Spouse Beneficiaries generally must be made no later than one year from the date of your death or, if later, as soon as practicable after the Trustees learn of the death. A non-Spouse Beneficiary may roll over an eligible rollover distribution only through a direct trustee-to-trustee transfer and only to an "inherited IRA" (see Section 10(C), page 17), Roth IRA, or annuity. An inherited IRA is one established by the Beneficiary solely to accept your death or survivor benefit and may include a Roth IRA. This can only be accomplished through a direct trustee-to trustee Rollover Distribution. Therefore, unlike a Participant or surviving Spouse, if the non-Spouse Beneficiary directly receives a distribution from the Plan, they do not have the option to convert the payment to a Rollover Distribution by depositing it to an inherited IRA within 60 days of payment. By rolling over the distribution, the non-Spouse beneficiary will be able to defer taxes.

Once rolled over into an inherited IRA, the benefits must still be distributed to the non-Spouse Beneficiary in installments over the life or life expectancy of the non-Spouse Beneficiary starting within one year after your death or distributed in full within five years after you die. Unlike a surviving Spouse, a non-Spouse Beneficiary will not be permitted to delay distribution from an inherited IRA until they would have attained the applicable age as defined under Code Section 401(a)(9)(C)(v).

A non-Spouse Beneficiary will be provided with a notice at the time of the distribution which will provide complete information as to the Beneficiary's options and rights with respect to a Rollover Distribution.

G) Disclaimer of Benefits

A Beneficiary who is eligible to receive benefits on behalf of a deceased participant may relinquish the right to such benefit by timely submission (no later than nine months after the death of the Participant) of a written disclaimer of benefits that satisfies the requirements of applicable federal and state law. If you would like to make a written disclaimer, you should contact the Fund Office for the necessary forms.

SECTION 12. APPLICATION FOR BENEFITS

Except for benefits from the Plan that are paid automatically, you must submit a written application to the Fund Office to receive benefits under the Plan. When you are ready to apply, contact the Fund Office for the necessary forms. An application will be treated as submitted on the date it is postmarked. If your application is incomplete, you will be notified with a written request for additional information.

All claims will be processed no later than 60 days after the end of the Plan Year in which you submit a claim. However, every effort will be made to process your claim as soon as administratively feasible after its receipt by the Fund Office.

SECTION 13. TAX ON DISTRIBUTIONS

When you receive money from your Individual Account, a Form 1099-R will be issued reporting this income to you and the IRS. The extent to which some or all of your distribution is taxable depends on several factors.

A) Employee Pre-tax 401(k) Contributions

Employee Pre-tax 401(k) Contributions are deducted from your wages before income tax, or income tax withholding, is calculated. These contributions are not taxed in the year you earn them. The contributions, and any investment earnings, are taxed only at the time of distribution. Employee Pre-tax 401(k) Contributions and earnings may be paid as a Rollover Distribution to your account in another qualified plan, or into an IRA, etc. In most cases, if a distribution of Employee Pre-tax 401(k) Contributions is not rolled over into another qualified plan or an IRA, the entire distribution amount will be subject to income tax and any applicable tax penalties.

B) Employee After-tax Roth 401(k) Contributions

Unlike Employee Pre-tax 401(k) Contributions, Employee After-tax Roth 401(k) Contributions are subject to income tax when the contribution is made and are generally not taxed when distributed. The earnings on Employee After-tax Roth 401(k) Contributions are also distributed tax-free so long as the distribution is "qualified". A distribution is qualified if it occurs after you turn age 59½

or because of your death or disability and if it occurs at least five years after the date of your first Employee After-tax Roth 401(k) Contribution. These contributions and earnings thereon may be paid as a Rollover Distribution but only into a Roth contribution account in another qualified plan or into a Roth IRA. In most cases, if a distribution of Employee After-tax Roth 401(k) Contributions is not qualified, the earnings will be subject to income tax and applicable tax penalties.

C) Employer 401(a) Contributions

Like Employee Pre-tax 401(k) Contributions, Employer 401(a) Contributions, and any investment earnings, are taxed only at the time of distribution. Employer 401(a) Contributions and earnings may be paid as a Rollover Distribution to your account in another qualified plan, or into an IRA, etc. In most cases, if a distribution of Employer 401(a) Contributions is not rolled over into another qualified plan or an IRA, the entire distribution amount will be subject to income tax and any applicable tax penalties.

D) Rollovers

You can elect a Rollover Distribution to eligible retirement accounts, such as other qualified plans, tax-qualified annuities, IRAs, and qualified state and local government plans which accept rollovers. Surviving Spouse Beneficiaries or Alternate Payees who are Spouses or former Spouses may similarly roll over their distributions to these types of eligible retirement accounts. Distributions to non-Spouse Alternate Payees are taxable to the Participant and cannot be rolled over. Non-Spouse Beneficiaries may roll over their benefit only to an Inherited IRA (see Section 11, page 18).

You must complete the appropriate forms and inform the Fund Office of the name of the retirement account to which you want your Rollover distribution payable, as well as any other information necessary to make the transfer.

Unless you are a non-Spouse Beneficiary, if you do not elect a Rollover Distribution, you may still convert your benefit payment into a Rollover Distribution by depositing the money in a qualified plan or IRA, etc., within 60 days of the payment to you. To avoid tax and tax penalties on the 20% federal income tax that the Plan withheld from your distribution, you must include with your deposit an amount equal to that withholding (and any state withholding).

To determine the best way to receive the money in your Individual Account and the tax consequences of any payments you receive, you are strongly advised to discuss your particular circumstances with a qualified tax advisor.

Generally, distributions that are not rolled over are taxable and subject to mandatory federal and state tax withholding.

E) Tax Withholding

Federal law governs the withholding of income tax from distributions.

If you are eligible for a Rollover Distribution to another eligible retirement account and do not elect that option, the Plan must withhold 20% of your distribution to offset some of the federal income tax you may owe. You may also be subject to a 10% federal penalty if you are under age 59½. State withholding, tax, and tax penalties may also apply. You will be notified about your right to elect a Rollover Distribution when you ask for a distribution.

SECTION 14. APPLICATION AND APPEALS PROCEDURES

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

A) Processing a Claim For a Benefit

The Fund will treat any application or written request for a Plan benefit or any other written claim for Fund action made by you or your authorized representative per the procedures described in this SPD as a “claim for benefits”. You can appeal any Fund decision regarding the amount or timing of a benefit or any other Fund decision affecting your rights under the Plan using the procedures set forth below.

Except for benefits from the Fund that are paid automatically, to make a claim for benefits, you must obtain an application form from the Fund Office. The form must be completed, signed, and submitted to the Fund Office. A claim will be treated as submitted on the date it is received by the Fund Office. If your application is incomplete, you will be notified as soon as possible with a written request for additional information.

Every effort will be made to process your claim within 90 days after its receipt by the Fund Office. This 90-day period will begin upon receipt of the completed and signed application form by the Fund Office without regard to whether all of the information necessary to decide the application has been submitted.

If a decision on your claim for benefits cannot be made within 90 days of its receipt, a letter will be sent to you before the expiration of the 90 days, explaining the special circumstances requiring another 90 days to take action. If final action cannot be taken at the end of the second 90-day period, you will be sent a written explanation in advance of the expiration of the second 90-day period. Where appropriate, you will be awarded any partial benefits that can be determined with the available information. If partial benefits cannot be awarded because of a lack of necessary information, the Fund Office will conditionally deny your claim. The Fund Office will continue to seek the necessary information to make a final determination.

B) Notice of Decision on Your Claim

If your claim for benefits is denied, in whole or in part, the Fund Office will provide you with a written notice that states (1) the specific reason 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 your application, (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.

C) Appealing a Benefit Denial

If your claim for benefits is denied, in whole or in part, you may request that the Board of Trustees review the benefit denial. The Board of Trustees has delegated the responsibility to decide appeals to its Appeals Committee. (In some cases, the Board of Trustees may decide to consider an appeal. In other cases, the Appeals Committee may delegate the responsibility to consider an appeal to a subset of the Committee.) All appeals must be in writing and must be received by the Fund Office within 180 calendar days after you receive the written notice of the denial from the Fund Office. Failure to file a timely written appeal shall constitute a complete waiver of your right to appeal, and the decision of the Fund Office will be final and binding.

In presenting your appeal, you can submit written comments, documents, records, and other information about your claim. You are also entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim. Personal appearances on appeals are at the discretion of the Appeals Committee.

Your written appeal should state the specific reasons why you believe the denial of your claim was in error. You should also submit any documents or records that support your claim. This does not mean that you are required to cite all of the Plan provisions that apply or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefits or other relief you are claiming. The Appeals Committee can best consider your position if it clearly understands your claims, reasons, or objections.

The review of 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 or considered by the Fund Office in its determination. The Appeals Committee will also not afford deference to the initial determination by the Fund Office.

The Fund Office 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.

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 Office. 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 you before the beginning of the extension. Such an extension may only last until the third meeting following receipt of the appeal.

D) Notice of Decision on Appeal

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

If your appeal is denied, in whole or in part, you will receive a written decision that will include: (1) the specific reason(s) for the denial; (2) the specific Plan provisions on which the denial is based; (3) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your appeal; and (4) a statement of your right to bring a lawsuit under Section 502(a) of ERISA.

E) The Decision on Appeal is Final and Binding

The decision of the Appeals Committee is final and binding on all parties, including anyone claiming a benefit on your behalf.

Once a final decision is rendered, there is no right to re-file the same appeal or request reconsideration, and if such an appeal or request for reconsideration is filed, the Appeals Committee may refuse to consider it.

The Board of Trustees and, by delegation, the Appeals Committee has full discretion and authority to determine all matters relating to appeals, including, but not limited to, eligibility for benefits, the amount of benefits to which individuals are entitled, the standard of proof required for any claim, and the application and interpretation of the Plan. The Board of Trustees has the ultimate authority to hear any appeal and has generally delegated this authority to the Appeals Committee to decide appeals. However, the Board of Trustees has the right and authority to hear any appeal, and in such case, the rights and procedures set forth herein shall apply equally to the Board of Trustees.

If the Appeals Committee denies your appeal and you decide to seek judicial review, the Appeals Committee's decision will be subject to limited judicial review to determine only whether the decision was arbitrary and capricious. Generally, 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 before the decision on your appeal. No legal action may be commenced against the Trust, the Plan, or the Trustees more than two years after the claim has been denied on appeal.

F) Right to Be Represented

In making a claim or appeal, you may be represented by any authorized representative. If your representative is not an attorney or court-appointed guardian, you must designate the representative by a signed written statement. However, neither you nor your representative has a right to an in-person hearing or appearance before the Trustees or the Appeals Committee.

G) Any Adverse Decision May be Appealed

The recipient of any written correspondence from the Fund Office that could be interpreted as adversely affecting the recipient's interest may appeal to the Appeals Committee for a determination on the content of that correspondence. Such a request for review must be in writing and must be made within 180 calendar days after receipt of the correspondence from the Fund Office. Such appeals will be processed in the same manner as appeals from determinations on benefit applications.

SECTION 15. IMPORTANT NOTICES

A) No Assignment of Benefits

Benefits may not be sold, assigned, or pledged as security for a loan. Furthermore, benefits are not subject to attachment or execution for the payment of a debt under any judgment or decree of a court or otherwise, except as provided in the Internal Revenue Code and applicable regulations. However, any benefits payable to a former Spouse or Alternate Payee under a legally binding Qualified Domestic Relations Order will be honored by the Fund.

B) Erroneous Payments

Every effort will be made to ensure accuracy in the payment of your benefits. However, if an error is discovered, and it is determined that the Fund has paid any benefits you are not entitled to, the Trustees have the right to seek repayment from you for the amount overpaid plus interest by all legal and equitable means, including through the reduction of future benefit payments to the extent permissible under ERISA.

C) 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 erroneous amounts paid by the Fund, and you will be liable for all costs of collection, including attorneys' fees. 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 payment made because of fraud or misrepresentation.

SECTION 16. INFORMATION REQUIRED BY ERISA

The following additional information concerning the Plan is provided to you per the Employee Retirement Security Act of 1974 (ERISA). The terms in this section are generally as defined in ERISA unless capitalized.

A) Name and Type of Plan

The name of the Plan is the Southern California Pipe Trades Defined Contribution Plan. It is a multiemployer profit-sharing defined contribution plan with a cash-or-deferred arrangement.

B) Identification Numbers

The Fund's Internal Revenue Service tax identification number is 95-4388338. The Plan number is 001.

C) Plan Year

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

D) Plan Sponsor, Named Fiduciary, and Administrator

The Plan is maintained according to a collectively bargained, jointly trusteed labor-management trust. The Board of Trustees is the plan sponsor, the plan administrator, and the named fiduciary under ERISA.

E) Board of Trustees

The Board of Trustees consists of Employer and Union representatives, selected by the Employers and Unions per 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	(800) 595-7473
Southern California Pipe Trades Defined Contribution Fund	(213) 385-6161
501 Shatto Place, Suite 500	www.scptac.org
Los Angeles, CA 90020	info@scptac.org

F) Fund Office

The Board of Trustees has designated the Southern California Pipe Trades Administrative Corporation to perform the daily business functions of the Plan. You may contact the Fund Office at:

Southern California Pipe Trades Administrative Corporation	(800) 595-7473
Attention: CEO/Administrator	(213) 385-6161
501 Shatto Place, Suite 500	www.scptac.org
Los Angeles, CA 90020	info@scptac.org

Some recordkeeping and investment functions are performed by John Hancock Retirement Plan Services. To contact John Hancock, write or call:

John Hancock Retirement Plan Services
690 Canton Street
Westwood, MA 02090
(833) 388-6466

G) Agent for Service of Legal Process

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

Southern California Pipe Trades Defined Contribution Fund
Attention: CEO/Administrator
501 Shatto Place, Suite 500
Los Angeles, CA 90020

Service of legal process may also be made upon a plan trustee or the plan administrator.

H) Source of Contributions and Identity of any Organization Through Which Benefits are Provided

Contributions to the Fund are made by:

i) Employers per their Collective Bargaining Agreements or per the terms of a Participation Agreement or reciprocal agreement, which require that contributions be made to the Fund at fixed rates per hour of work; and
ii) Employees in the form of Employee 401(k) Contributions and Rollover Contributions by Employees.

The Fund Office will provide you, upon written request, a complete list of Employers and Unions that are parties to a Collective Bargaining Agreement and their addresses. The Fund Office will also provide information about whether a particular employer is obligated to contribute to the Fund on behalf of employees working under a Collective Bargaining Agreement or Participation Agreement and the address of any such employer.

The Fund's assets are held in trust by the Board of Trustees. Custody of the Fund's assets is with U.S. Bank, N.A. Benefits are provided directly from the Fund's assets, which are accumulated under the provisions of the Trust Agreement. The assets are used

exclusively for providing benefits to participants and beneficiaries per the provisions of the Plan and for paying the reasonable administrative expenses of the Fund.

All of the types of benefits provided by the Plan are set forth in this SPD.

I) Collective Bargaining Agreement

Contributions to the Fund are made per Collective Bargaining Agreements between Employers and District Council No. 16 of the United Association or affiliated local Unions of District Council No. 16 or of the United Association. The United Association local Unions affiliated with District Council No. 16 are 78, 114, 230, 250, 345, 364, 398, 403, 460, 484, 582, and 761. The Fund Office will provide you, upon written request, a copy of the applicable Collective Bargaining Agreement. The Collective Bargaining Agreements are also available for examination at the Fund Office. The following are the employer associations with which District Council No. 16 has a bargaining relationship that requires contributions to this Fund:

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

J) Plan Termination and Termination Insurance

i) Plan Termination

It is intended that this Plan will continue indefinitely, but the Board of Trustees reserves the right to change or discontinue the Plan at any time. The Trustees may terminate the Plan 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 become due. The Plan may also be terminated if there are no individuals living who can qualify as participants or beneficiaries under the Plan or if there are no longer any Collective Bargaining Agreements requiring contributions to the Fund. The Trustees have the complete discretion to determine when and if the Fund should be terminated.

If the Plan is terminated, the Trustees will: (i) pay the expenses of the Fund incurred up to the date of termination as well as the expenses in connection with the termination; (ii) arrange for a final audit of the Fund; (iii) give any notice, and prepare and file any reports required by law; and (iv) apply the assets of the Fund per the law and the Plan, including amendments adopted as part of the termination, until the assets of the Fund are distributed. Under no circumstances will any portion of the Fund revert or inure to the benefit of an Employer, any employer association, or the Union.

Upon termination of the Plan and Fund, the Trustees will promptly notify the Union, any employer association, Employers, and all other interested parties. The Trustees will continue as Trustees to wind up the affairs of the Plan.

Upon termination, the Trustees will make a reasonable effort to contact every Participant or, if you are deceased, your Beneficiary. If you cannot be located or do not make a claim for payment of your Individual Account within six months following notice by certified mail to your last known address, the Trustees will roll over your Individual Account to an individual retirement plan (IRA) in your name or that of your missing Beneficiary. The provider of the individual retirement plan will be selected per the Department of Labor's rules and regulations, including any available safe harbor for distributions to missing Participants of terminated defined contribution plans. If it is not feasible to roll over the account into an individual retirement plan, the Trustees will determine the best alternative, including depositing the account into an interest-bearing federally insured savings account. The names of the individuals for whom an account is established will be available for reference with the Union.

ii) Termination Insurance

Benefits provided under this Plan are not insured by the Pension Benefit Guaranty Corporation (PBGC) or any other governmental agency because neither the PBGC nor any other agency insures the benefits of a defined contribution pension plan.

K) Actions of Trustees

The Trustees have full discretion and authority over the standard of proof for any inquiry, claim, or appeal, and over the application and interpretation of the Plan and trust. No legal proceeding may be filed in any court or before an administrative agency against the Plan or its Trustees unless all review procedures with the Trustees have been exhausted. No legal action may be commenced against the trust, the Plan, or the Trustees more than two years after a claim has been denied.

L) Right to Amend

The Trustees have the complete discretion to amend or modify the Plan or trust and any of their provisions, in whole or in part, at any time.

M) ERISA Rights

As a participant in the Southern California Pipe Trades Defined Contribution 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

a) Examine, without charge, at the plan administrator's office and 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 Employee Benefits Security Administration.

b) 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 an updated summary plan description. The administrator may make a reasonable charge for the copies.

c) Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each Participant with a copy of this summary annual report.

ii) 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, must 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 pension benefit or exercising your rights under ERISA.

iii) Enforce Your Rights

If your claim for a pension benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits 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 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.

iv) Assistance with Your Questions

If you have any questions about your Plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the 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 17. DEFINITIONS

Alternate Payee

Your Spouse, former Spouse, child, or other dependent, or any individual who is recognized under a Qualified Domestic Relations Order (QDRO) as having a right to receive some or all of your benefits accrued and otherwise due and payable to you.

Appeals Committee

A subset of the Board of Trustees empowered to review any claims as described in Section 14.

Beneficiary
A Beneficiary is a person designated by you or by the Plan to receive benefits when you die.

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

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

Collective Bargaining Agreement
Any and all negotiated labor agreements between a Contributing Employer, or employer association acting on behalf of Employers, and Southern California Pipe Trades District Council No. 16 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada ("United Association"), or any local Union affiliate of the District Council that requires contributions to the Southern California Pipe Trades Defined Contribution Fund. It also refers to an agreement to which the United Association is a party, requiring contributions to the Fund.

Contributing Employer
An Employer signed to a Collective Bargaining Agreement or Participation Agreement, or an Employer that assigns its bargaining rights to an employer association signed to a Collective Bargaining Agreement, that requires contributions to the Fund.

Covered Employment
Work by an Employee under a Collective Bargaining Agreement.

Employee
An Employee is anyone employed by a Contributing Employer in a position for which (1) the Employee is permitted to contribute to the Fund, or (2) the Employer is required by a Collective Bargaining Agreement to contribute to the Fund. Employees may also include an Employer or someone employed by an organization signatory to a Participation Agreement or other similar arrangement.

Employee 401(k) Contribution
An amount deducted from an Employee's pay and contributed to the Fund. An Employee 401(k) Contribution may be either an Employee Pre-tax 401(k) Contribution or an Employee After-tax Roth 401(k) Contribution. See Section 3(A), page 3.

Employee After-tax Roth 401(k) Contribution
An amount deducted from an Employee's pay after any income and payroll taxes are assessed. No income tax is due upon a "qualified" withdrawal. See Section 3(A), page 4.

Employee Pre-tax 401(k) Contribution
An amount deducted from an Employee's pay before any income taxes are assessed. Income tax is due upon withdrawal. See Section 3(A), page 4.

Employer
See Contributing Employer.

Employer 401(a) Contribution
An amount contributed by an Employer on behalf of an Employee, if required by a Collective Bargaining Agreement or Participation Agreement.

ERISA
Employee Retirement Income Security Act of 1974, as amended. See Section 16(M), page 25, for an explanation of your ERISA rights.

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

Fund Office
Southern California Pipe Trades Administrative Corporation
501 Shatto Place, Suite 500
Los Angeles, CA 90020

(800) 595-7473
(213) 385-6161
www.scptac.org
definedcontribution@scptac.org

Individual Account
The account established in the Plan for each Participant. The balance of your Individual Account equals all contributions made by you or your employer, plus/minus all earnings/losses on your investments, less any fees or expenses charged or withdrawals taken.

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 permitting a Contributing 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 not covered by a Collective Bargaining Agreement.

Plan
The benefits, rules, limitations, exclusions, and other provisions described in this SPD and established by the Plan Document.

Plan Document
The written document titled "Fourth Restatement of the Southern California Pipe Trades Defined Contribution Plan" and any amendments thereto.

Plan Year
January 1 through December 31 of each year.

Rollover Contribution
Money from your account in a variety of retirement accounts, including another qualified plan, tax-qualified annuity, qualified state or local government plan, or that portion of an IRA distribution that would otherwise be includable in gross income, that you roll over into this Plan. The amount you roll over will be placed in your Individual Account.

Rollover Distribution
A benefit payment from this Plan that is timely deposited to another qualified retirement plan that accepts rollovers, including individual retirement accounts (IRAs), Roth IRAs, individual retirement annuities, annuity contracts, annuity plans, and eligible state and local government plans, as permitted by federal law. A Rollover Distribution is generally not subject to income tax at the time of payment.

SPD
Summary Plan Description. This document. A summary of the provisions of, and benefits available under, the Southern California Pipe Trades Defined Contribution Fund.

Spouse
A person to whom you are legally married (or to whom you were married for purposes of and to the extent provided under a Qualified Domestic Relations Order).

Trust Agreement
The written document titled "Restated Agreement and Declaration of Trust Continuing the Southern California Pipe Trades Defined Contribution Fund" under which the Fund has been established and maintained and to which this Plan has been adopted, and any amendments thereto.

Trustees
Employer and Union representatives who oversee the Fund.

Uniformed Service and Qualified Uniformed Service
Uniformed Service is duty in the armed forces of the United States, the National Guard, the commissioned corps of the Public Health Service, and such other service designated by the President, which may entitle a Participant to the protections of USERRA.

Qualified Uniformed Service is Uniformed Service meeting the requirements under USERRA that establish reemployment and other rights.

Union(s)
Southern California Pipe Trades District Council No. 16 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada, AFL-CIO ("United Association"), and its affiliated local Unions, and such other Unions which have or may in the future become parties to and agree to be bound by the Trust Agreement.

SECTION 18. TRUSTEES

The following is a list of the Trustees as of the publication date of this SPD. The members of the Board of Trustees may change from time to time. If you want a current listing of the Trustees, contact the Fund Office.

A) Employer Trustees

RYAN CAVANAUGH
Murray Company
5995 Plaza Drive
Cypress, CA 90630

ROBERT FELIX
All Area Plumbing/ACCO Engineered Systems, Inc.
6446 E. Washington Blvd.
Commerce, CA 90040

JASON GORDON
Prime SC Mechanical, Inc.
7392 Earl Circle
Huntington Beach, CA 92647

JEFF HACHEY
H.L. Moe Company, Inc.
526 Commercial Street
Glendale, CA 91203

ADAM KAPLAN
Sierra Commercial Plumbing, Inc.
4645 Industrial Street, Unit C
Simi Valley, CA 93063

CHIP MARTIN
CPMCA
1735 Flight Way, Suite 204
Tustin, CA 92782

JOHN MODJESKI
University Mechanical & Engineering Contractors
1168 Fesler Street
El Cajon, CA 92020

JEFF STEVANUS
Southland Industries
12131 Western Avenue
Garden Grove, CA 92841

BRYAN SUTTLES
Suttles Plumbing
2267 Agate Court
Simi Valley, CA 93065

STEVE VALOT
Pan-Pacific Mechanical
18250 Euclid Street
Fountain Valley, CA 92708

LAWRENCE VERNE
Verne's Plumbing, Inc.
8561 Whitaker Street
Buena Park, CA 90621

PIP ZAIDE
Allegiant Mechanical, Inc.
7776 Westminster Blvd.
Westminster, CA 92683

B) Union Trustees

DAVID BALDWIN
U.A. Local No. 403
3710 Broad Street
San Luis Obispo, CA 93401

STEVEN BERINGER
U.A. Local No. 230
6313 Nancy Ridge Drive
San Diego, CA 92121

SHANE BOSTON
U.A. Local No. 484
1955 N. Ventura Avenue
Ventura, CA 93001

BEN CLAYTON
U.A. Local No. 250
18355 South Figueroa Street
Gardena, CA 90248

RODNEY COBOS
District Council No. 16
501 Shatto Place, Suite 400
Los Angeles, CA 90020

JEREMY DIAZ
U.A. Local No. 78
1111 W. James M. Wood Blvd.
Los Angeles, CA 90015

STEVEN GOMEZ
U.A. Local No. 460
6718 Meany Avenue
Bakersfield, CA 93308

ROBERT JAMES
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1916 W. Chapman Avenue
Orange, CA 92868

GREG LEWIS
U.A. Local No. 761
1305 North Niagara Street
Burbank, CA 91505

RICARDO PEREZ
U.A. Local No. 345
1430 Huntington Drive
Duarte, CA 91010

JOE RAYMOND
U.A. Local No. 364
223 S. Rancho Avenue
Colton, CA 92324

BILL STEINER
U.A. Local No. 398
8590 Utica Avenue, Suite 200
Rancho Cucamonga, CA 91730

SASHA STEVENS
U.A. Local No. 114
93 Thomas Road
Buellton, CA 93427

Summary Plan Description

of the

Southern California Pipe Trades

RETIREMENT FUND

Contents

SECTION 1. INTRODUCTION

The Southern California Pipe Trades Retirement Fund ("Fund" or "Plan") was established in 1957 through the negotiating efforts of District Council No. 16 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States, and Canada ("United Association") and Employers in the plumbing and pipefitting industry in Southern California. Union and Employer Trustees manage the Fund.

A) This Summary Plan Description

This Summary Plan Description ("SPD") summarizes the provisions of the Southern California Pipe Trades Retirement Plan. It applies on and after September 1, 2025. You must read this SPD carefully to understand how the Plan works. Please keep this SPD for future reference.

This summary is not meant to interpret, extend or change the Plan Document or the Trust Agreement in any way. If there is a conflict between this summary and the actual provisions of the Plan Document, your rights and benefits will be governed by the Plan Document. Plan rules may change from time to time, in which case a written notice explaining any important change will be sent to all covered households. Please read all Plan communications and keep them with this SPD.

B) Purpose of the Plan

The Plan was set up to provide retirement, death, and disability benefits. The Plan is funded by Employers who make contributions on behalf of their Employees on a per-hour basis under a Collective Bargaining Agreement or a Participation Agreement. Covered Employees do not, themselves, make contributions to the Plan and do not have individual accounts in the Fund. Employees accumulate credit under the Plan based on hours worked and their years of employment covered by the Plan. Qualification for benefits and the amount of those benefits are based upon an Employee's years of service with Contributing Employers, Pension Credits, Pension Hours, and age at retirement.

C) Role of the Board of Trustees

The Board of Trustees is authorized to interpret all Plan rules and documents, including the Plan Document, the Trust Agreement, and this SPD. The Board of Trustees has discretion to decide all questions about the Plan including, but not limited to, questions about eligibility for participation in the Plan, rights to benefits, the amount of benefits that are payable, the information and proof necessary to substantiate a claim for benefits, and the definition of any Plan term. The Board of Trustees also has the authority to make any factual determinations concerning claims. No individual Trustee, Employer, or Union representative has the authority to interpret any Plan document on behalf of the Board of Trustees or to act as an agent of the Board of Trustees. The Board of Trustees may delegate its authority to a subcommittee or other subset of the Board of Trustees.

The Trustees intend to continue the Fund indefinitely. However, the Board of Trustees has the authority to amend or terminate the Plan as they deem appropriate.

D) Role of the Fund Office

The Board of Trustees has authorized the Fund Office to respond in writing to your written questions. As a courtesy, the Fund Office may also respond informally to questions by telephone, email, or in person at the Fund Office. However, such information and answers are not binding upon the Board of Trustees and cannot be relied upon in any dispute. Remember 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 independently determine your entitlement to benefits.

NOTE	**If you have any questions regarding eligibility, benefits, or procedures, contact the Fund Office.** **Southern California Pipe Trades Administrative Corporation** **501 Shatto Place, Suite 500** **Los Angeles, CA 90020** **Toll-Free: (800) 595-7473 / Outside U.S.: (213) 385-6161** **Website: www.scptac.org / Email: pension@scptac.org** **Change of Address Form submission: coa@scptac.org**

NOTE	**Capitalized terms are defined in Section 18, page 41.**

SECTION 2. PARTICIPATION IN THE PLAN

A) Initial Participation

You become a Participant in the Plan on the following January 1st or July 1st after any 12 consecutive month period during which you first complete 1,000 Hours of Service in Covered Employment. Hours worked in a job not covered by this Plan also count if such non-Covered Employment comes immediately before or after Covered Employment and is with the same Employer. Once you become a Participant, all your Hours of Service in Covered Employment will count toward eligibility for a benefit under the Plan, including any Hours of Service before you become a Participant if those Hours of Service were not previously canceled by a Permanent Break in Covered Employment.

B) Ongoing Participation

You are an Active Participant so long as you have not experienced a One-Year Break in Covered Employment. A One-Year Break in Covered Employment occurs if you fail to complete more than 500 Hours of Service in a Calendar Year. The break in covered employment rules are described in Section 5, page 7.

C) Loss and Reinstatement of Participation

If you experience a One-Year Break in Covered Employment, you cease to be an Active Participant at the end of the Calendar Year in which the One-Year Break in Covered Employment occurs. You may again become an Active Participant upon re-employment in Covered Employment. However, if you have incurred a Permanent Break in Covered Employment, you must again establish participation under the initial participation rules described above. The break in covered employment rules are described in Section 5, page 7.

D) Covered Employment

Covered Employment is generally work you perform that is covered under a District Council No. 16 Collective Bargaining Agreement or Participation Agreement and for which your Employer is required to contribute to this Plan. You are not eligible to participate in the Plan if you are a sole proprietor or a partner in a partnership. Participation in the Plan is available to eligible Employees of District Council No. 16, its affiliated local unions, and other organizations related to the Union, provided there is a Participation Agreement between the employing organization and the Plan.

SECTION 3. PENSION CREDIT

Hours of Service are hours for which you are paid or entitled to be paid for work performed for an Employer. Hours of Service are mainly used to determine your Vesting Credits described in Section 4, page 6.

If you work in Covered Employment, your Employer is required to make contributions to the Fund based on your Hours of Service, and you will therefore earn Pension Hours. You may also earn Pension Hours for certain periods of absence from Covered Employment, such as Qualified Uniformed Service, and periods covered by the weekly accident and sickness benefit from the Southern California Pipe Trades Health & Welfare Fund. For more information about the weekly accident and sickness benefit, see the Southern California Pipe Trades Health & Welfare SPD or contact the Fund Office.

Currently, Pension Hours determine the amount of your benefit. The number of Pension Hours you earn will determine the number of your Pension Credits.

Your Pension Credits determine the following:

- The number of your Pension Credits;
- Whether you are eligible for a benefit;
- The type of benefit; and
- The amount of your benefit (for Covered Employment before 1999).

Pension Credit is also used in part to determine whether you can become eligible for coverage under the Southern California Pipe Trades Pensioners and Surviving Spouses Health Plan and the amount of your Premium in that plan.

Pension Credit is divided into two categories: Past Service Credit (for periods before July 1, 1957) and Future Service Credit (for periods after July 1, 1957).

A) Past Service Credit

Past Service Credit is credit for work performed at or after the age of seventeen, between January 1, 1937, and July 1, 1957 (before the Plan was established and Employers were required to contribute to the Plan) in job classifications subsequently covered by the Plan. To Qualify as Past Service Credit:

i) The classification must now be included in a District Council No. 16 Collective Bargaining Agreement;
ii) The work must have been in the geographical jurisdiction of District Council No. 16; and
iii) The work must have been for a Contributing Employer (or an entity that later became a Contributing Employer).

B) Future Service Credit

You generally receive Future Service Credit for work in Covered Employment according to the following schedules:

Effective July 1, 1957

Hours Worked in a Calendar Year	Future Service Credit
Less than 350	None
350 – 699	One Quarter
700 - 1,049	Two Quarters
1,050 - 1,399	Three Quarters
1,400 or more	One Year

Effective January 1, 1971

Hours Worked in a Calendar Year	Future Service Credit
Less than 315	None
315 - 629	One Quarter
630 - 944	Two Quarters
945 - 1,259	Three Quarters
1,260 or more	One Year

However, note that:

i) Beginning April 1, 1965, if the hourly contribution rate paid on your behalf is less than the journeyman rate required under the Master Labor Agreement (or, if applicable, a predecessor or successor agreement) in effect at the time the contribution was paid, then the hours credited to you will be reduced proportionately, and your Future Service Credit will be based on the number of hours credited after the reduction is made. This reduction is not made in determining your Vesting Credits or Breaks in Covered Employment.
ii) Beginning January 1, 1976, if you work fewer than 315 hours in Covered Employment in a Calendar Year but earn a Vesting Credit, you will be credited with a portion of a full year of Future Service Credit determined by dividing the hours of work in Covered Employment by 1,000.
iii) A special proration rule was in effect from July 1, 2006, through July 1, 2008, because of a series of contribution rate increases under the Master Labor Agreement. The additional contribution rate increases sometimes did not apply immediately for an Employer's earmarked jobs that were started or bid before July 1, 2006. If your Employer had one of these earmarked jobs but had otherwise agreed to the additional contribution rate increases, your pension hours were still prorated for hours worked at the lower rate on the earmarked jobs, but the hours credited were the same as they would have been based on the proration in effect immediately before July 1, 2006.
iv) Hours may also be prorated for hours reciprocated to this Plan from another plan if these hours were worked under a contribution rate that is higher or lower than the rate set forth in the Master Labor Agreement. See Section 6, page 18, for a description of the reciprocity rules.

EXAMPLE

If the hourly contribution rate is 75% of the hourly rate paid under the Labor Agreement, then 75% of an hour will be credited for each hour worked at the lower rate. Below are various examples.

Plan Year	Worked Hours	Pension Hours	Pension Credit	Job Class	Contribution Rate	Journeyman Contribution Rate*
2018	800	0	0	Apprentice 2	$0.00	$8.00
2019	1,000	474.12	0.25	Apprentice 3	$4.03	$8.50
2020	1,500	794.21	0.50	Apprentice 4	$5.03	$9.50
2021	2,000	1,165.48	0.75	Apprentice 5	$5.74	$9.85
2022	2,040	2,040	1	Journeyman	$10.35	$10.35
2023	2,040	2,040	1	Journeyman	$10.45	$10.45
2024	2,040	2,040	1	Journeyman	$10.45	$10.45

Because this Participant worked in a job class with a lower rate than the standard Journeyman rate during the first four years of their career, their Pension Hours were reduced proportionately.

*Rates have been simplified for illustrative purposes.

C) Carryover of Excess Pension Hours

i) Effective for the Period January 1, 1971, through December 31, 1998:

Once you reach age 52, if you work in Covered Employment for more hours in a Calendar Year than are needed to establish a quarter-year multiple of Future Service Credit, the excess Pension Hours you earn in that Calendar Year will be carried forward to succeeding year(s) to provide additional Pension Credit.

Excess Pension Hours carried forward will only be used to produce additional Pension Credit, if needed, in a Calendar Year in which you worked sufficient hours in Covered Employment to earn at least one-quarter of Future Service Credit. In no event, however, will you receive more than a full year of Future Service Credit in any one Calendar Year as a result of Pension Credit you earned under this provision.

There is an exception to this rule. Beginning with the first day of the Calendar Year in which you attain age 62, all hours you worked in Covered Employment for which Pension Credit is not received will be carried forward and added to any hours worked in such succeeding years to produce additional Pension Credit, if needed. In no event, however, will you receive more than a full year of Future Service Credit in any one Calendar Year as a result of Pension Credit you earned under this provision.

Once you have accumulated 25 Pension Credits, you will not be allowed to carry over excess Pension Hours. Moreover, you may not apply carryover hours to any hours earned after your Annuity Starting Date.

ii) Effective for Periods after December 31, 1998:

No excess Pension Hours earned after December 31, 1998, can be applied to determine the amount of your pension. However, if you were age 52 or older on December 31, 1998, and if the use of your remaining excess Pension Hours ending on that date provides additional Future Service Credits for a succeeding Plan Year(s), the value of the resulting total Future Service Credit for the succeeding year(s) (at a rate of $25.00 for each complete quarter of Future Service Credit) will be compared to the value of the pension hours for that year, multiplied by the rate(s) per hour as applicable during the year; the greater benefit amount shall apply for the given Plan Year.

D) Credit for Non-Working Periods

You may receive Pension Hours for certain periods when you are not working in Covered Employment. If your absence from Covered Employment is due to one of the following reasons:

i) If you were in Covered Employment when you left for Qualified Uniformed Service under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), you will be entitled to credit for time spent in such service if you timely report back to work after discharge. When you return from Qualified Uniformed Service, you must register for work at the union hiring hall within the time frames set forth in USERRA and be available to accept referrals to receive Pension Hours for the period of Qualified Uniformed Service. The time frames set forth in USERRA are as follows:

a) Qualified Uniformed Service of fewer than 31 days (or for any length for a fitness for duty examination) – you must register for work on the first regularly-scheduled workday that begins at least eight hours after you arrive home from the service. If it is impossible or unreasonable to register for work within that time period through no fault of your own, you must register for work as soon as possible.

b) Qualified Uniformed Service of more than 30 days but fewer than 181 days – you must register for work within 14 days after completion of service. If it is impossible or unreasonable to register for work within that time period through no fault of your own, you must register for work as soon as possible.
c) Qualified Uniformed Service of more than 180 days – you must register for work within 90 days after completion of the service.
d) The deadlines for reporting for work are extended if you are hospitalized for, or convalescing from, an illness or injury incurred or aggravated during your period of Qualified Uniformed Service. Generally, this period of recovery may not last more than two years.

When you return from Qualified Uniformed Service, you must work in Covered Employment within twelve months after you return in order to be awarded Pension Credit for the period of Qualified Uniformed Service.

If you are not actively employed at the time you enter Qualified Uniformed Service and you have not yet incurred a One-Year Break in Covered Employment and/or were still eligible for coverage under the Southern California Pipe Trades Health and Welfare Plan, then you will be treated as if you were employed in Covered Employment at the time of leaving for Qualified Uniformed Service for the purpose of being eligible to have Pension Hours awarded for the period of Qualified Uniformed Service under USERRA. If you are entitled to credit for Qualified Uniformed Service, you will be provided with credit based on the average number of hours worked during the 12 months of work (or less if you have not yet worked 12 months) immediately preceding the Qualified Uniformed Service.

ii) Disability for a period in which you received weekly accident and sickness benefits from the Southern California Pipe Trades Health & Welfare Fund. You will receive Pension Hours based on a 40-hour workweek. This provision does not apply if at the time contributions to the Southern California Pipe Trades Health & Welfare Fund were made, the Participant was not earning Future Service Credit in the Retirement Fund for a prior period, as determined by the Fund Office.

E) Quarterly Statement

The Fund Office issues quarterly statements that you should carefully review. Any hours worked and prorated Pension Hours will appear on these statements. The "Quarterly Statement Schedule" set forth below summarizes the statement cycle.

Quarterly Statement Schedule

Hours Worked During:*	Deposits Processed During:	Date of Quarterly Statement
January 1st through March 31st	February 1st through April 30th	May 1
April 1st through June 30th	May 1st through July 31st	August 1
July 1st through September 30th	August 1st through October 31st	November 1
October 1st through December 31st	November 1st through January 31st	February 1

* Delinquent reporting by the Employer will affect the work months that appear on the statement.

F) Your Obligation to Timely Inform the Fund that Your Credited Hours are Incorrect

You must promptly inform the Fund Office:

i) If you believe the hours reported by the Fund Office are incorrect;
ii) If you have non-work periods for which the Plan provides credit; or
iii) If you have reason to believe that an Employer has incorrectly reported your hours to the Fund Office.

You are responsible for closely reviewing the periodic statements you receive from the Fund Office to confirm the accuracy of the hours and credit reported. You must notify the Fund Office of incorrect hours or additional hours for which you seek credit within 24 months from the date you knew or should have known that the hours were not correctly reported to the Fund or, in the case of non-work period credit, within 24 months from the end of the non-work period. Failure to timely notify the Fund Office about these hours may result in the permanent loss of these hours and your losing entitlement to any credit for these hours.

SECTION 4. VESTING CREDIT

Vesting Credit is another measure of your work used to establish your right to a benefit. Vesting Credit differs from Pension Credit in several respects:

i) It is earned only for work after January 1, 1959;
ii) It is calculated by a different formula than Pension Credit; and
iii) It is only used to establish your right to a benefit and not the amount and type of your benefit.

A) Earning Vesting Credit

i) You earn one Vesting Credit for each Calendar Year following January 1, 1959, in which you earn at least 1,000 Hours of Service.
ii) If you complete fewer than 1,000 Hours of Service in a Calendar Year, you will not earn a Vesting Credit for that year (you may, however, earn a partial Pension Credit).
iii) If you complete more than 1,000 Hours of Service in a Calendar Year, you will still receive only one Vesting Credit for that Calendar Year.

B) Hours of Service

Hours of Service include:

i) Hours in Covered Employment for which you are paid for the performance of duties for an Employer; and
ii) Vacation, holiday, illness, other leave and incapacity (including disability) for which you are paid or entitled to payment by an Employer for work in Covered Employment to a maximum of 501 hours for a single continuous period.

However, under no circumstances will you be entitled to credit for more than one Hour of Service for the same hour of work, pay, or benefits, even if you receive duplicate payment or benefits.

C) Other Service Counted for Vesting Credit

i) Hours in a job not covered by this Plan will be used to calculate Vesting Credit if such non-Covered Employment comes immediately before or after Covered Employment and is with the same Employer.
ii) Periods of disability for which you earn Future Service Credit will be used to calculate Vesting Credit.
iii) Periods of Qualified Uniformed Service will be used to calculate Vesting Credit as required by federal law.

D) Vesting Rule for the Period Beginning January 1, 1999

You will be a vested Participant in a benefit when you have earned five Vesting Credits, provided you have at least one Hour of Service on or after January 1, 1999, before incurring a Permanent Break in Covered Employment.

E) Vesting Rule Before January 1, 1999

If you have not met the five Vesting Credits rule in Section 4(D) above, you may still be a vested Participant if you meet one of the following requirements:

i) You have earned ten Vesting Credits before incurring a Permanent Break in Covered Employment; or
ii) You have earned at least 25 Pension Credits and have worked at least 5,000 hours in Covered Employment since July 1, 1957; or
iii) You attain age 50 with at least 12 Pension Credits and have worked at least 5,000 hours in Covered Employment since July 1, 1957; or
iv) You attain Normal Retirement Age; or
v) You are a non-bargaining unit employee covered by a Participation Agreement and not covered under a Collective Bargaining Agreement who has at least five Vesting Credits and have earned at least one Hour of Service on or after January 1, 1989.

F) Effect of Being Vested

Once you are a vested Participant, you cannot lose your accumulated Pension Credit or Vesting Credit through a break in covered employment. You will be entitled to receive a benefit starting at the permitted retirement age, provided you satisfy other eligibility requirements, even if you leave Covered Employment or earn no additional Pension Credit or Vesting Credit.

EXAMPLE

This chart shows how you can become a vested Participant.

This Participant started Covered Employment in 2019 and only earned 750 Hours of Service that year. The Participant did not have at least 1,000 Hours of Service that Calendar Year, so they did not receive a year of Vesting Credit. But during the next five years (2020 through 2024), this Participant earned at least 1,000 Hours of Service each year. Once the Participant completed 1,000 Hours of Service in 2024, they had five Vesting Credits and became a vested Participant.

Year	Hours	Vesting Credit	Total Vesting Credit	Vested?
2019	750	0	0	NO
2020	1000	1	1	NO
2021	1500	1	2	NO
2022	2000	1	3	NO
2023	2250	1	4	NO
2024	2250	1	**5**	**YES**

SECTION 5. BREAKS IN COVERED EMPLOYMENT

This Plan was created to help provide financial security for eligible Participants who spend a significant portion of their career in the plumbing and pipefitting industry in Southern California. For this reason, the Plan provides certain reasonable standards for continuity of service. This is the basis for the rules concerning Breaks in Covered Employment.

If you do not earn the required number of Pension Credits or Vesting Credits over a specified time, you may incur a break in covered employment. If you incur too many One-Year Breaks in Covered Employment, you may lose your previously earned Pension Credits and Vesting Credits unless you are already a vested Participant. The rules regarding breaks in covered employment are set forth below.

A) Break in Covered Employment Before January 1, 1976

You must have earned at least one-quarter of Future Service Credit in any one Calendar Year during any period of five consecutive years after January 1, 1967, to keep your years of previously accumulated Pension Credit. If you do not satisfy this requirement, then you have a "break in covered employment", and all the Pension Credits (Past and Future) earned before the "break in covered employment" will be canceled.

NOTE

Once you are vested, you cannot lose your right to a benefit.

B) One-Year Break in Covered Employment After January 1, 1976

i) On or after January 1, 1976, a One-Year Break in Covered Employment occurs if you fail to complete more than 500 Hours of Service in a Calendar Year. This break can be permanent, depending on how many Vesting Credits you have accumulated.

ii) When counting Hours of Service, the Plan counts the hours you performed work in Covered Employment and the following additional hours:

a) Paid vacations, holidays, and disability time covered by certain disability benefits;
b) Periods you were in Qualified Uniformed Service and then returned to Covered Employment within the time prescribed by law;
c) Periods of employment not covered by the Plan if such employment is continuous with your Covered Employment and with the same Employer; and
d) Periods you are away from Covered Employment because of:

1) Your pregnancy;
2) The birth of your child;
3) The placement of a child with you in connection with adoption;
4) The care for such child for a period beginning immediately after such birth or placement. (You will be credited with a maximum of 501 Hours of Service for parental leave to prevent a One-Year Break in Covered Employment.); or
5) Approved Family and Medical Leave absences.

iii) Repairing a One-Year Break in Covered Employment
A One-Year Break in Covered Employment can be repaired if, before you incur a Permanent Break in Covered Employment, you earn a Vesting Credit (1,000 Hours of Service in a Calendar Year).

C) Permanent Break in Covered Employment After January 1, 1976

Beginning January 1, 1976, a Permanent Break in Covered Employment is based on two factors: First, the number of Consecutive One-Year Breaks in Covered Employment you have incurred, and second, the number of Vesting Credits you have earned.

i) Between January 1, 1976 and January 1, 1987, you have a Permanent Break in Covered Employment if the number of Consecutive One-Year Breaks in Covered Employment you have incurred equals or exceeds the number of Vesting Credits you have previously accrued.

EXAMPLE	**If you earned three Vesting Credits and then have three Consecutive One-Year Breaks in Covered Employment, you will incur a Permanent Break in Covered Employment.**

ii) Beginning January 1, 1987, if you have not vested, you have a Permanent Break in Covered Employment if you have at least five Consecutive One-Year Breaks in Covered Employment and the number of these One-Year Breaks in Covered Employment equals or exceeds the number of Vesting Credits you previously accrued.

EXAMPLE

This chart shows an example of how a Participant can incur a Permanent Break in Covered Employment.

Assume a Participant previously had four years with at least 1,000 Hours of Service from 2016 through 2019. They then had five successive One-Year Breaks in Covered Employment (because in each of these years, they did not earn more than 500 Hours of Service). They suffer a Permanent Break in Covered Employment in 2024 because they have five Consecutive One-Year Breaks in Covered Employment.

Year	Hours	One-Year Breaks	Total One-Year Breaks	Permanent Break?
2016	1000	0	0	NO
2017	1000	0	0	NO
2018	1500	0	0	NO
2019	2000	0	0	NO
2020	325	1	1	NO
2021	480	1	2	NO
2022	325	1	3	NO
2023	325	1	4	NO
2024	475	1	**5**	**YES**

D) Avoiding a One-Year Break In Covered Employment But Not Earning a Vesting Credit

For purposes of the Permanent Break in Covered Employment rule, Consecutive One-Year Breaks in Covered Employment means that there have been a sufficient number of One-Year Breaks in Covered Employment during which there has been no intervening year in which you have earned at least 1,000 Hours of Service.

You will not incur a One-Year Break in Covered Employment for a Calendar Year in which you earned more than 500 but fewer than 1,000 Hours of Service. If you had a One-Year Break in Covered Employment or Consecutive One-Year Breaks immediately preceding the year in which you had more than 500 but fewer than 1,000 Hours of Service, you will not have repaired the previous One-Year Break(s) in Covered Employment and the count of Consecutive One-Year Breaks will remain.

A year in which you have fewer than 1,000 but more than 500 Hours of Service does not repair preceding One-Year Breaks in Covered Employment; the previous One-Year Breaks in Covered Employment are repaired only when you have had 1,000 or more Hours of Service within a Calendar Year.

EXAMPLE

This chart shows an example of how a Participant can repair a One-Year Break(s) in Covered Employment.

This Participant previously had four years with at least 1,000 Hours of Service, then had three successive or Consecutive One-Year Breaks in Covered Employment. However, in 2023 they had a year in which they had at least 1,000 Hours of Service. This one year with at least 1,000 Hours of Service in 2023 cancels out or repairs the three previous One-Years Breaks in Covered Employment.

Year	Hours	One-Year Breaks	Total One-Year Breaks	Break Repaired?	Permanent Break?
2016	1000	0	0		
2017	1000	0	0		NO
2018	1500	0	0		NO
2019	2000	0	0		NO
2020	325	1	1	NO	NO
2021	480	1	2	NO	NO
2022	325	1	3	NO	NO
2023	1500	0	0	**YES**	NO
2024	475	1	1	NO	NO

E) A Summary of Break in Covered Employment Rules after January 1, 1976

i) You will incur a One-Year Break in Covered Employment if you do not have more than 500 Hours of Service within a Calendar Year.

ii) Any One-Year Break in Covered Employment can be repaired, provided you do not accumulate so many Consecutive One-Year Breaks as to establish a Permanent Break in Covered Employment.

iii) Between January 1, 1976 and January 1, 1987, a break becomes permanent when the number of Consecutive One-Year Breaks in Covered Employment equals or exceeds the number of Vesting Credits you have earned.

iv) On and after January 1, 1987, a break becomes permanent when you have incurred five or more Consecutive One-Year Breaks in Covered Employment, and the number of consecutive One-Year Breaks equals or exceeds the number of Vesting Credits you have previously earned.

v) Any time before a Break in Covered Employment becomes permanent, you can repair the Break with one Vesting Credit.

vi) The Permanent Break in Covered Employment rules no longer apply once you are vested.

NOTE	If you incur a Permanent Break in Covered Employment, you will lose your previously earned Pension Credits and Vesting Credits unless you have already met the requirements for Vesting.

SECTION 6. PENSION TYPES AND AMOUNTS

The Plan provides several types of pension benefits. Requirements for the different types of pension generally vary depending on your age and your number of Pension Credits. In general, you must file an application for a pension benefit with the Fund Office. You may receive only one type of pension from the Fund and may not change from one type of pension to another unless the change is specifically allowed under the Plan rules. The Fund Office is available to answer your questions on eligibility and the Plan rules and to assist you when considering retirement. The pension amounts specified in this section will determine a Single Life Annuity With 60 Certain Payments. A Single Life Annuity With 60 Certain Payments will be reduced for the Qualified Joint and Survivor Annuity and the Joint and Survivor Options discussed in Section 7, page 20.

IMPORTANT	If you are under age 65, to be eligible for a service or early retirement benefit, you must intend to retire and have completely severed any employment with any Contributing Employer before your Annuity Starting Date. This includes employment in positions covered by a Collective Bargaining Agreement and non-bargaining unit positions.

NOTE	No Benefit Increases for Pensioners
	Pensions will not automatically increase after retirement, even if the benefit accrual rate increases. The Trustees may provide benefit increases to pensioners, but they are not required to do so, nor are they required to provide an increase in any year merely because they have provided one or more increases in previous years.

A) Regular Pension

i) Eligibility

You will be eligible for a regular pension if you meet the following requirements:

a) You have attained age 65 and have at least 10 Vesting Credits; or
b) You have attained age 65 and have at least 12 Pension Credits, including at least 5,000 hours of Covered Employment since July 1, 1957.

ii) Regular Pension Amount

If you have at least one Hour of Service during 1999 (excluding hours in 1999 under the former Local Union No. 460 Pipe Trades Pension Plan), your regular pension, effective on or after January 1, 2000, will be calculated as follows:

$6.00 multiplied by each quarter of Past Service Credit earned
plus
$8.50 multiplied by each quarter of Future Service Credit earned before January 1, 1975
plus
$12.50 multiplied by each quarter of Future Service Credit earned during
January 1, 1975 – December 31, 1996
plus
$25.00 multiplied by each quarter of Future Service Credit earned during
January 1, 1997 – December 31, 1998
plus
6.25 cents for each hour worked in Covered Employment during
January 1, 1999 – December 31, 2001
plus

6.50 cents for each hour worked in Covered Employment during
January 1, 2002 – June 30, 2002
plus
6.75 cents for each hour worked in Covered Employment during
July 1, 2002 – June 30, 2003
plus
7.05 cents for each hour worked in Covered Employment during
July 1, 2003 – June 30, 2013
plus
9.35 cents for each hour worked in Covered Employment, in excess of 25 Pension Credits, during
January 1, 2006 – June 30, 2013
plus
7.55 cents for each hour worked in Covered Employment during
July 1, 2013 – June 30, 2015
or
9.85 cents per each hour worked in Covered Employment, in excess of 25 Pension Credits, during
July 1, 2013 – June 30, 2015
plus
7.91 cents for each hour worked in Covered Employment during
July 1, 2015 – August 31, 2018
or
10.21 cents per each hour worked in Covered Employment, in excess of 25 Pension Credits, during
July 1, 2015 – August 31, 2018
plus
8.41 cents for each hour worked in Covered Employment during
September 1, 2018 – August 31, 2021
or
10.71 cents per each hour worked in Covered Employment, in excess of 25 Pension Credits, during
September 1, 2018 – August 31, 2021
plus
8.97 cents for each hour worked in Covered Employment during
September 1, 2021 – August 31, 2022
or
11.27 cents for each hour worked in Covered Employment, in excess of 25 Pension Credits, during
September 1, 2021 – August 31, 2022
plus
9.24 cents for each hour worked in Covered Employment
on or after September 1, 2022
or
11.54 cents for each hour worked in Covered Employment, in excess of 25 Pension Credits,
on or after September 1, 2022

Important Note: If you do not have an Hour of Service during 1999, the benefit is calculated the same as above except for the following:

$9.75 multiplied by each quarter of Future Service Credit earned during
January 1, 1975 – December 31, 1988
plus
$12.50 multiplied by each quarter of Future Service Credit earned during
January 1, 1989 – December 31, 1998

Benefit rates for anyone not meeting the above requirements are described in Section 6(F), page 15.

NOTE	**As of January 1, 1999, the benefit formula was modified from using Pension Credits to using Pension Hours multiplied by the accrual rate(s) in effect for the period specified.**

NOTE	Treatment of Carryover Excess Pension Hours for Periods after December 31, 1998
	Generally, any balance of excess Pension Hours will not be used to determine the amount of your pension.

Effective for periods after December 31, 1998, if you were age 52 or older on December 31, 1998, and if the use of your remaining excess Pension Hours ending on that date provides additional Future Service Credits for a succeeding Plan Year(s), the value of the resulting total Future Service Credit for the succeeding year(s) (at a rate of $25.00 for each complete quarter of Future Service Credit) will be compared to the value of the Pension Hours for that year multiplied by the rate(s) per hour as applicable during the year; the greater benefit amount shall apply for the given Plan Year.

Effective September 1, 2022, pension benefits accrued before September 1, 2022 were increased by 3%. Pension benefits payable to Pensioners, surviving spouses, or co-annuitants/beneficiaries with an Annuity Starting Date on or before September 1, 2022, and who were receiving a monthly benefit as of this date, increased by 3%. Whether this increase applied to any benefit subject to a Qualified Domestic Relations Order ("QDRO") is governed by the terms of the QDRO. Therefore, Pensioners whose benefits are or may be affected by a QDRO may receive an additional adjustment to their monthly benefit.

B) Service Pension

i) Eligibility

If you earned at least one Hour of Service before July 1, 2006, you will be eligible to retire with a service pension under the following conditions:

a) You have at least 25 Pension Credits; and
b) You have worked at least 5,000 hours in Covered Employment since July 1, 1957.

ii) Service Pension Amount

The monthly amount of a service pension is calculated in the same manner as the regular pension.

iii) Service Pensions as of July 1, 2006

If you earned the first Hour of Service in the Plan on or after July 1, 2006, you are eligible for a Service Pension upon earning 30 Pension Credits. You will be considered to have earned the first Hour of Service in the Plan on or after July 1, 2006, if you worked in and then left Covered Employment before July 1, 2006, and before or upon your return to Covered Employment after July 1, 2006, either experienced a Permanent Break in Covered Employment or failed to work 1,000 hours to earn your initial eligibility to participate in the Plan.

C) Early Retirement Pension

i) Eligibility

If you wish to retire before age 65, an early retirement pension is available if you meet the following requirements:

a) You must be at least age 55 but not yet 65;
b) You must have at least 10 Pension Credits.

ii) Early Retirement Pension Amount

If you qualify for and elect to receive an early retirement pension, the amount of your early retirement pension is calculated as follows:

a) Calculate the monthly pension amount you would receive under the regular pension formula if you retired at age 65; then
b) Reduce the amount by ¼ of 1% for each month you are younger than age 65 but over age 60, and ½ of 1% for each month you are younger than age 60; or
c) If you retire on or after January 1, 2000, with 15 or more Pension Credits, the amount is reduced by ½ of 1% for each month you are younger than 62.

D) Disability Pension

i) Eligibility

On or after January 1, 2000, if you are Totally Disabled, you will be eligible for a disability pension if you are an Active Participant at the time when you are deemed disabled by Social Security Administration and you have earned 12 Pension Credits or five Vesting Credits. For more information on Social Security and Medicare, contact the nearest Social Security Office and request a current booklet explaining the benefits.

Effective January 1, 2022, in addition to a Social Security disability determination, the Plan will also accept a determination of 100% disability from the Department of Veterans Affairs (VA).

ii) Disability Pension Amount

The monthly amount of a disability pension is calculated in the same manner as a regular pension.

iii) Proof of Disability

To prove Total Disability for the purpose of eligibility for a disability pension, you must submit a determination from the Social Security Administration that you are entitled to a Social Security disability benefit.

Effective January 1, 2022, the Plan will treat a determination by the U.S. Department of Veterans Affairs (VA) that an individual is entitled to VA disability benefits based on a 100% disability determination in the same way as the Plan treats a determination by the Social Security Administration that an individual is entitled to Social Security disability benefits.

iv) When Disability Payments Begin

Pension checks or direct deposits for a disability pension may begin as early as your Annuity Starting Date (generally the first day of the month after you apply for a disability pension), and it is determined that you are eligible. However, payments will not begin earlier than your Social Security "disability entitlement date", which is usually six months after your Social Security "disability onset date", which is the date the Social Security Administration determines that you first became Totally Disabled.

Effective January 1, 2022, an individual's date of entitlement to VA disability benefits based on a 100% disability determination will be treated the same way as an individual's Social Security disability entitlement date.

Payments will continue for as long as you remain Totally Disabled and you provide evidence to the Board of Trustees annually, by completing an Annual Verification of Disability Statement, which will be used to certify that you continue to receive Social Security disability benefits or, effective January 1, 2022, VA benefits based on 100% disability. If this information is not provided by May 15, you will not receive your July pension payment, and payments will not resume until the Fund Office receives the information. Once you turn age 65, your disability pension will be continued regardless of whether or not you remain Totally Disabled.

If you file an application for a disability pension with a copy of your Social Security disability "notice of award" letter within one year after you receive your "notice of award" letter from Social Security (or, effective January 1, 2022, notice from the U.S. Department of Veterans Affairs of an individual's entitlement to VA disability benefits based on a 100% disability determination) benefits from this Plan will be paid back to your Social Security or VA "disability entitlement date". However, the amount of that benefit will still be based on your Annuity Starting Date (usually the first of the month after you submit your application). Otherwise, benefits will only be paid as of the first of the month following the date you both file the application and become entitled to Social Security or VA 100% disability benefits.

v) Early Retirement or Service Pensions: Awaiting Social Security or VA Disability Award

You may, if eligible, begin to receive an early retirement or service pension while waiting for a determination of your eligibility for a Social Security disability benefit or, effective January 1, 2022, a determination of 100% disability from the Department of Veterans Affairs.

If, while you are receiving an early retirement or service pension, you are awarded a Social Security, or VA 100%, disability benefit, you may elect to receive a disability pension from the Plan instead of the early retirement or service pension.

This change can only be made if you are Totally Disabled on the date your application for the early retirement or service pension is filed and if your Social Security or VA "disability entitlement date" is not more than six months after the month you filed the application for the early retirement or service pension.

Your request to change from an early retirement or service pension to a disability pension must be made in writing and filed with the Fund Office.

If your election to change from an early retirement or service pension to a disability pension is filed within one year of the date on your "notice of award" letter from the Social Security Administration or the VA, the conversion will be effective retroactive to your Social Security or VA "disability entitlement date".

If your election to convert is filed more than one year after the date of your "notice of award" letter, the conversion to a disability pension will be effective the first of the month following the month in which the Fund Office receives the election and "notice of award" letter.

vi) Loss of Entitlement to a Disability Pension

If you are receiving a disability pension and you lose the entitlement to a Social Security or VA 100% disability benefit, your pension payments will stop. You may, however, be eligible for another type of pension benefit, such as an occupational disability pension, as explained in (E) below.

If you return to work in Covered Employment after losing your disability pension, you can earn additional Pension Credits.

If you are younger than 65 and receiving a disability pension, and you lose the entitlement to a Social Security or VA 100% disability benefit, you must report this fact to the Fund Office within 30 days after receiving notice from the Social Security Administration or the VA.

E) Occupational Disability Pension

i) Eligibility

You will be entitled to receive an occupational disability pension if you meet all the following requirements:

a) You had been receiving a disability pension from this Plan and a Social Security or VA 100% disability benefit and lost entitlement to each;
b) You have appealed the loss of your Social Security or VA 100% disability benefit to the Social Security Administration or the VA and lost the appeal;
c) You have at least 12 Pension Credits;
d) You have worked at least 5,000 hours in Covered Employment since July 1, 1957;
e) You are not eligible for any other type of pension under this Plan; and
f) You are Totally Disabled from performing work in the plumbing and pipefitting trades.

ii) Occupational Disability Pension Amount

The monthly amount of an occupational disability pension will be determined in the same manner as an early retirement pension. If you are younger than 55, the benefit will be calculated as if you were 55.

iii) Proof of Disability

Disability for the purpose of eligibility for an occupational disability pension means that you are totally unable, as a result of bodily injury or disease, to engage in any activity in the plumbing and pipefitting trade because of any medically determinable physical or mental impairment which can be expected to result in death or to be of long, continued, and indefinite duration. Whether or not you are disabled for this purpose will be determined by the Board of Trustees.

iv) Occupational Disability Payments

Payment of an occupational disability pension will start on the first of the month following the date on the notice to you from the Administrative Law Judge denying your appeal to the Social Security Administration or similar VA appeal process. Occupational disability pension payments will continue for as long as you remain disabled from performing work in the plumbing and pipefitting trades, except that upon attainment of age 65, your occupational disability pension will be continued regardless of whether or not you remain Totally Disabled from performing work in the plumbing and pipefitting trades.

v) Loss of Entitlement to an Occupational Disability Pension

If you receive an occupational disability pension and you recover from the disability, your pension payments will stop.

If you return to work in Covered Employment, you can earn additional Pension Credits.

If you are younger than 65 and receiving an occupational disability pension, and you recover from the disability, you must report this fact to the Fund Office within 30 days after the date of your recovery.

F) Vested Pension

i) Eligibility

You have the right to receive a vested pension if you meet one of the following requirements:

a) You have at least five Vesting Credits (or at least ten Vesting Credits if you do not have at least one Hour of Service on or after January 1, 1999) before incurring a Permanent Break in Covered Employment; or
b) You have at least 25 Pension Credits and have worked at least 5,000 hours in Covered Employment since July 1, 1957; or
c) You are at least age 50, have at least 12 Pension Credits, and have worked at least 5,000 hours in Covered Employment since July 1, 1957; or
d) You are a non-bargaining unit employee and have at least five Vesting Credits and at least one Hour of Service on or after January 1, 1989; or
e) You have attained Normal Retirement Age, which is the latest of:

1) The date you reach age 65; or
2) The fifth anniversary of the date on which you began participating in the Plan, counting only years of participation after January 1, 1988; or
3) The tenth anniversary of the date you began participating in the Plan, including years before 1988.

(Participation before a Permanent Break in Covered Employment is not counted in determining Normal Retirement Age.)

ii) Payable Amount

Once one of the requirements in Subsection (F)(i) above has been met, the date your vested pension benefits become payable is determined based on the following rules:

a) If you are eligible to receive a vested pension under Subsection (F)(i) items a, d, or e above, your benefits will become payable when you attain age 65 and retire.
b) If you meet the requirements of Subsection (F)(i) item b, your benefits will be payable as soon as you retire, regardless of age.
c) If you are eligible under Subsection (F)(i) item c above, pension payments can begin at any time after you attain age 55 and retire.

See also Section 14, page 32.

iii) Vested Pension Amount

The monthly amount of your vested pension is determined per the eligibility requirements described in Subsection (F)(i) above, your age on your Annuity Starting Date, and the amount of Pension Credit you have accrued and when it was earned.

If you meet the requirements set forth under Subsection (F)(i) item a (after January 1, 1976), or the requirements of Subsection(F)(i), items b, c, d, or e at any time, your benefits will be calculated as follows:

a) If you have attained age 65, your vested pension will be calculated in the same manner as the regular pension.
b) If you are at least 55 but less than 65 and have earned at least 12 but fewer than 25 Pension Credits, your vested pension will be calculated in the same manner as the early retirement pension.
c) If you are younger than 65 and have earned 25 or more Pension Credits, your vested pension will be calculated in the same manner as the service pension.

G) Separation in Service Rules

The amount of your benefit is subject to the rules on separation in service:

i) Before January 1, 1976, you have a separation in service when you would have incurred a One-Year Break in Covered Employment had you not been vested.
ii) After January 1, 1976, you have a separation in service if you have two Consecutive One-Year Breaks in Covered Employment.
iii) Effective January 1, 1996, if you are a non-bargained unit employee of an Employer, you will not incur a separation in service as a result of the cessation of your coverage, as long as you remain employed by that Employer, and provided the Employer remains signatory to a Collective Bargaining Agreement.
iv) If you incur a separation, your benefit amount will be frozen at the benefit rate in effect at the time of your separation. If you later return to work in Covered Employment and earn additional Pension Credit, your pension amount for such additional credit will be calculated based on the benefit rate in effect at the time of your retirement or a subsequent separation, if any.
v) You may eliminate the effect of a separation by returning to Covered Employment and earning more than 500 Hours of Service in each of two consecutive Calendar Years for each One-Year Break in Covered Employment.
vi) To the extent a prior separation in service has not been eliminated as described directly above in paragraph (v), the Pension Credit you have accumulated before any separation in service will be multiplied by the benefit value in effect at the time of your separation. Refer to the charts below in Section (H)(ii).

H) Benefit Values and Accrual Rates

You must be a vested Participant to have a right to the benefit below.

i) Before January 1, 1976

Your benefit amount is determined based on when you would have incurred a break in employment. Contact the Fund Office for rates and rules before January 1, 1976.

ii) Beginning January 1, 1976

The amount of your benefit is determined based on the rate value in effect at the time of your separation, multiplied by each Past Service Credit and Future Service Credit for the periods below:

Benefit Value for Past Service Credit Earned	
Period In Which Past Service Credit Earned	**Benefit Value**
Before July 1, 1957	$24.00

Benefit Values for Full Future Service Credit Earned		
Separation in Service Dates[1]	**Period In Which Full Future Service Credit Earned**	**Benefit Value**
January 1, 1976 – December 31, 1976	On or After January 1, 1976	$22.00
January 1, 1977 – June 30, 1980	On or After January 1, 1977	$24.00
July 1, 1980 – June 30, 1981	On or After July 1, 1980	$28.00
July 1, 1981 – June 30, 1984	On or After July 1, 1981	$30.00
July 1, 1984 – June 30, 1989	On or After July 1, 1984	$34.00
July 1, 1989 – December 31, 1990	Before January 1, 1975	$34.00
	January 1, 1975 – January 1, 1989	$34.00
	After January 1, 1989	$44.00
January 1, 1991 – December 31, 1998	Before January 1, 1975	$34.00
	January 1, 1975 – January 1, 1989	$39.00
	After January 1, 1989	$50.00
On or After January 1, 1999	Before January 1, 1975	$34.00
	January 1, 1975 – December 31, 1988	$39.00
	January 1, 1989 – December 31, 1998	$50.00
On or After July 1, 2001[2]	Before January 1, 1975	$34.00
	January 1, 1975 – December 31, 1996	$50.00
	January 1, 1997 – December 31, 1998	$100.00

1. For rates and rules in effect before 1976, contact the Fund Office.
2. Applies only for pensioners with an Annuity Start Date on or after January 1, 2000, and at least one Hour of Service during the 1999 Plan Year (not counting hours under the Local 460 plan).

iii) Beginning January 1, 1999

The benefit formula was modified from using Pension Credits to using Pension Hours multiplied by the accrual rate(s) in effect for each Pension Hour worked during the period specified below. Beginning January 1, 2006, if you earned more than 25 Pension Credits, your pension hours earned in excess of 25 Pension Credits are multiplied by a higher accrual rate as shown below:

Benefit Accrual Rate For Each Pension Hour Earned		
Period In Which Pension Hours Earned	**Fewer Than 25 Pension Credits**	**More Than 25 Pension Credits**
January 1, 1999 – December 31, 2001	$0.0625	N/A
January 1, 2002 – June 30, 2002	$0.0650	N/A
July 1, 2002 – June 30, 2003	$0.0675	N/A
July 1, 2003 – December 31, 2005	$0.0705	N/A
January 1, 2006 – June 30, 2013	$0.0705	$0.0935
July 1, 2013 – June 30, 2015	$0.0755	$0.0985

Benefit Accrual Rate For Each Pension Hour Earned		
July 1, 2015 – August 31, 2018	$0.0791	$0.1021
September 1, 2018 – August 31, 2021	$0.0841	$0.1071
September 1, 2021 – August 31, 2022	$0.0897	$0.1127
On or After September 1, 2022	$0.0924	$0.1154

EXAMPLE

Participant enters the Plan on January 1, 2021

He works 600 Pension Hours during each of the following periods: January 1, 2021 - August 31, 2021, September 1, 2021 – December 31, 2021, and January 1, 2022 – August 31, 2022. He works 600 Pension Hours during September 1, 2022 – December 31, 2022 and 2,000 Pension Hours during 2023 and 2024.

He has fewer than 25 Pension Credits. Based on the above charts, his benefit is calculated as follows:

Benefits earned before September 1, 2022

- 600 hours x $0.0841 = $50.46
- Plus 1,200 hours x $0.0897= $107.64
- Pre-September 2022 Subtotal: $158.10

- 3% increase to benefits earned prior to September 1, 2022 $4.74

Benefits earned after September 1, 2022

- 600 hours x $0.0924= $55.44
- 2,000 hours x 2 years= 4,000 x $0.0924= $369.60
- Post-September 2022 Subtotal: $425.04

Total accrued monthly benefit:

- $158.10+$4.74+$425.04 $587.88

EXAMPLE

Participant enters the Plan on January 1, 1977

He works 1,500 Pension Hours per year in all Calendar Years from January 1, 1977, through December 31, 1989. Therefore, he has 12 years of Future Service Credit earned before January 1, 1989 and one year of Future Service Credit earned after January 1, 1989. He then works 200 Pension Hours per year during 1990 – 1991. As of December 31, 1991, he has incurred a separation in service because he has two consecutive One-Year Breaks because he worked fewer than 500 Hours of Service during 1990 – 1991. Therefore, his benefit amount is frozen at the benefit rates in effect on December 31, 1991.

Based on the above charts, the participant's benefit is calculated as follows:

- 12 years x $39 = $468.00
- Plus 1 year x $50 = $50.00

Total accrued monthly benefit: $518.00

Total after 3% increase to pre-September 1, 2022 accruals $533.54

EXAMPLE	Participant enters the Plan on January 1, 1975
	He works 1,500 Pension Hours per year in all Calendar Years from January 1, 1975 – December 31, 1988. Therefore, he has 14 years of Future Service Credit earned before January 1, 1989. He then has no more Covered Employment. As of December 31, 1990, he has incurred a separation in service because he has two consecutive One-Year Breaks, because he worked fewer than 500 Hours of Service in 1989 and 1990. Therefore, his benefit amount is frozen at the benefit rates in effect on December 31, 1990. Based on the above charts, the participant's benefit is calculated as follows: • 14 years x $34 = $476.00 Total accrued monthly benefit: $476.00 Total after 3% increase to pre-September 1, 2022 accruals $490.28

EXAMPLE	
	The following example shows how a Participant can incur a separation in service, eliminate the effect of the separation in service, and earn benefits under a more generous and more current accrual table. The Participant works 1,500 Pension Hours per year during 1975 – 1988, and does not work any hours from 1989-1992 and therefore has four One-Year Breaks during 1989 – 1992, and then works 1,500 Pension Hours over eight years during 1993 – 2000 (but not in Local 460). He has eliminated the effect of the 1989 – 1992 separation in service of four One-Year Breaks by returning to Covered Employment for eight years and earning more than 500 Hours of Service in each of two consecutive Calendar Years for each One-Year Break. Based on the above charts, and assuming an Annuity Starting Date on or after 2000, the Participant's benefit is calculated as follows: • 14 years during 1975 – 1988 x $50 = $700.00 • Plus 4 years during 1993 – 1996 x $50 = $200.00 • Plus 2 years during 1997 – 1998 x $100 = $200.00 • Plus 1,500 hours x 2 years during 1999 – 2000) x $0.0625 = $187.50 Total accrued monthly benefit: $1,287.50 Total after 3% increase to pre-September 1, 2022 accruals $1,326.13

l) Reciprocal Pension

This Plan is signatory to the United Association Pension Fund Reciprocal Agreement and the United Association Pension Fund Reciprocal Agreement Optional Addendum for Pro Rata/Partial Pensions, which provide for money-follows-the-Member reciprocity with pension funds that have also signed to these agreements, as well as with the Plumbers and Pipefitters National Pension Fund. Under these agreements, contributions are automatically transferred to your home local pension funds. You may be able to qualify for a pension for which you would not otherwise qualify, and/or you may be able to qualify for higher benefits than you would otherwise receive. This Fund may also enter into similar reciprocity agreements.

Note: If you have contributions made directly to this Plan, but those contributions are reciprocated to another plan, no credit, including Future Service Credit or Pension Hours, will be granted by this Plan either for the contributions reciprocated or for any of the hours worked for which contributions have been reciprocated.

There are two types of reciprocity, money-follows-the-Member reciprocity and Pro Rata/Partial Pension reciprocity:

i) Money-Follows-the-Member Reciprocity

a) Incoming Reciprocity

If your home local is a District Council No. 16 local and you travel and work outside the jurisdiction of District Council No. 16, contributions made to another fund that has signed an applicable reciprocal agreement will be automatically transferred to this Fund according to the terms or the reciprocal agreement. You will receive credit for these contributions

under the provisions of this Plan. If the contribution rate received by this Plan is more or less than the rate under the Master Labor Agreement, the hours will be prorated in determining the amount of your Future Service Credit or Pension Hours, as applicable, but not in determining your Vesting Credit. However, hours will not be prorated for vesting purposes.

b) Outgoing Reciprocity

If your home local is not a District Council No. 16 local and you work within the jurisdiction of District Council No. 16, contributions to this Fund will be transferred to your home local pension fund(s) if your home local pension fund has signed an applicable reciprocal agreement, according to the terms of the reciprocal agreement.

ii) Pro Rata/Partial Pension

Under the United Association Pension Fund Reciprocal Agreement Optional Addendum for Pro Rata/Partial Pensions, credit from the United Association National Pension Fund or credit earned under another United Association pension fund signatory to the Addendum (a "related pension plan"), after completion of money-follows-the-Member reciprocity, combined with Pension Credit earned under this Plan.

The combined hours credited in both funds will be recognized by each fund for purposes of repairing One-Year Breaks in Covered Employment and benefit eligibility. However, the amount of benefits paid by each fund will be based only on the contributions and hours retained by each fund.

In effect, the Pro Rata/Partial Pension Addendum allows this Plan to treat vesting credits and pension credits earned under the Plumbers and Pipefitters National Pension Fund or other "related pension plan" as though they were earned under this Plan to repair or avoid One-Year Breaks in Covered Employment and benefit eligibility.

To be eligible for a pro-rata/partial pension, you must have earned at least one year of Future Service Credit under this Plan and one year of Future Service Credit under the Plumbers and Pipefitters National Pension Fund or other "related pension plan" signatory to the Addendum after the completion of the money-follows-the-Member reciprocity and without regard to the provision of the Addendum.

Also, you must have earned at least a partial year of Future Service Credit, after the completion of the money-follows-the-Member reciprocity and without regard to the provisions of the Addendum, in at least one defined benefit pension fund signed to the United Association Pension Fund Reciprocal Agreement during at least one of the five Calendar Years before your Annuity Starting Date.

Contributions and hours are reciprocated based on your home local as reflected in the United Association's records. For more information about money-follows-the-Member reciprocity, pro rata/partial pensions, or "related pension plans", contact the Fund Office.

J) Maximum Pension Provisions

Over the years, maximum caps have been placed on the number of Pension Credits that will be considered when calculating your pension benefit.

i) For pensions with Annuity Starting Dates on or after January 1, 1994, the maximum cap on the number of Pension Credits considered when calculating a pension benefit is 35 Pension Credits until all Past Service Credits (earned for work before January 1, 1959) have been offset by Future Service Credits (earned for work after January 1, 1959). Thereafter, all Future Service Credits are used to determine the pension amount payable. This means that once you have earned 35 Future Service Credits, your retirement benefit will be calculated based on the total number of Future Service Credits you have earned. Any Past Service Credits will be disregarded for purposes of calculating your benefit.

ii) Section 415 of the Internal Revenue Code also puts legal limits on the annual amount you may receive from this Plan. The Fund Office will notify you if these limits apply to your benefit.

K) Small Pension Cash-Outs

If the actuarial present value of your pension benefit is $7,000 or less, upon application for a benefit, you will automatically receive that benefit in a lump sum payment with no other options.

L) Delayed Retirement

If your Annuity Starting Date is after Normal Retirement Age (generally, age 65), your benefit may be actuarially adjusted to reflect the delay in the commencement of benefits. Your benefit will never be less than the benefit payable as a regular pension.

SECTION 7. FORMS OF PAYMENT

The normal form of payment for a single person is a Single Life Annuity With 60 Certain Payments. The normal form of payment for a married person is a 50% Qualified Joint and Survivor Annuity. A married Participant has the option of electing a Single Life Annuity With 60 Certain Payments. Both single and married Participants have the option of selecting a 50%, 75%, or 100% Joint and Survivor Option. The Fund Office will provide you with a statement of what your monthly benefit will be as a Single Life Annuity With 60 Certain Payments and as a 50%, 75%, or 100% Joint and Survivor Option. The various forms of payment and the procedures for electing them are discussed in this section.

A) Single Life Annuity With 60 Certain Payments

The normal monthly benefit payment for a single person is the Single Life Annuity With 60 Certain Payments. The benefit amount is derived using the benefit amounts and formula set forth in Section 6, page 10, with no reductions. This form of payment provides you with monthly benefits for your lifetime. In addition, if you die before you have received at least 60 monthly benefit payments, the full monthly amount will be paid to your Beneficiary until the Plan has paid a total of 60 monthly benefit payments to you and your Beneficiary combined.

If you are single when you retire, your benefit will automatically be paid as a Single Life Annuity With 60 Certain Payments unless you reject it in writing at the time you retire and elect another form of payment.

If you are married and want the Single Life Annuity With 60 Certain Payments, you and your Spouse must reject the 50% Qualified Joint and Survivor Annuity and elect the Single Life Annuity With 60 Certain Payments at the time you retire. The rules and procedures for making these elections are explained below.

B) 50% Qualified Joint and Survivor Annuity

i) General Provisions

The normal monthly benefit for a married person is the 50% Qualified Joint and Survivor Annuity. This benefit provides that after your death, your surviving Spouse will receive monthly payments for the rest of their lifetime equal to 50% of the monthly amount you were entitled to receive.

Because the 50% Qualified Joint and Survivor Annuity extends protection over two lifetimes, benefit levels are adjusted accordingly. During your lifetime, you will receive a lower monthly benefit than you would have received under a Single Life Annuity With 60 Certain Payments. Monthly payments to your surviving Spouse after your death will be one-half of the amount you received and will continue for the rest of your Spouse's life.

The amount of monthly benefit reduction depends on the difference in age between you and your Spouse. If your Spouse is much younger than you, benefits will be reduced more than if you and your Spouse are both around the same age or if your Spouse is older than you.

Under the 50% Qualified Joint and Survivor Annuity, payments to your surviving Spouse continue for life; they do not stop even if your surviving Spouse remarries.

If you are eligible for any type of pension other than a disability pension, your monthly pension will be reduced for the 50% Qualified Joint and Survivor Annuity by multiplying it by an appropriate actuarial equivalence factor which depends on the respective ages of you and your Joint Annuitant.

ii) Rejection of the 50% Qualified Joint and Survivor Annuity and Selection of an Optional Form of Benefit

If you are married when you retire, your pension will automatically be paid in the form of a 50% Qualified Joint and Survivor Annuity unless you and your Spouse sign a notarized statement rejecting the 50% Qualified Joint and Survivor Annuity and file it with the Fund Office at the time you retire.

The Fund Office will provide you with information explaining the normal and optional forms of benefit, the financial effect of choosing an optional form, and information regarding the process involved in revoking the normal form of benefit. You and your Spouse may reject the 50% Qualified Joint & Survivor Annuity (or revoke a previous rejection) at any time and any number of times during the 180-day period ending on your Annuity Starting Date.

If you and your Spouse properly reject the 50% Qualified Joint and Survivor Annuity, you must elect either the Single Life Annuity With 60 Certain Payments or a 50%, 75%, or 100% Joint and Survivor Option.

IMPORTANT	**If you are married, payment in the form of the 50% Qualified Joint and Survivor Annuity will occur automatically unless you reject it and your Spouse consents to the rejection in writing on forms provided by the Fund Office. Be sure to have your Spouse's signature notarized as indicated on the form.** **Your Spouse's consent must acknowledge the effect of the rejection and must consent to a specific Beneficiary and optional payment form, which cannot be changed without your Spouse's consent. Your rejection may be revoked at any time before your payments begin.** **If you are single, payment in the form of a Single Life Annuity with 60 Certain Payments will occur automatically unless you reject it in writing on forms provided by the Fund Office.**

iii) Pop-Up Protection

Once payments have started on a 50% Qualified Joint and Survivor Annuity, the monthly benefits will generally continue on that basis. However, if your Spouse should die before you, the monthly amount of the 50% Qualified Joint and Survivor Annuity will be increased to the amount that would have been payable to you as a Single Life Annuity without the 60 Certain Payments. The increased pension will be effective the month following the month in which your Spouse died, provided you file a copy of the death certificate within 12 months of your Spouse's death. If the death certificate is filed more than 12 months after your Spouse's death, the increased pension will begin with the month following the month during which the death certificate is received by the Fund Office.

Similarly, your Surviving Spouse benefit may be canceled, and the amount of a 50% Qualified Joint and Survivor Annuity may be increased to the amount that would have been payable to you as a Single Life Annuity without the 60 Certain Payments, if your marriage is legally terminated, provided the terms of a Qualified Domestic Relations Order (QDRO) state that your former Spouse is to receive no benefits from this Plan and is to be no longer treated as the Spouse for purposes of the 50% Qualified Joint and Survivor Annuity. If the QDRO is filed with the Fund Office within 12 months of the date of entry, the increased monthly pension will be effective for the month following the month it was entered. Otherwise, the increased benefit will become effective as of the first month following the month during which the Fund Office receives the QDRO.

C) 50%, 75%, or 100% Joint and Survivor Options

The normal form of benefit is a 50% Qualified Joint and Survivor Annuity if you are married or a Single Life Annuity With 60 Certain Payments if you are single. Whether you are married or unmarried, you may waive the normal form of payment and elect either a 50%, 75%, or 100% Joint and Survivor Option. For each option, you will receive a smaller amount for your lifetime, but your Beneficiary will receive 50%, 75%, or 100% of that amount for their lifetime if they survive you. Your Beneficiary is called a Joint Annuitant and may be anyone you choose, except as limited below.

If you are married, you may name a non-Spouse Joint Annuitant only with your Spouse's consent. Also, you may not have more than one Joint Annuitant, and you may not change your Joint Annuitant, even in the event of a divorce.

If your Joint Annuitant predeceases you after payments start, the monthly amount payable to you will be increased to the amount that would have been payable to you as a Single Life Annuity without the 60 Certain Payments feature. The increased pension will be effective the month following the month in which the Joint Annuitant died, provided you file a copy of the death certificate within 12 months of the Joint Annuitant's death. If the death certificate is filed more than 12 months after the Joint Annuitant's death, the increased pension will begin with the month following the month during which the death certificate is received by the Fund Office.

The pension amount of the 50%, 75%, and 100% Joint and Survivor Options will be adjusted by multiplying each by a factor that is actuarially equivalent to the pension before reduction. These amounts also depend on your age and your Beneficiary's age on your Annuity Starting Date.

i) Age Limitations for Beneficiaries Under the 100% and 75% Joint and Survivor Options

The 100% Joint and Survivor Option is available to you and your non-Spouse Joint Annuitant only if such Joint Annuitant is no more than ten years younger than you. However, if you begin receiving benefits before age 70, the age difference between you and your non-Spouse Joint Annuitant is reduced by the number of years you are younger than 70 on your Annuity Starting Date. If, due to this adjustment, the age difference between you and your non-Spouse Joint Annuitant is ten years or less, you may elect the 100% Joint and Survivor Option.

The 75% Joint and Survivor Option is available to you and your non-Spouse Joint Annuitant only if such Beneficiary is no more than 19 years younger than you. However, if you begin receiving benefits before age 70, the age difference between you and your non-Spouse Joint Annuitant is reduced by the number of years you are younger than age 70 on your Annuity Starting Date. If, as a result of this adjustment, the age difference between you and your non-Spouse Joint Annuitant is 19 years or less, you may elect the 75% Joint and Survivor Benefit Option.

For example, if you retire at age 65 and your non-spouse beneficiary is 13 years younger than you, since you are 5 years younger than age 70, the age difference of 13 years is reduced by 5 years to 8 years and you would be able to elect either the 100% or 75% option because the adjusted age difference is less than both the 10 year and 19 year age limits respectively.

ii) Election and Changes to Optional Forms of Benefits

If you wish to elect the 50%, 75%, or 100% Joint and Survivor Options, you must do so in writing before your Annuity Starting Date. Once elected, a 50%, 75%, or 100% Joint and Survivor Option may not be revoked unless the revocation is made in writing not later than the end of the month of your Annuity Starting Date.

However, the survivor benefit to the Joint Annuitant may be canceled, and the amount payable during your life under a Joint and Survivor Option may be increased to the amount that would have been payable to you as a Single Life Annuity without the 60 Certain Payments, if your Joint Annuitant is your Spouse and your marriage is legally terminated, provided the terms of a Qualified Domestic Relations Order (QDRO) state that your former Spouse is receiving no benefits from this Plan and is to be no longer treated as the Joint Annuitant for purposes of the Joint and Survivor Options. If the QDRO is filed with the Fund Office within 12 months of the date of entry, the increased monthly pension will be effective for the month following the month it was entered. Otherwise, the increased benefit will become effective with the first month following the month during which the Fund Office receives the QDRO.

NOTE	**Monthly benefit payments to Participants (and also Beneficiaries) are rounded up to the next 50 cents unless the benefit payment results in a dollar or 50 cent amount. This is illustrated in the following examples. Monthly benefit payments to an Alternate Payee under a Qualified Domestic Relations Order are not rounded.**

EXAMPLE

Retirement Payment Options – Joint and Survivor Option Examples

The following examples are based on a Participant retiring at age 65 with a Spouse (or eligible Joint Annuitant) age 60. For other age combinations, please contact the Fund Office.

Benefit Type	50% Qualified Joint and Survivor Annuity Benefit	75% Joint and Survivor Benefit	100% Joint and Survivor Benefit
Total Accrued Single Life Benefit	$1,000.00	$1,000.00	$1,000.00
Joint and Survivor Factor	0.890	0.839	0.794
Total Monthly Benefit **x** Joint and Survivor Factor = Joint and Survivor Monthly Benefit	**$890.00**	**$839.00**	**$794.00**
Benefit amount your surviving Spouse will receive per month for the remainder of their life if you die before your Spouse.	$445.00	$629.50	$794.00
Benefit amount you will receive if your Spouse dies before you.	$1,000.00	$1,000.00	$1,000.00

D) Disability Pensions vs. Non-Disability Pensions

Generally, a disability pension benefit will be greater than an early retirement pension benefit before Joint and Survivor Option factors are applied, depending on your age and the age of your Joint Annuitant. The Joint and Survivor Option factors for disability pensions generally reduce a disability pension benefit more than that of a non-disability pension benefit to account for the shorter expected lifetime for a disabled Participant and the additional average benefit payout to their Joint Annuitant.

If you might qualify for a disability pension, you should discuss eligibility with the Fund Office, and, before commencing receipt of any benefits or electing any optional forms of benefit, you should request that the Fund Office provide you with a statement of what your disability and early retirement monthly benefit options might be in the various forms of benefit (as a Single Life Annuity With 60 Certain Payments and as a 50%, 75%, or 100% Joint and Survivor Option).

IS IT ALWAYS BEST TO CONVERT AN EARLY RETIREMENT PENSION TO A DISABILITY PENSION?

It depends on the form of benefit you choose, your age, and the age of your Spouse/Joint Annuitant.

EXAMPLE	A Participant age 62 with a Spouse (or Joint Annuitant) age 57 has an accrued normal retirement benefit of $1,000.00 with 10 Pension Credits. While waiting for a determination from the Social Security Administration or VA for a disability benefit, the Participant decides to commence an early retirement benefit. At age 62, the Participant is entitled to 91% of his accrued normal retirement benefit, or $910.00. The Participant elects the 75% Joint and Survivor Option, so the Participant's early retirement benefit ($910.00) is multiplied by the 75% Joint and Survivor Option adjustment factor for a healthy person age 62 and beneficiary age 57, which is 85.5%, which results in a monthly 75% Joint and Survivor Option benefit of $778.50. If a Social Security or VA disability benefit is awarded, the Participant may elect to convert the early retirement pension to a disability pension. The disability pension benefit has no reduction for early commencement and, payable as a 75% Joint and Survivor Option, has a factor of 68.3% for a disabled participant age 62 and beneficiary age 57. This results in a monthly 75% Joint and Survivor Option benefit of $683.00. The disability pension payable from the Plan is less than the early retirement pension, but monthly disability benefits would be payable to the Participant retroactively to the date of entitlement of the Social Security or VA 100% disability benefit.
EXAMPLE	A Participant age 55 with a Spouse (or Joint Annuitant) age 50 has an accrued normal retirement benefit of $1,000.00 with 10 Pension Credits. While waiting for a determination from the Social Security Administration or VA for a disability benefit, the Participant decides to commence an early retirement benefit. At age 55, the Participant is entitled to 55% of his accrued normal retirement benefit, or $550.00. The Participant elects the 75% Joint and Survivor Option, so the Participant's early retirement benefit ($550.00) is multiplied by the 75% Joint and Survivor Option factor for a healthy participant age 55, and a beneficiary age 50, which is 89.2%, which results in a monthly 75% Joint and Survivor Option benefit of $491.00. If a Social Security or VA 100% disability benefit is awarded, the Participant may elect to convert the early retirement pension to a disability pension. The disability pension benefit has no reduction for early commencement and, payable as a 75% Joint and Survivor Option, has a factor of 68.2% for a disabled participant age 55 and beneficiary age 50. This results in a monthly 75% Joint and Survivor Option benefit of $682.00. The disability pension payable from the Plan is more than the early retirement pension, and monthly disability payments would be payable to the Participant retroactively to the date of entitlement of the Social Security or VA 100% disability benefit.

E) Mortality Factors Used

For non-disability pensions, the Joint and Survivor Annuity options are calculated using the GAR 50/50 Blended mortality table and 5% interest.

For disability pensions, the Joint and Survivor Annuity options are calculated using the ERISA Section 4044 Mortality Rates for 2007 Valuation Dates with 50/50 Blend for Disabled Lives eligible for Social Security Disability Benefits for the participant and the GAR 50/50 Blended mortality table for the Joint Annuitant and 5% interest.

SECTION 8. DEATH BENEFITS

A) Death Before Retirement

i) 100% Joint and Survivor Pre-Retirement Death Benefit

If you are a vested Participant in this Plan and you die before retiring, the pre-retirement death benefit payable to your surviving Spouse will be equal to the survivor's portion of the 100% Joint and Survivor Option. The amount of the 100% Joint and Survivor Option payable will be calculated as if you retired the day before your death and elected the 100% Joint and Survivor Option. If you die before your earliest possible Annuity Starting Date, the 100% Joint and Survivor Option payable will be calculated as if you had retired upon reaching your earliest possible Annuity Starting Date and then died on the last day of the month in which this date falls.

However, if you were eligible for a vested pension at age 65 and died after age 55 but before age 65, the amount of the 100% Joint and Survivor Option payable will be calculated as if your Annuity Starting Date was the first day of the month following your date of death.

This death benefit will continue for the lifetime of your surviving Spouse, regardless of any later remarriage.

The 100% Joint and Survivor Option pre-retirement death benefit can also be payable to a non-Spouse Beneficiary designated by you, provided you are not married or, if married, your Spouse has waived, in writing, their entitlement to this benefit. For your non-Spouse Beneficiary to be able to receive this pre-retirement death benefit, you must have satisfied the eligibility requirements for a regular or service pension at the time of your death.

Payments to your surviving Spouse, or if applicable, the non-Spouse Beneficiary, begin as of the month following the month of death. However, your surviving Spouse may elect to defer payments to the later of the date on which you would have reached the Applicable Age defined in Section 13(F), or December 1 of the Calendar Year following your year of death.

ii) Lump Sum Pre-Retirement Death Benefit

There is an alternative pre-retirement death benefit in the form of a lump sum. If elected, the benefit will be paid if you were an Active Participant or vested Participant at the time of your death. The amount will be the greater of (1) $1,000 times the number of Pension Credits you have earned or (2) an amount equal to all contributions made on your behalf (not to exceed $10,000). To qualify for this pre-retirement death benefit, you must have had at least $100 contributed to this Fund on your behalf. This benefit is not payable to anyone else if there is a surviving Spouse.

iii) Election By Beneficiary

a) Surviving Spouse Beneficiary

Your surviving Spouse may elect either the surviving Spouse's portion of the 100% Joint and Survivor Option or the lump sum benefit. If the lump sum benefit is elected and the actuarial present value of the 100% Joint and Survivor Option is greater than the elected lump sum death benefit, your surviving Spouse will receive the excess value in monthly payments for as long as they live.

b) Non-Spouse Beneficiary

Your non-Spouse Beneficiary is entitled to elect either the surviving non-Spouse's portion of the 100% Joint and Survivor Option (provided eligibility for this benefit is met) or the lump sum benefit. However, if the lump sum benefit is elected, your non-Spouse Beneficiary is not entitled to any excess value in monthly payments as provided to surviving Spouses.

NOTE	Payments to Minor Beneficiaries
	If a benefit is payable to a minor, the Fund may pay it to any legally appointed guardian. If there is no such person, the Fund may pay benefits to the person having present custody or care of the minor and with whom the minor resides. The Fund also has the discretion to make any benefit payment to a minor by depositing the payment in a federally insured savings account in the name of the minor and by giving the notice of the deposit to the minor.

iv) If You Die While In Qualified Uniformed Service

Under the Heroes Earnings Assistance and Relief Act of 2008 ("HEART Act"), to determine eligibility for any death benefit, including a 100% Joint and Survivor Option pre-retirement death benefit and a lump sum death benefit, if you die as a result of Qualified Uniformed Service on or after January 1, 2007, you will be treated as having returned to Covered Employment and then died. Therefore, you will be treated as an Active Participant, and time spent in Qualified Uniformed Service immediately before your death will be counted toward Vesting Credit and, to avoid breaks in employment, as Hours of Service. However, you will not be deemed to have earned Pension Hours for the period of Qualified Uniformed Service immediately before your death to determine the amount of your death benefit.

B) Post-Retirement Death Benefits

i) Single Life Annuity

If you are receiving the Single Life Annuity With 60 Certain Payments and die after retirement but before receiving all 60 payments, then your designated Beneficiary – whether your surviving Spouse or other designated Beneficiary – will receive the rest of those payments until all 60 are paid.

ii) Joint and Survivor Options

If you are survived by the Spouse or Joint Annuitant upon which your 50% Qualified Joint and Survivor Annuity or Joint and Survivor Option was based, that Spouse or Joint Annuitant will receive monthly benefits per the requirements of the applicable form of payment.

iii) Post-Retirement Lump Sum Benefit

In addition to the Single Life Annuity With 60 Certain Payments and any benefits due under the 50% Qualified Joint and Survivor Annuity or the Joint and Survivor Options, upon your death, a death benefit equal to $80 for each full year of Pension Credit, up to a maximum of $2,000, will be paid to your Beneficiary.

C) Beneficiary Designation

i) Naming your Beneficiary

Although some death benefits are automatically paid to a surviving Spouse or a Joint Annuitant, others are paid to your Beneficiary. To ensure that these death benefits are paid to the person(s) to whom you want them to be paid, you must file a Beneficiary Form with the Fund Office. A designation of Beneficiary will not be effective unless a Beneficiary Form is submitted to the Fund Office before your death.

You may name someone other than your Spouse as your Beneficiary. Your Spouse's consent is required, which must be in writing and witnessed by a notary.

You may obtain a Beneficiary Form from any local union office, the Fund Office, or the Fund website at www.scptac.org.

ii) When There is No Named Beneficiary

If you have no named Beneficiary or if your Beneficiary predeceases you, the Plan will pay survivor benefits to one or more of the following surviving relatives in the following order:

a) Surviving Spouse;
b) If none, to be divided equally among the surviving child(ren), including legally adopted child(ren);
c) If none, to the surviving parent(s);
d) If none, to be divided equally among the surviving sibling(s); or
e) If none, to your estate.

Domestic partners are never considered beneficiaries under these circumstances.

iii) Automatic Revocation of Spouse Beneficiary

The designation of a Spouse as a Beneficiary of any death benefit will be automatically revoked if the marriage is later dissolved. Thus, a former Spouse will no longer be your designated Beneficiary unless named as such in a new Beneficiary Form, completed and submitted to the Fund Office after the marriage is dissolved. This rule limits the chance of conflicting claims to death benefits if you forget to change your Beneficiary designation from a former Spouse to a subsequent Spouse or other Beneficiary.

NOTE	**The designation of a Spouse as a Beneficiary of any death benefit will be automatically revoked if the marriage is later dissolved.**

IMPORTANT	**If there is a change in your family status, such as marriage, divorce, death, or a change in status of a Beneficiary, or if your address changes, notify the Fund Office as soon as possible, but no later than 90 days after the change.**

SECTION 9. TAX INFORMATION

A) Pension Benefits as Taxable Income

As a pensioner, Beneficiary, Alternate Payee, or Joint Annuitant, you will receive from the Fund Office each year a Form 1099-R showing the benefits paid to you. As required by law, this information will also be supplied to the Internal Revenue Service.

B) Lump Sum Payments and Rollovers

Two types of benefits may be eligible for rollover directly to an eligible retirement plan:

i) Lump sum payments; and

ii) Any payment that is not part of a series of regular substantially equal periodic payments (e.g., monthly) paid for your life or the life of your Beneficiary, or for a period of ten years or more, under this Plan to you or your Spouse.

Eligible retirement plans include other qualified plans, tax-qualified annuities, IRAs, Roth IRAs, and qualified state and local government plans which accept rollovers. An eligible rollover will not be taxed if it is transferred directly to one of these eligible retirement plans.

In addition, a benefit payment to a non-Spouse Beneficiary may be an eligible rollover distribution exempt from tax if directly rolled over to an inherited IRA, Roth IRA, or annuity.

If a distribution is eligible for rollover, the Fund Office will provide you with forms and information regarding the procedure for rolling over such a distribution.

C) Tax Withholding

The Fund will withhold tax from distributions that are not eligible rollovers, such as regular monthly benefit payments unless you elect to forgo the withholding. Government agencies may require withholding even if you elect otherwise.

Distributions eligible to be rolled over that are paid directly to you or your Beneficiary are subject to 20% mandatory federal tax withholding and state tax withholding, if applicable. However, you have, or your Beneficiary has, 60 days to deposit the eligible rollover into a plan, annuity, or IRA that is eligible to accept rollovers to convert the distribution to a tax-exempt payment. Eligible rollover distributions transferred directly from this Plan to an eligible retirement plan – including an IRA or a Roth IRA – are not subject to mandatory withholding.

When you apply for benefits, additional information will be provided about withholding.

SECTION 10. QUALIFIED DOMESTIC RELATIONS ORDERS

The Retirement Equity Act of 1984 provides that the Plan must recognize and follow any order it finds to be a Qualified Domestic Relations Order (QDRO). As directed by a QDRO, payments will be made directly to any Spouse, former Spouse, child, or other

dependent (called an “Alternate Payee”) of a Plan Participant. A QDRO is a state domestic relations order, such as a divorce decree, which creates or recognizes an Alternate Payee's right, or assigns to an Alternate Payee the right, to receive all or a portion of the benefits payable to you under the Plan. Any lawful judgment, decree, order, or property settlement agreement may be a QDRO if it relates to the provision of child support, alimony payments, or marital property of your Spouse, former Spouse, child, or other dependent, and if it is made under state domestic relations law.

A) Payment to Alternate Payee Before You Retire

The Alternate Payee under a QDRO may be allowed to begin receiving benefits as soon as you could have retired, even if this is before your Annuity Starting Date. If the Alternate Payee chooses to receive their share of benefits before you retire, the benefits payable to the Alternate Payee will be based on the benefits payable to you without regard to any early retirement subsidy.

B) No Change in Form of Benefit if You are in Pay Status when a QDRO is Obtained

If you are already receiving benefits when a domestic relations order is obtained, the Alternate Payee's share of the pension must be paid in the same form as previously elected by you.

C) Alternate Payee May Choose Any Form of Benefit if the Benefit has not Commenced when the QDRO is Obtained

If the QDRO is obtained before any benefit payments have begun, the order may provide that the Alternate Payee may elect to receive their share in any form permitted by the Plan, except for a Joint and Survivor Options Annuity based on the life of a subsequent Spouse of the Alternate Payee. Thus, an Alternate Payee may elect to have their share payable over their lifetime or over the joint lives of you and the Alternate Payee.

D) Your Benefit Increase Following the Death of the Alternate Payee

As described above, if you are already receiving benefits when a domestic relations order is obtained, the Alternate Payee's share of the pension must be paid in the same form as previously elected by you. If benefits are paid according to a QDRO in these circumstances, and the Alternate Payee dies before you, your share of benefits will be increased to the amount that would have been paid if there had been no QDRO. However, no increase will occur if the Alternate Payee's share was paid as a life annuity over the Alternate Payee's lifetime.

E) Actuarial Equivalence

If the Alternate Payee's share is to be paid over the lifetime of the Alternate Payee, the benefit will be actuarially adjusted.

F) Procedures Governing QDROs

The Fund has written procedures regarding QDROs. A copy of those procedures may be obtained, without charge, from the Fund Office. If you are contemplating a divorce or are a party to a domestic relations proceeding, you should review these procedures carefully before any domestic relations order or decree is signed by the judge.

The Trustees cannot recognize or honor a domestic relations order which attempts to divide a pension unless and until they determine that the order or decree contains certain information and otherwise complies with federal law. Therefore, if a court order is issued that assigns some or all of your benefit to another person, it must be submitted to the Fund Office for a determination as to whether or not the Fund can honor the order. The order will not be honored until it is submitted and determined by the Fund to be a qualified order.

Upon receipt of written notice from you, your spouse, former spouse, or attorney of a dissolution of marriage or otherwise stating that there is a competing claim on your benefits, the Plan(s) may place an administrative hold on your benefits and decline to make any benefit payment without further clarification. If you demand payment of your benefits because no QDRO is in effect, the Plan may allow the prospective Alternate Payee a reasonable period to seek a court order preventing such distribution. The Trustees and their delegates have absolute discretion to delay paying benefits when the Plan is on notice of a dissolution action or similar proceeding. The parties are responsible for keeping the Plan informed about the status of their property settlement and resolving the matter without undue delay. The Plan may terminate an administrative hold and pay benefits under normal plan rules if the parties fail to submit a final QDRO within a reasonable time.

While a court order is being reviewed to determine if it is a QDRO, the Plan may segregate the amounts that may be payable to the Alternate Payee in a separate account or in an escrow account. If the Plan determines that the order is not a QDRO or if 18 months have expired without determining whether the order is qualified, benefits may be paid as provided in the Plan.

SECTION 11. MERGER OF LOCAL 460 PENSION PLAN

Effective January 1, 2000, Local Union No. 460 Pipe Trades Pension Trust Fund ("Local 460 Pension Plan") was merged into the Southern California Pipe Trades Retirement Fund. The details of the merger and its effect on participants from the Local 460 Pension Plan are set forth in this section.

A) Participation in this Plan

If you were a participant in the Local 460 Pension Plan as of January 1, 2000, you became a Participant in this Plan as of that date. To be eligible for a benefit under this Plan for periods on and after January 1, 2000, you must meet the eligibility requirements for a pension under this Plan, including Hours of Service under this Plan on or after January 1, 2000. However, as explained below, service under the Local 460 Pension Plan before January 1, 2000, counts toward meeting this Plan's eligibility requirements.

B) Retention of Local 460 Pension Plan Service

If you were a Local 460 Pension Plan participant in periods before January 1, 2000, you retain your years of vesting service and Pension Credit earned under the Local 460 Pension Plan. Periods of service under the Local 460 Pension Plan not lost under the terms of that plan before January 1, 2000, are treated as if earned under this Plan but only for purposes of eligibility under this Plan.

C) Service by Participants of the Local 460 Pension Plan After January 1, 2000

Vesting service and Pension Credit earned on or after January 1, 2000 are determined under this Plan and are in addition to the service earned before that date under the Local 460 Pension Plan. However, if you were a Local 460 Pension Plan participant who was not fully vested on January 1, 2000, you continued to accrue vesting service under the terms of the Local 460 Pension Plan for employment covered under this Plan after January 1, 2000, for purposes of vesting under both plans. For Local 460 Pension Plan participants who are not vested on January 1, 2000, the break in service and cancellation of service rules of the Local 460 Pension Plan continue to apply.

D) Combined Pension Amounts and Accrual Rates of this Plan Effective January 1, 2000

Pension amounts for periods before January 1, 2000 are based on the Local 460 Pension Plan in effect before that date. Pension amounts for service on or after January 1, 2000 are based on the Hours of Service earned under this Plan on or after that date, using the benefit values set forth in this Plan. Local 460 Pension Plan participants receive the total of the amounts under the Local 460 Pension Plan for periods before January 1, 2000, and under this Plan for periods on or after January 1, 2000.

E) Service Pensions

All Local 460 Pension Plan participants will be able to become eligible for a service pension under this Plan, and service earned under the Local 460 Pension Plan before January 1, 2000 will count in determining eligibility for a service pension under this Plan. In addition, Local 460 Pension Plan participants who commenced participation in the Local 460 Pension Plan before January 1, 1992 will continue to be eligible for a service pension under the Local 460 Pension Plan. The amount of all service pensions will be calculated using Pension Credits both before and after January 1, 2000, without any reduction for early retirement.

F) Early Retirement Pensions

For pensions first effective on or after January 1, 2000, Local 460 Pension Plan participants continue to be eligible for an early retirement pension under the Local 460 Pension Plan's rules based on combined service under both plans. For Local 460 Pension Plan participants with at least 400 Hours of Service from January 1, 1998 through December 31, 2000, this Plan's reduction factors apply to the entire early retirement pension if they produce a higher monthly amount. For other Local 460 Pension Plan participants, the reduction for early retirement is calculated under the terms of the Local 460 Pension Plan for service before January 1, 2000 and under the terms of this Plan for service after January 1, 2000.

G) Forms of Payment

For pensions first effective on or after January 1, 2000, the forms of payment under the Local 460 Pension Plan are continued under this Plan for Local 460 Pension Plan participants, except that the "pop-up" protection feature is automatic for all joint and survivor forms of payment. In addition, this Plan's more favorable Joint and Survivor Option factors, including the pop-up protection, are applied. For single Local 460 Pension Plan participants, the normal form of payment for pensions first effective on or after January 1, 2000 will be a Single Life Annuity With 60 Certain Payments. For any disability pension awarded on or after January 1, 2000, this Plan's provisions govern all determinations of whether a Local 460 Pension Plan participant is permanently and Totally Disabled.

H) Local 460 Pension Plan Pensioners and Beneficiaries as of January 1, 2000

Any monthly payments from the Local 460 Pension Plan, as of January 1, 2000 will be continued from this Plan in the same amount and form of payment. Any Local 460 Pension Plan pensioner who returns to work will have their benefit suspended per this Plan's rules. In addition, any Local 460 Pension Plan pensioner who returns to work is entitled to have, upon their re-retirement, their

pension amount re-determined under the terms of this Plan but only for the credit earned during the period of the pensioner's reemployment.

Local 460 Pension Plan participants, who were pensioners as of January 1, 2000, receive that plan's "pop-up" feature only if they elected it at the time their pensions began.

I) Inactive Vested Participants in the Local 460 Pension Plan

Vested participants in the Local 460 Pension Plan who became inactive before January 1, 2000, and do not return to Covered Employment under this Plan will receive their Local 460 Pension Plan benefits upon retirement.

Inactive vested participants in the Local 460 Pension Plan who do return to Covered Employment will have their benefit based on a combination of their Local 460 Pension Plan benefits and their benefits under this Plan.

J) Death Benefits

If a Local 460 Pension Plan participant died before January 1, 2000, their Beneficiary (or surviving Spouse as applicable) receives any unpaid death or survivor benefits to which they are entitled under the Local 460 Pension Plan. If a Local 460 Pension Plan participant died on or after January 1, 2000, their Beneficiary (or surviving Spouse if applicable) is entitled to the sum of the death or survivor benefit under this Plan and the death and survivor benefit under the Local 460 Pension Plan (the eligibility for both will be based on combined service but the amount of each will be based only on the service earned under each plan). In addition, for pensions first effective on or after January 1, 2000, Local 460 Pension Plan participants will be entitled to the post-retirement lump sum death benefit under this Plan based upon combined service under both plans.

K) Additional Information

If you were a participant of the Local 460 Pension Plan, the terms set forth in this booklet are subject to the provisions of this section. If you have any questions about the merger or would like a copy of the former Local 460 Pension Fund summary plan description, its plan document, or the merger documents, please contact the Fund Office.

SECTION 12. RETIREMENT AND SUSPENSION

A) Retirement-Severance from Employment

i) Before Age 65

If you have not reached Normal Retirement Age (generally age 65), then to be considered retired and eligible to apply for and receive an early or service pension benefit from the Plan, you must retire and refrain from any and all employment with Employers participating in the Retirement Fund and must sever any and all employment with Employers participating in the Retirement Fund before your Annuity Starting Date.

ii) Age 65 and Older

If you have reached Normal Retirement Age or older, you will be considered retired and eligible to apply for and receive benefits if you refrain from employment prohibited by the Plan and from all employment or work in the State of California in the plumbing and pipefitting industry in the same trade or craft in which you earned Pension Credits, with any Employer (whether or not signatory to a Collective Bargaining Agreement) or self-employed. However, you may work up to 39 hours per month in this type of employment without affecting your eligibility to retire.

B) Suspension of Benefits Upon Return to Employment

If you retire but subsequently return to work and work in what the Plan defines as "disqualified employment", your benefit may be suspended as explained below.

i) Disqualified Employment Before Age 65

If you retire before age 65 and later return to work, your benefit will be suspended from payment if you accept employment or activity in the plumbing or pipefitting industry. Employment or activity in the plumbing and pipefitting industry means the industry in which Employees covered by this Plan are employed and related businesses and any industry that falls under the trade jurisdiction of the United Association or any of its local unions. Disqualified Employment in this industry includes all job site and offsite construction, prefabrication, pre-cutting, supervisorial, design, labor relations, expediting and maintenance work, employment as an Employer or for a labor organization. The scope of this prohibition includes work for another person or company or through self-employment even if the pensioner is not doing the work directly but is supervising, directing or assigning work, or subcontracting.

Certain work in the industry is acceptable and will not be considered "disqualified employment".

a) It is acceptable for you to return to work and perform design, estimating, or consulting work in the plumbing and pipefitting industry so long as all of the following requirements are met:

1) The work is for an Employer that is a signatory to a Collective Bargaining Agreement with the United Association or an affiliated local union; and
2) The work is not performed on a job site; and
3) The work is performed as an actual employee of an Employer, not as an independent employer or sub-employer; and
4) The product of your work is supplied only to an entity that is a signatory to a Collective Bargaining Agreement with the United Association or an affiliated local union.

b) It will not be considered "disqualified employment" if you return to work as a corporate officer and hold a contractor's license or serve as an officer of the corporation or perform managerial, design, estimating, or consulting work for a corporation signatory to Collective Bargaining Agreement requiring contributions to the Fund.

c) In addition, it will not be considered "disqualified employment" if you return to work with the United Association or any of its affiliates outside District Council No. 16. Employment by the United Association is also acceptable.

d) Public and private employment as an instructor teaching skills related to the plumbing and pipefitting industry is permissible, but only if such instruction is related to and approved by an apprenticeship or journeymen training program sponsored by the United Association or an affiliated local union.

e) For credit earned before January 1, 2006, work as a Civil Servant will not be considered "disqualified employment." You may return to work in the plumbing and pipefitting industry as a Civil Servant for a federal, state, local, or quasi-governmental entity pursuant to applicable laws governing Civil Servants. However, with respect to all credit earned in excess of 7.05 cents per hour after January 1, 2006, and prior to January 1, 2025, governmental employment as a Civil Servant in the plumbing and pipefitting industry was considered "disqualified employment." Beginning January 1, 2025, employment as a Civil Servant in the plumbing and pipefitting industry will not be considered "disqualified employment," unless such employment is covered under the scope of work of any collective bargaining agreement covering District Council No. 16 of the United Association.

If you worked your first Hour of Service under the Plan on or after July 1, 2006, work in the plumbing and pipefitting industry in governmental employment as a Civil Servant on or after January 1, 2025, will not be considered "disqualified employment," unless such employment is covered under the scope of work of any collective bargaining agreement covering District Council No. 16 of the United Association. If you are a post-June 30, 2006 Participant who returns to work as a Civil Servant in the plumbing and pipefitting industry after January 1, 2025, you will not have your pension benefit suspended, unless the work is covered by such collective bargaining agreement.

ii) Disqualified Employment Between Age 65 and Age 70½

If you are between the ages of 65 and 70½ and you retire and later return to work, your benefit will be suspended from payment if you work, within the State of California, 40 or more hours per month in the same industry, trade, or craft in which you accrued pension benefits. This includes self-employment as well as work as an Employee.

It will not be considered disqualified employment, however, and your benefit will not be suspended if you return to work in any of the categories of jobs that constitute exceptions to "disqualified employment" for Pensioners returning to work before Normal Retirement Age, as set forth immediately above, either as an Employee or as an independent contractor.

iii) Employment Permitted After Age 70½

Starting when you reach age 70½, there are no restrictions on the type of work or the number of hours of work you may perform while receiving pension payments.

C) Suspension of Payments

If you become employed in "disqualified employment" as described above, your benefits from the Plan will be suspended for any month of such employment. If you are younger than 65, payments will be suspended for an additional six months following the end of the "disqualified employment", (18 months) if you fail to notify the Fund Office, but in no event beyond age 65.

If you are contemplating post-retirement employment, you should notify the Fund Office in writing before starting work.

If you are younger than age 70½ and receiving a pension from this Fund, you will be required to complete an Annual Statement by Pensioner form, which lists all employment performed by you or which certifies that you did not engage in "disqualified employment" during the preceding year. If this information is not provided by May 15, you will not receive your July pension payment, and payments will not resume until the Fund Office receives the information. You will be required to submit your tax

returns if the Trustees request that you confirm the information you have provided in the Annual Statement by Pensioner or where no other appropriate evidence is available.

The Trustees will recover the amount of any previous payments that should have been suspended through offset against future monthly benefit payments or other lawful means. A pensioner who returns to work in disqualified employment without notifying the Fund Office, you will be deemed culpable for any resulting overpayment.

If your benefits have been suspended, you must notify the Trustees, in writing, when the "disqualified employment" has ended. Benefit payments will not be re-started until such notice has been received. When the Trustees receive the notice, they will examine the circumstances of the employment and advise you on how the recovery of any improperly made payments will be scheduled.

If you have any questions as to whether a job you plan to take will cause a suspension, you should write to the Fund Office, giving the name of the Employer for whom you intend to work and a complete job description signed by the Employer describing the work you propose to perform. You will be advised if this work will cause a suspension of your benefits.

NOTE	**The Southern California Pipe Trades Pensioners and Surviving Spouses Health Fund says that a pensioner who engages in certain kinds of post-retirement employment must have his coverage suspended. Certain post-retirement employment may result in a permanent loss of eligibility to participate in the Pensioners Health Plan. In certain cases, you may instead be eligible for coverage under the Southern California Pipe Trades Health & Welfare Fund (active plan). You are strongly encouraged to study the Pensioners Health Fund SPD.**

SECTION 13. TEMPORARY WAIVER PROGRAM FOR PENSIONERS TO RETURN TO WORK

Although employment in the plumbing and pipefitting industry is considered disqualified employment for which benefits may be suspended, the Trustees may temporarily permit employment in certain positions in the industry as they determine reasonable and appropriate given the needs of the industry. All such waivers of the disqualified employment rules set forth above shall be temporary and shall expire on a date set by the Trustees or upon revocation by the Trustees. The following categories of work, which may be expanded or contracted by the Trustees in their discretion as circumstances warrant, are subject to the temporary work waiver program:

A) Work as a Superintendent, Project Manager, or Labor Relations Representative in the Plumbing and Pipefitting Industry, Provided All of the Following Conditions are Met:

i) The work is for an Employer that is a signatory to a Collective Bargaining Agreement with the United Association or an affiliated local union;
ii) The work does not displace or take away any work from bargaining unit Employees under the applicable Collective Bargaining Agreement;
iii) The work does not involve employment for which contributions will be paid to the Southern California Pipe Trades Retirement Fund;
iv) The work must not include any of the duties of a foreman or a general foreman;
v) The duties of a position as a superintendent or project manager must include the supervision of general foremen and foremen and must not include the direct supervision of work crews;
vi) The employment must not be in the same position or involve substantially the same duties as the pensioner had with the Employer before he retired;
vii) The majority of the duties performed in a position as a labor relations representative must involve labor relations;
viii) If the pensioner is age 65 or older, the work may be performed either as an Employee, or as an independent contractor. If the pensioner is under age 65, the work must be performed as an actual Employee, not as an independent contractor or subcontractor; and
ix) The product of the work for the Employer may not be supplied to an entity that is not a signatory to a Collective Bargaining Agreement with the United Association or an affiliated local union.

B) Design or Estimating Work in the Plumbing and Pipefitting Industry, Performed Either On or Off a Jobsite, Provided All of the Following Conditions are Met:

i) The work is for an Employer that is a signatory to a Collective Bargaining Agreement with the United Association or an affiliated local union;
ii) The work does not displace or take away work from bargaining unit Employees under the applicable Collective Bargaining Agreement;
iii) If the pensioner is age 65 or older, the work may be performed either as an Employee, or as an independent contractor. If the pensioner is under age 65, the work must be performed as actual Employee, not as an independent contractor or subcontractor; and
iv) The product of the work may not be supplied to an entity that is not a signatory to a Collective Bargaining Agreement with the United Association or an affiliated local union.

C) Work in Covered Employment for an Employer Contributing to the Fund Under the Following Requirements and Conditions:

i) This program applies only to jobs for which a waiver has been granted. If there is a manpower shortage that working Participants cannot meet, District Council No. 16 may ask the Trustees for a temporary waiver. A special committee of the Trustees will then decide whether to grant a temporary waiver of the rules for the suspension of pension benefits.
ii) The waivers will be limited to work at a specific job site or work of a specific skill type. The waivers will be temporary and subject to cancellation at any time. Work outside the scope of the waivers will still be subject to suspension of pension benefits.
iii) The program is only available to pensioners who have been receiving a pension for at least two years.
iv) If you are employed under this program, you will continue to receive your monthly pension benefit as long as you are working per the job site and other waiver limitations. You will also receive credit under the Plan for periods of such employment, and your pension amount will be adjusted annually to account for the increased credit. No adjustments will be made to the pension amount for any prior years. Any adjustment will be limited to the additional incremental amount earned for the year during the waiver employment.
v) If you are employed under this program, you will not lose your entitlement to the annual payment from the Southern California Pipe Trades Christmas Bonus Fund as long as you work per the job site or other limitations of the waiver.
vi) If you stay on the job after the waiver is canceled or if you work outside the limitations of the waiver, your pension benefits will be suspended, your coverage will terminate, and you will not be entitled to a benefit from the Southern California Pipe Trades Christmas Bonus Fund for the applicable year.

NOTE	**These waivers only apply to the Southern California Pipe Trades Retirement Fund. You should check with the Plumbers and Pipefitters National Pension Fund or other benefit funds to determine if benefits received from those plans will be affected by this type of employment.**

SECTION 14. APPLICATION PROCESS

A) How to apply for a benefit

To claim benefits, you must obtain an application form from the Fund Office. The form must be completed, signed, and submitted to the Fund Office.

i) Basic Pension Application

To receive benefits from the Fund, you must meet requirements and submit a formal written application. The first step in applying for a pension benefit is to request a Basic Pension Application form from the Fund Office. At the same time, or at any time before that, you may obtain information from the Fund Office about your Pension Credits, benefits, options, and any other information that will help you complete the Basic Pension Application.

Along with the Basic Pension Application form, you must provide various supporting documents, such as birth certificates, marriage certificates, and divorce documents.

You will be considered to have applied for a pension benefit only when the Fund Office has received your completed Basic Pension Application. Payments cannot begin before the completed Basic Pension Application is received. Benefits will generally be payable as of your Annuity Starting Date (see Section 14(D) below) and will be distributed to you on or after your Annuity Starting Date (see Section 14(E) below).

ii) Application for Disability Pension

If you are applying for a disability pension, you must submit proof that you have been awarded a Social Security disability benefit by the Social Security Administration, or, effective January 1, 2022, a notice of award of a Department of Veterans Affairs (VA) 100% disability benefit. If you submit your Basic Pension Application before you receive notice of entitlement to a Social Security or VA 100% disability benefit, you should indicate on the Basic Pension Application that you have applied for a Social Security or VA 100% disability benefit. Your notice of entitlement to a Social Security or VA 100% disability benefit should be sent to the Fund Office within one year after you receive it to have your benefit begin at the same time your Social Security or VA 100% disability benefit is effective.

iii) Beneficiary's Application for Benefit

If you die before retirement, your surviving Spouse or other Beneficiary may be required to submit a form to the Fund Office to receive death benefits.

To make it possible for payments to begin with minimum delay, the Beneficiary or a representative should contact the Fund Office as soon as possible after your death. The Fund Office will provide, to properly authorized representatives, information regarding possible benefits due.

NOTE	**Payments to Minor Beneficiaries**
	If a benefit is payable to a minor, the Fund may pay it to any legally appointed guardian. If there is no such person, the Fund may pay benefits to the person having present custody or care of the minor and with whom the minor resides. The Fund also has the discretion to make any benefit payment to a minor by depositing the payment in a federally insured savings account in the name of the minor and by giving the notice of the deposit to the minor.

B) How an Application is Processed

Notwithstanding Section 14(A) above, the Fund will treat any application or written request for a Plan benefit or any other written claim for Fund action made by you or your authorized representative per the procedures described in this SPD as a "claim for benefits".

A claim will be treated as submitted on the date it is postmarked. If your application is incomplete, you will be notified with a written request for additional information as soon as possible.

Every effort will be made to process your claim within 90 days after receipt by the Fund Office. This 90-day period will begin upon receipt of the completed and signed application form by the Fund Office without regard to whether all of the information necessary to decide the application has been submitted.

If a decision on your claim for benefits cannot be made within 90 days of its receipt, a letter will be sent to you, before the expiration of the 90 days, explaining the special circumstances requiring another 90 days to take action. If final action cannot be taken at the end of the second 90-day period, you will be sent a written explanation in advance of the expiration of the second 90-day period. Where appropriate, you will be awarded any partial benefits that can be determined with the available information. If partial benefits cannot be awarded because of a lack of necessary information, the Fund Office will conditionally deny your claim. The Fund Office will continue to seek the necessary information to make a final determination.

A shorter decision period applies to an application for an occupational disability pension, in which case the Fund Office will make a decision within 45 days. This period may be extended by up to two additional 30-day periods for circumstances beyond the control of the Fund. You will be notified in writing of any extension before the expiration of either of these two periods. This notice will also explain (1) the standards on which entitlement to benefits is based; (2) the unresolved issues that prevent the claim from being decided; (3) any additional information needed to decide your claim; and (4) if additional information is necessary, you will have at least 45 days in which to provide the specified information.

C) Notice of Decision on Your Claim

If your claim for benefits is denied, in whole or in part, the Fund Office will provide you with a written notice that states (1) the specific reason(s) for the denial, (2) refers to the specific Plan provisions on which the denial is based, (3) describes any additional material or information that might help your 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 lawsuit under Section 502(a) of ERISA.

If your claim involves a disability determination made by the Fund Office, the Trustees, or their agents (and not the Social Security Administration or the VA) the written notice of a claim denial will contain, in addition to the other information required in a notice

of claim denial as described in the previous section, either the specific rule, guideline, protocol, or other similar criterion on which the decision was based or a statement that such criterion does not exist. The written notice will also include, if applicable, a discussion of the Fund's basis for disagreeing with or not following (1) views presented by your treating health care professionals and/or vocational professionals who evaluated you; (2) views of medical or vocational experts whose advise the Fund obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination; or (3) a disability determination made by the Social Security Administration or the VA.

If you receive such a notice, you may submit a written appeal to the Board of Trustees requesting that it review your benefit denial. The procedures and timelines for submitting an appeal are discussed in Section 15(A) below.

D) Annuity Starting Dates

Your Annuity Starting Date is usually the first day of the month after the postmark date of your completed Basic Pension Application. However, the start of payments may sometimes be delayed because of processing. Once the processing is completed and you are found eligible for a pension benefit, you will receive payments retroactively to your Annuity Starting Date.

i) Non-disability Pension

Your Annuity Starting Date is usually the first day of the month after the postmark date of your completed Basic Pension Application. However, the start of payments may sometimes be delayed because of processing. Once the processing is completed and you are found eligible for a pension benefit, you will receive payments retroactively to your Annuity Starting Date.

ii) Disability Pensions

Your Annuity Starting Date for a disability pension generally depends on your Social Security "disability entitlement date". Usually, your Social Security "disability entitlement date" is six months after your Social Security "disability onset date", which is the date the Social Security Administration determines that you first become disabled.

Your Annuity Starting Date for a disability pension will be the same as your Social Security "disability entitlement date", if your application for a disability pension and your Social Security disability "notice of award" are filed with the Fund Office no later than one year after the Social Security "notice of award" was issued. If you file your Social Security disability "notice of award" with the Fund Office more than one year after it was issued, you Annuity Starting Date will be delayed until the first of the month after your Social Security disability "notice of award" and your Basic Pension Application form are received by the Fund Office.

To assure that your pension benefits will be payable as early as possible, you should (1) file your Basic Pension Application form with the Fund Office at about the same time you apply for Social Security disability benefits and (2) promptly send your Social Security disability "notice of award" to the Fund Office.

Effective January 1, 2022, in addition to a Social Security disability determination, the Fund will also accept a VA determination of 100% disability following procedures similar to those for Social Security disability.

E) When Payments Begin

i) Non-disability Pensions

Your pension checks or direct deposits may begin on your Annuity Starting Date, which usually is the first day of the month after you have met all requirements for entitlement to benefits, including filing a complete Basic Pension Application. If required information is not provided timely, but your application is ultimately approved, your payments may be delayed, but you will receive them back to your Annuity Starting Date. If processing delays the payment beyond this date, you will receive payments back to your Annuity Starting Date.

ii) Disability Pensions

Your pension checks or direct deposits my begin as early as your Annuity Starting Date but not earlier than your Social Security "disability entitlement date", which is generally six months after your Social Security "disability onset date", which is the date the Social Security Administration determines that you first became Totally Disabled.

If you file an application for a disability pension with a copy of your Social Security disability "notice of award" letter within one year after you receive your "notice of award" letter from Social Security, benefits from this Plan will be paid back to your Social Security "disability entitlement date". Otherwise, benefits will only be paid as of the first of the month following the date you both file the application and become entitled to Social Security disability benefits.

Effective January 1, 2022, in addition to a disability determination, the Fund will also accept a VA determination of 100% disability following procedures similar to those for Social Security disability.

F) Mandatory Benefit Commencement

If you are about to reach the Applicable Age defined below based on your birth date, and have not yet filed for a pension benefit, you are urged to contact the Fund Office for a Basic Pension Application. The Plan will automatically begin your pension in the normal form of benefit as of April 1 of the Calendar Year following the year you reach the Applicable Age set forth below regardless of whether you have applied.

Birth Date	Applicable Age
Before July 1, 1949	70 1/2
After June 30, 1949 and before January 1, 1951	72
1951 - 1959	73
1960 - later	75

G) Benefits Accrued After Retirement

Benefits earned by a pensioner who re-enters Covered Employment after retirement will be determined as of the end of each Plan Year and will be payable in the following year provided payment of benefits at that time is not suspended due to work in disqualified employment. Such additional earned Pension Credit shall not be used to increase the portion of the pension attributable to Pension Credit earned before that period in Covered Employment after retirement. If you originally retired on or after Normal Retirement Age, any additional earned credit will be payable in the benefit form originally selected at the time of the initial retirement. If you originally retired before Normal Retirement Age, a new Annuity Starting Date will be established for any subsequent retirement and the additional accrued benefits will be payable in the benefit form selected at the time of the subsequent retirement.

SECTION 15. APPEALS PROCEDURE

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

A) Appealing a Benefit Denial

If your claim for benefits is denied, in whole or in part, you may request that the Board of Trustees review the benefit denial. The Board of Trustees has delegated the responsibility to decide appeals to its Appeals Committee. (In some cases, the Board of Trustees may decide to consider an appeal; in other cases, the Appeals Committee may delegate the responsibility to consider an appeal to a subset of the Committee.) All appeals must be in writing and received by the Fund Office within 180 calendar days after you receive the written notice of the denial from the Fund Office. Failure to file a timely written appeal shall constitute a complete waiver of your right to appeal, and the decision of the Fund Office will be final and binding.

In presenting your appeal, you can submit written comments, documents, records, and other information about your claim. You are also entitled to receive reasonable access to and copies of all documents, records, and other information relevant to your claim upon request and free of charge. Personal appearances on appeals are at the discretion of the Appeals Committee.

Your written appeal should state the specific reasons why you believe the denial of your claim was in error. You should also submit any documents or records that support your claim. This does not mean that you are required to cite all of the Plan provisions that apply or to make “legal” arguments; however, you should state clearly why you believe you are entitled to the benefits or other relief you are claiming. The Appeals Committee can best consider your position if it clearly understands your claims, reasons, or objections.

The review of the Appeals Committee will consider all comments, documents, records, and other information you submit, without regard to whether such information was submitted or considered by the Fund Office in its determination. The Appeals Committee will also not afford deference to the initial determination by the Fund Office.

In the case of appeals involving a disability determination made by the Fund, the Trustees, or their agents (and not the Social Security Administration or VA), no Trustees reviewing your appeal will have participated in the initial benefit determination or be the subordinate of any person who did participate. If the initial determination was based, in whole or in part, on medical judgment, the Trustees shall consult a health care professional who has appropriate training and experience in the field of medicine involved and who was neither consulted as part of the initial determination nor the subordinate of such individual. In addition, the Fund will identify any medical or vocational experts whose advice was obtained in considering your initial benefit determination.

You will be provided, free of charge, any new or additional evidence considered, relied upon, or generated by, or at the direction of the Fund, the Trustees, or any person other person reviewing the benefit determination. Such information will be provided to you as soon as possible and with sufficient time to give you a reasonable opportunity to respond to such new or additional information. In addition, you will be provided with the same opportunity before an adverse benefit determination on appeal may be rendered based on a new or additional rationale.

The Fund Office 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.

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 Fund Office receives the appeal. 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 you before the beginning of the extension. Such an extension may only last until the third meeting following receipt of the appeal.

B) Notice of Decision on Appeal

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

If your appeal is denied, in whole or in part, you will receive a written decision that will include: (1) the specific reason(s) for the denial; (2) the specific Plan provisions on which the denial is based; (3) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your appeal; and (4) a statement of your right to bring a lawsuit under Section 502(a) of ERISA.

In the case of the denial, in whole or in part, of an appeal involving a disability determination made by the Fund, the Trustees, or their agents (and not the Social Security Administration or VA), you will receive a notice containing the information described in the previous paragraph as well as either the specific rule, guideline, protocol, or other similar criterion on which the decision was based or a statement that such a criterion does not exist. The written notice will also contain, if applicable, a discussion of the Fund's basis for disagreeing with or not following (1) views presented by your treating health care professionals and/or vocational experts who evaluated with you; (2) views of medical or vocational experts whose advice the Fund obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination; or (3) a disability determination made by the Social Security Administration or VA.

The decision of the Appeals Committee is final and binding on all parties, including anyone claiming a benefit on your behalf.

C) The Decision on Appeal is Final

Once a final decision is rendered, there is no right to re-file the same appeal or to request reconsideration. If such an appeal or request for reconsideration is filed, the Appeals Committee may refuse to consider it.

The Board of Trustees and, by delegation, the Appeals Committee has full discretion and authority to determine all matters relating to appeals, including, but not limited to, eligibility for benefits, the amount of benefits to which individuals are entitled, the standard of proof required for any claim and the application and interpretation of the Plan. The Board of Trustees has the ultimate authority to hear any appeal and has generally delegated this authority to the Appeals Committee to decide appeals. However, the Board of Trustees has the right and authority to hear any appeal, and in such case, the rights and procedures set forth herein shall apply equally to the Board of Trustees.

If the Appeals Committee denies your appeal and you decide to seek judicial review, the Appeals Committee's decision will be subject to limited judicial review to determine only whether the decision was arbitrary and capricious. Generally, 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 before the decision on your appeal. No legal action may be commenced against the Trust, the Plan, or the Trustees more than two years after the claim has been denied on appeal.

D) Right to Be Represented

In making a claim or appeal, you may be represented by any authorized representative. If your representative is not an attorney or court-appointed guardian, you must designate the representative by a signed written statement. However, neither you nor your representative has a right to an in-person hearing or appearance before the Trustees or the Appeals Committee.

E) Any Adverse Decision May be Appealed

The recipient of any written correspondence from the Fund Office that could be interpreted as adversely affecting the recipient's interest may appeal to the Appeals Committee for a determination of the content of that correspondence. Such a request for review

must be in writing and must be made within 180 calendar days after receipt of the correspondence from the Fund Office. Such appeals will be processed in the same manner as appeals from determinations on benefit applications.

SECTION 16. IMPORTANT NOTICES

A) No Assignment of Benefits

Benefits may not be sold, assigned, or pledged as security for a loan. Furthermore, benefits are not subject to attachment or execution for the payment of a debt under any judgment or decree of a court or otherwise, except as provided in the Internal Revenue Code and applicable regulations. However, the Fund will honor any benefits payable to a former Spouse or Alternate Payee, under a legally binding Qualified Domestic Relations Order.

B) Erroneous Payments

Every effort will be made to ensure accuracy in the payment of your benefits. However, if an error is discovered, and it is determined that the Fund has paid any benefits you are not entitled to, the Trustees have the right to seek repayment from you for the amount overpaid plus interest by all legal means, including through reduction of future benefit payments to the extent permissible under ERISA.

C) 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 erroneous amounts paid by the Fund, and you will be liable for all costs of collection, including attorneys' fees. 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 payment made because of fraud or misrepresentation.

SECTION 17. INFORMATION REQUIRED BY ERISA

The following additional information concerning the Plan is provided to you per the Employee Retirement Income Security Act of 1974 (ERISA). The terms in this section are generally as defined in ERISA unless capitalized.

A) Name and Type of Plan

The name of the Plan is the Southern California Pipe Trades Retirement Plan. It is a multiemployer defined benefit plan.

B) Identification Numbers

The Fund's Internal Revenue Service tax identification number is 51-6108443. The Plan number is 001.

C) Plan Year

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

D) Plan Sponsor, Named Fiduciary, and Administrator

The Plan is maintained under a collectively bargained, jointly trusteed labor-management trust. The Board of Trustees is the Plan sponsor, the plan administrator, and the names fiduciary under ERISA.

E) Board of Trustees

The Board of Trustees consists of Employer and Union representatives, selected by the Employers and Unions per 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	(800) 595-7473
Southern California Pipe Trades Retirement Fund	(213) 385-6161
501 Shatto Place, Suite 500	www.scptac.org
Los Angeles, CA 90020	info@scptac.org

F) Fund Office

The Board of Trustees has designated the Southern California Pipe Trades Administrative Corporation to perform the daily business functions of the Plan. You may contact the Fund Office at:

Southern California Pipe Trades Administrative Corporation	(800) 595-7473
Attention: CEO/Administrator	(213) 385-6161
501 Shatto Place, Suite 500	www.scptac.org
Los Angeles, CA 90020	info@scptac.org

G) Agent for Service of Legal Process

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

Southern California Pipe Trades Retirement Fund	(800) 595-7473
Attention: CEO/Administrator	(213) 385-6161
501 Shatto Place, Suite 500	www.scptac.org
Los Angeles, CA 90020	info@scptac.org

H) Source of Contributions and Identity of any Organization Through Which Benefits are Provided

All contributions to the Fund are made by Employers per their Collective Bargaining Agreements or the terms of a Participation Agreement. The Collective Bargaining Agreements and Participation Agreements require that contributions be made to the Plan at fixed rates per hour of work.

Upon written request, the Fund Office will provide you with a complete list of Employers and unions that are parties to a Collective Bargaining Agreement and their addresses. The Fund Office will also provide information about whether a particular Employer is obligated to contribute to the Fund on behalf of Employees working under a Collective Bargaining Agreement or Participation Agreement and the address of any such Employer.

The Fund's assets are held in trust by the Board of Trustees. Custody of the Fund's assets is with U.S. Bank, N.A. Benefits are provided directly from the Fund's assets, which are accumulated under the provisions of the Trust Agreement. The assets are used exclusively for providing benefits to participants and beneficiaries per the provisions of the Plan and for paying the reasonable administrative expenses of the Fund.

All types of benefits the Plan provides are set forth in this SPD.

I) Collective Bargaining Agreement

Contributions to the Fund are made per Collective Bargaining Agreements between Employers and District Council No. 16 of the United Association or affiliated local unions of District Council No. 16 or the United Association. The United Association local unions affiliated with District Council No. 16 are 78, 114, 230, 250, 345, 364, 398, 403, 460, 484, 582, and 761. Upon written request, the Fund Office will provide you with a copy of the applicable Collective Bargaining Agreement. The Collective Bargaining Agreement is also available for examination at the Fund Office. The following are the employer associations with which District Council No. 16 has a bargaining relationship that requires contributions to this Plan:

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

J) Plan Termination and Termination Insurance

i) Plan Termination

It is intended that the Plan will continue indefinitely, but the Board of Trustees reserves the right and has the discretion to change or discontinue the Plan at any time. The Trustees may terminate the Plan 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 become due under the Plan. The Plan may also be terminated if no individuals living can qualify as participants or beneficiaries under the Plan or if there are no longer any Collective Bargaining Agreements requiring contributions to the Fund. The Plan is considered terminated by law if it is amended to provide that no further benefits will be earned by employees for employment with employers if every employer withdraws from the Plan within the meaning of Section 4203 of ERISA upon the cessation of the obligation of all employers to contribute under the Plan, or if the Plan is amended to become a defined contribution plan.

If the Plan terminates, you will not accrue (earn) any further benefits under the Plan. However, the benefits you have already accrued will become vested, that is, non-forfeitable, to the extent your benefits can be funded by the Fund assets allocated to such benefits.

If the termination occurs because the Plan is amended to provide that no further benefits will be earned by employees for employment with employers or is amended to become a defined contribution plan, the Plan will continue to pay non-forfeitable benefits. If the Plan does not have sufficient assets to pay all non-forfeitable benefits, employers will be required to contribute to the Fund until all non-forfeitable benefits are fully funded and can be paid.

If the Plan terminates because there are no longer any Collective Bargaining Agreements requiring contributions to the Fund, the Plan may be amended to reduce benefits to the extent necessary to ensure that the Fund's assets are sufficient to pay non-forfeitable benefits when they are due. If the Plan has been amended and the Fund does not have enough assets to pay non-forfeitable benefits, the Plan has the authority to suspend benefits. If benefits are suspended, the Plan will continue to pay the highest level of benefits that can be paid out of the Plan's available resources. If benefits are suspended, the Plan will not be required to make retroactive benefit payments for that portion of a suspended benefit.

Once the Fund assets and non-forfeitable benefits are valued, the Trustees, as a general rule, will use the available assets to purchase annuity contracts to provide for your benefits. However, if the Plan terminates because of an amendment, and the value of your non-forfeitable benefit attributable to employer contributions is less than $7,000.00, the Plan may require that you be paid in cash.

If the Plan is terminated, the Trustees will: (i) pay the expenses of the Fund incurred up to the date of termination as well as the expenses in connection with the termination; (ii) arrange for a final audit of the Fund; (iii) give any notice and prepare and file any reports required by law; and (iv) apply the assets of the Fund per the law and the Plan including amendments adopted as part of the termination, until the assets of the Fund are distributed.

No part of the assets or income of the Fund will be used for purposes other than for the exclusive benefit of the Employees and the Beneficiaries or the administrative expenses of the Fund. Under no circumstances will any portion of the Fund revert to the benefit of any contributing Employer, employer association, or Union.

Upon termination of the Plan and Fund, the Trustees will promptly notify the Union, any employer association, Employers, and all other interested parties. The Trustees will continue as Trustees to wind up the affairs of the Plan.

ii) Termination Insurance

Your pension benefits under this multiemployer plan are insured by the Pension Benefit Guaranty Corporation (PBGC), a federal insurance agency. A multiemployer plan is a collectively bargained pension arrangement involving two or more unrelated employers, usually in a common industry.

Under the multiemployer plan program, the PBGC provides financial assistance through loans to insolvent plans. A multiemployer plan is considered insolvent if the plan is unable to pay benefits (at least equal to the PBGC's guaranteed benefit limit) when due.

The maximum benefit that the PBGC guarantees is set by law. Under the current multiemployer program, the PBGC guarantee equals a participant’s years of service multiplied by (1) 100% of the first $11 of the monthly benefit accrual rate and (2) 75% of the next $33 times your years of service. The PBGC's maximum guarantee limit is $35.75 per month times a participant’s years of service. For example, the maximum annual guarantee for a pensioner with 30 years of service is $12,870.

The PBGC guarantee generally covers (a) normal and early retirement benefits, (b) disability benefits if you become disabled before the plan becomes insolvent, and (C) certain benefits for your survivors.

The PBGC guarantee generally does not cover the following:

(a) Benefits greater than the maximum guaranteed amount set by law;
(b) Benefit increases and new benefits based on plan provisions that have been in place for fewer than five years at the earlier of (1) the date the plan terminates or (2) the time the plan becomes insolvent;
(c) Benefits that are not vested because you have not worked long enough;
(d) Benefits for which you have not met all of the requirements when the plan becomes insolvent; and
(e) Non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

For more information about the PBGC and the benefits it guarantees, ask your plan administrator or contact the PBGC's Office of Benefits Administration, P.O. Box 151750, Alexandria, VA 22315-9923 or call the PBGC at (800) 400-7242. TTY/TDD users may call the federal relay service toll-free at (800) 877-8339 and ask to be connected to (800) 400-7242. Additional information about the PBGC's pension insurance program is available through the PBGC's website at http://www.pbgc.gov.

K) Action of the Trustees

The Trustees have full discretion and authority over the standard of proof for any inquiry, claim, or appeal and over the application and interpretation of the Plan and trust. No legal proceeding may be filed in any court or before an administrative agency against the Plan or its Trustees unless all review procedures with the Trustees have been exhausted. No legal action may be commenced against the trust, the Plan, or the Trustees more than two years after a claim has been denied.

L) Right to Amend

The Trustees have complete discretion to amend or modify the Plan or trust and any of their provisions, in whole or in part, at any time.

M) ERISA Rights

As a Southern California Pipe Trades Retirement Plan Participant, 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

a) Examine, without charge, at the plan administrator's office and 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 Employee Benefits Security Administration.

b) 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 an updated summary plan description. The administrator may make a reasonable charge for the copies.

c) Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

d) Obtain a statement telling you whether you have a right to receive a pension at normal retirement age and, if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

ii) 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, must 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 pension benefit or exercising your rights under ERISA.

iii) Enforce Your Rights

If your claim for a pension benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits 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 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.

iv) Assistance with Your Questions

You should contact the plan administrator if you have any questions about your plan. If you have any questions about this statement or your rights under ERISA, or if you need assistance in 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 18. DEFINITIONS

Active Participant
You are an Active Participant if you are an Employee who meets the requirements for Plan participation summarized in Section 2, page 2, who has not experienced a one-year or more break in covered employment. An Active Participant is not a pensioner, Beneficiary, or Inactive Vested Participant.

Alternate Payee
Your Spouse, former Spouse, child, or other dependent, or any individual recognized under a Qualified Domestic Relations Order (QDRO) as having a right to receive some or all of your benefits accrued and otherwise due and payable to you.

Annuity Starting Date
The date you are first entitled to receive a benefit from the Plan, although the actual payment may be made later. Usually, your Annuity Starting Date is the first of the month after you have met the Plan eligibility requirements and have submitted a pension application.

Appeals Committee
A subset of the Board of Trustees empowered to review any claims as described in Section 15.

Beneficiary
A Beneficiary is a person designated by you or by the Plan to receive benefits when you die.

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

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

Civil Servant
You are a Civil Servant if you are employed full-time by a governmental entity (including any federal, state, local, or other quasi-governmental agency) and the employment is covered under a public employee retirement system.

Collective Bargaining Agreement
Any and all negotiated labor agreements between a Contributing Employer, or employer association acting on behalf of Employers, and Southern California Pipe Trades District Council No. 16 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada ("United Association"), or any local union affiliate of the District Council that requires contributions to the Southern California Pipe Trades Retirement Fund. It also refers to an agreement to which the United Association is a party, requiring contributions to the Fund.

Consecutive One-Year Breaks
Successive Calendar Years in which you incur a One-Year Break in Covered Employment. See Section 5, page 7.

Contributing Employer
An Employer signed to a Collective Bargaining Agreement or Participation Agreement, or an Employer that assigns its bargaining rights to an employer association signed to a Collective Bargaining Agreement that requires contributions to the Fund.

Covered Employment
Work by an Employee under a Collective Bargaining Agreement.

Defined Benefit Pension Plan
A Defined Benefit Pension Plan like this one requires that the Employer make contributions to pay predetermined benefits to plan participants at retirement.

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. Employees may also include an Employer or someone employed by an organization signatory to a Participation Agreement.

Employer
See Contributing Employer.

ERISA
Employee Retirement Income Security Act of 1974, as amended. See Section 17(M), page 40 for an explanation of your ERISA rights.

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

Fund Office
Southern California Pipe Trades Administrative Corporation
501 Shatto Place, Suite 500
Los Angeles, CA 90020

(800) 595-7473
(213) 385-6161
www.scptac.org
info@scptac.org

Future Service Credit
The years of service that are accumulated and maintained for Employees per the rules of the Plan.

Hour(s) of Service
Each hour for which an Employee is paid or entitled to be paid for their performance of duties for Employer(s).

Inactive Vested Participant
An Inactive Vested Participant is a vested participant who has incurred a One-Year Break in Covered Employment.

Joint and Survivor Options
These benefit options may be elected for married or unmarried Participants. When retiring under one of the Joint and Survivor options, you will receive a smaller amount during your lifetime But, if your Beneficiary survives you, they will receive 50%, 75%, or 100% of that amount for the Beneficiary's lifetime.

Joint Annuitant
Your Spouse or eligible designated non-spouse Beneficiary who will receive a monthly lifetime survivor benefit after your death. See Section 7(C), page 21.

Master Labor Agreement
The Collective Bargaining Agreement between District Council No. 16 and the California Plumbing & Mechanical Contractors Association (CPMCA).

Normal Retirement Age
Generally means the later of age 65 and the Participant's 5th anniversary of Plan participation.

One-Year Break
After January 1, 1976, a Calendar Year in which you do not have at least 501 Hours of Service. See Section 5, page 7.
(See also Permanent Break.)

Participant
An Employee who has satisfied the rules to become eligible under the terms of the Plan, who has not incurred a Permanent Break in Covered Employment.

Participation Agreement
An agreement approved by the Board of Trustees permitting a Contributing 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 not covered by a Collective Bargaining Agreement.

Past Service Credit
Pension Credit for certain work performed after the age of 17, between January 1, 1937, and July 1, 1957. See Section 3(A), page 3.

Pension Credit(s)
The years of service which are accumulated and maintained for Employees. See also Section 3.

Pension Hours
Hours worked which require contributions to this Fund. If you are working in a job class with a contribution rate lower or higher than the Journeyman rate under the Master Labor Agreement, then your Pension Hours will be adjusted proportionately. The Plan's benefit calculation formula, as of January 1, 1999, assigns a benefit value to each Pension Hour you work.

Permanent Break
As of January 1, 1986, if you are not vested, five Consecutive One-Year Breaks in Covered Employment. A Permanent Break in Covered Employment results in the loss of Pension Credit, Vesting Credit, and any benefits accrued before the Permanent Break in Covered Employment. (See also One-Year Break.)

Plan
The benefits, rules, limitations, exclusions, and other provisions described in this SPD and established by the Plan Document.

Plan Document
The written document titled "Sixth Restatement of the Rules and Regulations of the Pension Plan of the Southern California Pipe Trades Retirement Fund" and any amendments to it.

Plan Year
January 1 through December 31 of each year.

Premium
The monthly charge for coverage under the Southern California Pipe Trades Pensioners and Surviving Spouses Health Plan.

Qualified Domestic Relations Order (QDRO)
A QDRO is a state domestic relations order, such as a divorce decree, that meets several specific legal requirements and that creates or recognizes an Alternate Payee's right, or assigns to an Alternate Payee the right, to receive all or a portion of the benefits payable to Participant under the Plan.

Qualified Joint and Survivor Annuity
This is the default form of benefit if you are married. Under this form of benefit, when you die, your Spouse, if still living, will receive 50% of your benefits for their lifetime. Benefit levels are adjusted actuarially based on the difference in age between you and your Spouse.

Single Life Annuity With 60 Certain Payments
This is the default form of benefit if you are unmarried. Under this form of benefit, if you die within the 60-month period beginning with your Annuity Starting Date, then your monthly pension benefit becomes payable to your Beneficiary for the remainder of the 60-month period or until the death of your Beneficiary, whichever comes first.

SPD
Summary Plan Description. This document. A summary of the provisions of, and benefits available under, the Southern California Pipe Trades Retirement Fund.

Spouse
A person to whom you are legally married (or to whom you were married for purposes of and to the extent provided under a Qualified Domestic Relations Order).

Totally Disabled
For purposes of determining eligibility for a disability pension benefit, or an occupational disability benefit, totally unable, as a result of bodily injury or disease, to engage in any substantial, gainful activity because of any medically determinable physical or mental impairment which can be expected to result in death or to be of long, continued and indefinite duration as determined by the Board of Trustees and that results in entitlement to Social Security Disability benefits or, effective January 1, 2022, a determination of 100% disability from the Department of Veterans Affairs (VA).

Trust Agreement
The written document titled "Restated Agreement and Declaration of Trust Continuing the Southern California Pipe Trades Retirement Fund" under which the Fund has been established and maintained and to which this Plan has been adopted and any amendments to it.

Trustees
Employer and Union representatives who oversee the Fund.

Uniformed Service and Qualified Uniformed Service

Uniformed Service is duty in the armed forces of the United States, the National Guard, the commissioned corps of the Public Health Service, and such other service designated by the President, which may entitle a Participant to the protections of USERRA.

Qualified Uniformed Service is Uniformed Service meeting the requirements under USERRA that establish reemployment and other rights.

Union(s)

Southern California Pipe Trades District Council No. 16 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada, AFL-CIO ("United Association"), and its affiliated local unions and such other unions which have or may in the future become parties to and agree to be bound by the Trust Agreement.

Vesting Credit

A Calendar Year in which you earn at least 1,000 Hours of Service. Used to establish your right to a benefit. See Section 4, page 6.

SECTION 19. TRUSTEES

The following is a list of the Trustees as of the publication date of this SPD. The members of the Board of Trustees may change from time to time. If you want a current listing of the Trustees, contact the Fund Office.

A) Employer Trustees

RYAN CAVANAUGH
Murray Company
5995 Plaza Drive
Cypress, CA 90630

ROBERT FELIX
All Area Plumbing/ACCO Engineered Systems, Inc.
6446 E. Washington Blvd.
Commerce, CA 90040

JASON GORDON
Prime SC Mechanical, Inc.
7392 Earl Circle
Huntington Beach, CA 92647

JEFF HACHEY
H.L. Moe Company, Inc.
526 Commercial Street
Glendale, CA 91203

ADAM KAPLAN
Sierra Commercial Plumbing, Inc.
4645 Industrial Street, Unit C
Simi Valley, CA 93063

CHIP MARTIN
CPMCA
1735 Flight Way, Suite 204
Tustin, CA 92782

JOHN MODJESKI
University Mechanical & Engineering Contractors
1168 Fesler Street
El Cajon, CA 92020

JEFF STEVANUS
Southland Industries
12131 Western Avenue
Garden Grove, CA 92841

BRYAN SUTTLES
Suttles Plumbing
2267 Agate Court
Simi Valley, CA 93065

STEVE VALOT
Pan-Pacific Mechanical
18250 Euclid Street
Fountain Valley, CA 92708

LAWRENCE VERNE
Verne's Plumbing, Inc.
8561 Whitaker Street
Buena Park, CA 90621

PIP ZAIDE
Allegiant Mechanical, Inc.
7776 Westminster Blvd.
Westminster, CA 92683

B) Union Trustees

DAVID BALDWIN
U.A. Local No. 403
3710 Broad Street
San Luis Obispo, CA 93401

STEVEN BERINGER
U.A. Local No. 230
6313 Nancy Ridge Drive
San Diego, CA 92121

SHANE BOSTON
U.A. Local No. 484
1955 N. Ventura Avenue
Ventura, CA 93001

BEN CLAYTON
U.A. Local No. 250
18355 South Figueroa Street
Gardena, CA 90248

RODNEY COBOS
District Council No. 16
501 Shatto Place, Suite 400
Los Angeles, CA 90020

JEREMY DIAZ
U.A. Local No. 78
1111 W. James M. Wood Blvd.
Los Angeles, CA 90015

STEVEN GOMEZ
U.A. Local No. 460
6718 Meany Avenue
Bakersfield, CA 93308

ROBERT JAMES
U.A. Local No. 582
1916 W. Chapman Avenue
Orange, CA 92868

GREG LEWIS
U.A. Local No. 761
1305 North Niagara Street
Burbank, CA 91505

RICARDO PEREZ
U.A. Local No. 345
1430 Huntington Drive
Duarte, CA 91010

JOE RAYMOND
U.A. Local No. 364
223 S. Rancho Avenue
Colton, CA 92324

BILL STEINER
U.A. Local No. 398
8590 Utica Avenue, Suite 200
Rancho Cucamonga, CA 91730

SASHA STEVENS
U.A. Local No. 114
93 Thomas Road
Buellton, CA 93427

Summary Plan Description / Plan Rules & Regulations

of the

Southern California Pipe Trades

CHRISTMAS BONUS FUND

Contents

SECTION 1. INTRODUCTION

The Southern California Pipe Trades Christmas Bonus Fund ("Fund" or "Plan") was established in 1990 through the negotiating efforts of District Council No. 16 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada ("United Association") and Employers in the plumbing and pipefitting industry in Southern California. Union and Employer Trustees manage the Fund.

A) This Summary Plan Description

This Summary Plan Description/Plan Rules and Regulations ("SPD") summarizes the provisions of the Southern California Pipe Trades Christmas Bonus Plan. It applies on and after September 1, 2025. You must read this SPD carefully to understand how the Plan works. Please keep this SPD for future reference.

Plan rules may change from time to time, in which case a written notice explaining any important change will be sent to all covered households. Please read all Plan communications and keep them with this SPD.

B) Purpose of the Plan

The Plan was set up to provide benefits to certain Participants, surviving Spouses, or Beneficiaries in the Southern California Pipe Trades Retirement Fund. The Plan is funded by active Union members whose employers make contributions on their behalf per hour under a Collective Bargaining Agreement or a Participation Agreement.

C) Role of the Board of Trustees

The Board of Trustees is authorized to interpret all Plan rules and documents, including the Trust Agreement and this SPD. The Board of Trustees has the discretion to decide all questions about the Plan, including, but not limited to, questions about eligibility for participation in the Plan, rights to benefits, the amount of benefits that are payable, the information and proof necessary to substantiate a claim for benefits, and the definition of any Plan term. The Board of Trustees also has the authority to make any factual determinations concerning claims. No individual Trustee, Employer, or Union representative has the authority to interpret any Plan document on behalf of the Board of Trustees or to act as an agent of the Board of Trustees. The Board of Trustees may delegate its authority to a subcommittee or other subset of the Board of Trustees.

The Trustees intend to continue the Fund indefinitely. However, the Board of Trustees has the authority to amend or terminate the Plan as they deem appropriate.

D) Role of the Fund Office

The Board of Trustees has authorized the Fund Office to respond in writing to your written questions. As a courtesy, the Fund Office may also respond informally to questions by telephone, email, or in person at the Fund Office. However, such information and answers are not binding upon the Board of Trustees and cannot be relied upon in any dispute. Remember 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 independently determine your entitlement to benefits.

NOTE	**If you have any questions regarding eligibility, benefits, or procedures, contact the Fund Office.** **Southern California Pipe Trades Administrative Corporation** **501 Shatto Place, Suite 500** **Los Angeles, CA 90020** **Toll-Free: (800) 595-7473 / Outside U.S.: (213) 385-6161** **Website: www.scptac.org / Email: pension@scptac.org** **Change of Address Form submission: coa@scptac.org**

NOTE	**Capitalized terms are defined in Section 12, page 9.**

SECTION 2. CONTRIBUTIONS AND PLAN EXPENSES

The Plan is funded by contributions made by Employers signed to a Collective Bargaining Agreement that requires contributions to the Fund. The amount of the contributions is based on the hours worked by active Employees, and the Collective Bargaining Agreement determines the contribution rate. Contributions from Employers plus income earned, if any, from Fund investments go into a general fund from which the reasonable and necessary expenses of operating the Plan are deducted.

SECTION 3. DISTRIBUTABLE AMOUNT

The Accumulation Period is the 12-month period starting on November 1 of each year and ending on October 31. The Distributable Amount is the sum of the following:

i) The contributions received by the Fund during the Accumulation Period, on an accrual basis; plus
ii) Any income earned during the Accumulation Period; minus
iii) Any investment losses experienced during the Accumulation Period; minus
iv) The administrative costs paid during the Accumulation Period; minus
v) A small amount held in reserve.

See Section 8, page 4, for the formula for allocating the Distributable Amount.

SECTION 4. ELIGIBILITY FOR BENEFITS

A) Participants Eligible for benefits

A Participant is eligible to receive a Christmas Bonus benefit from the Fund if they:

i) Are a member in good standing with the Union; and
ii) Have received at least one pension payment from the Retirement Fund during the Accumulation Period; and
iii) Have not had their Retirement Fund pension benefit suspended by the Retirement Fund at any time during the Accumulation Period; and
iv) Have not engaged, during the Accumulation Period, in any work (including self-employment) in the plumbing and pipefitting industry unless that work was for an Employer signed to a Collective Bargaining Agreement with the United Association or an affiliated local union or district council.

B) Surviving Spouses

A surviving Spouse of a deceased participant in the Southern California Pipe Trades Retirement Fund is eligible for Christmas Bonus benefits for Accumulation Periods after the death of the Participant if:

i) The Participant was eligible for a Christmas Bonus Fund benefit at the time of their death; and
ii) The surviving Spouse received a monthly benefit from the Retirement Fund during the Accumulation Period; and
iii) The surviving Spouse was married to the Participant on the date of the Participant's death; and
iv) The surviving Spouse is alive on the date of the distribution.

Former Spouses who were not married to the Participant on the date of the Participant's death are not eligible for Christmas Bonus benefits payments. This is true even if they are receiving a monthly surviving Spouse benefit from the Retirement Fund or any other benefit payable by the Retirement Fund resulting from a Qualified Domestic Relations Order.

A surviving Spouse will not receive a Christmas Bonus benefit for the Accumulation Period during which the Participant died unless the Spouse is entitled to a benefit as a Beneficiary under the following section.

C) Beneficiaries

A Beneficiary of a deceased Participant is eligible for a single Christmas Bonus benefit payment if:

i) The Beneficiary is designated in writing as the Beneficiary by the Participant; and

ii) The Participant dies during the Accumulation Period; and
iii) The Beneficiary is alive on the date of the distribution.

There are no other benefit payments to a Beneficiary except for a single payment for the Accumulation Period during which the Participant dies.

The Beneficiary is the person or persons designated by the Participant. If there is more than one Beneficiary, the payment is divided equally among the Beneficiaries unless the Participant, before their death, has explicitly made a different allocation on a Beneficiary Form approved by the Fund Office.

If the Participant has not designated a Beneficiary or if the Beneficiary dies before the Participant, the payment will be made to the following in order of priority:

1) Surviving Spouse;
2) If none, to be divided equally among the surviving child(ren), including legally adopted child(ren);
3) If none, to the surviving parent(s);
4) If none, to be divided equally among the surviving sibling(s); or
5) If none, to your estate.

Domestic partners are never considered beneficiaries under these circumstances.

Participants may only designate a Beneficiary on the Beneficiary Form available from any local Union office, the Fund Office, or the Fund Office website at www.scptac.org. If the Participant designates their Spouse as their Beneficiary and subsequently gets divorced, the former Spouse is automatically revoked as the designated Beneficiary upon the date of divorce. Therefore, it is important that the Participant completes a new Beneficiary Form following a divorce, especially if they want the former Spouse to remain as the designated Beneficiary or want to designate a Beneficiary who would not be entitled to a benefit under the order of priority set forth above.

IMPORTANT	**If there is a change in your family status, such as marriage, divorce, death, or a change in status of a Beneficiary, or if your address changes, notify the Fund Office as soon as possible, but no later than 90 days after the change.**

SECTION 5. AMOUNT AND PAYMENT OF BENEFITS

The Distributable Amount is determined each year for the Accumulation Period ending October 31. This amount is automatically distributed among the eligible Participants, eligible surviving Spouses, and eligible Beneficiaries on or before December 31. The Christmas Bonus Fund benefit payments will only be mailed (or transmitted electronically via ACH if the Retirement Fund benefit is being sent via ACH). Christmas Bonus Fund checks cannot be picked up in person at the Fund Office.

The Trustees will allocate the Distributable Amount among the eligible Participants, eligible surviving Spouses, and eligible Beneficiaries based on one or more formulas as the Trustees may determine. The Trustees may change the formula or formulas each year based on such objective factors as they may determine from time to time. Such factors may include, but are not limited to, the number of Pension Credits with which each Participant has been credited, the amount of the monthly pension payable to each Participant, and the current contributions made to the Fund in the Union areas where the Participant worked.

SECTION 6. TAXATION OF BENEFITS

Christmas Bonus benefits are taxable income. You will receive a Form 1099-MISC from the Fund Office each year by the legal deadline. You should consult a tax professional for questions on taxes that may be due on this income.

SECTION 7. FORFEITURE OF UNCLAIMED BENEFITS

Any Christmas Bonus benefit that was not claimed by the eligible Participant, eligible surviving Spouse, or eligible Beneficiary within two years following the end of the Plan Year during which the benefit was distributed will be forfeited and retained by the Fund. No Employer, Participant, Surviving Spouse, Beneficiary, or any person, entity, or association, other than the Trustees, shall have any right, title, or interest in such monies. These forfeited benefits will be included as income to the Fund and will be included in the calculation of the Distributable Amount.

SECTION 8. BENEFIT FORMULA

The method by which the Distributable Amount is allocated to "eligible persons" (see Section 4) is summarized below. This method will continue to be used until the Trustees revise it.

A) Preliminary Benefit

The preliminary benefit is determined as follows:

i) The Distributable Amount is divided into two parts.
   a) The first part is for those eligible persons attached to pensions where most pension credits were earned under the former Local 460 Retirement Plan.
   b) The second part is for the remaining eligible persons.

   The Distributable Amount is allocated between the two parts proportionally, based on the number of eligible persons in each part.

ii) The portion of the Distributable Amount for each part is allocated pro-rata among that part's eligible persons based on the last monthly pension payment received by each eligible person during the Accumulation Period.

B) Reduction and Reallocation of Benefits

An eligible person's preliminary benefit is reduced as follows:

i) The preliminary benefit for an eligible person attached to a pension with any service originally earned under the former Local 460 Retirement Plan is reduced so that it does not exceed the amount of the largest benefit among the remaining eligible persons.

ii) An eligible person's benefit is reduced proportionally for those years after 1993, in which the Participant had Christmas Bonus Fund contributions based on a number of hours that is less than 50% of their hours reported to the Retirement Fund. This reduction is based on a fraction, the numerator of which is the total number of Retirement Fund pension credits earned during such years with insufficient Christmas Bonus Fund contributions and the denominator of which is the total number of Retirement Fund pension credits earned.

   In determining whether the Participant had Christmas Bonus Fund contributions for at least 50% of their Retirement Fund hours in the years 1994 through 1999, credit under the Local 460 Retirement Plan is treated as if it had been earned under the Retirement Fund and as if Christmas Bonus Fund contributions had been made for those hours.

   Christmas Bonus Fund contributions are not made based on hours worked outside District Council No. 16, even when pension contributions for those hours are reciprocated to the Retirement Fund. In addition, some Collective Bargaining Agreements do not require contributions to the Christmas Bonus Fund.

C) Final Benefit

The total amount of all reductions is then reallocated to eligible persons whose benefits were not reduced, as outlined above in Sections 8(A) and 8(B)(i).

SECTION 9. APPEALS PROCEDURE

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

A) Processing a Claim for Benefits

The Fund will treat any application or written request for a Plan benefit or any other written claim for Fund action made by you or your authorized representative in accordance with the procedures described in this SPD as a "claim for benefits." You have the right to appeal any Fund decision regarding the amount or timing of a benefit or any other Fund decision affecting your rights under the Plan using the procedures set forth below.

Every effort will be made to process your claim within 90 days after receipt by the Fund Office. This 90-day period will begin upon receipt of the written claim by the Fund Office without regard to whether all of the information necessary to decide the application has been submitted.

If a decision on your claim for benefits cannot be made within 90 days of its receipt, a letter will be sent to you before the expiration of the 90 days, explaining the special circumstances requiring another 90 days to take action. If final action cannot be taken at the end of the second 90-day period, you will be sent a written explanation before the expiration of the second 90-day period. Where appropriate, you will be awarded any partial benefits that can be determined with the available information. If partial benefits cannot be awarded because of a lack of necessary information, the Fund Office will conditionally deny your claim. The Fund Office will continue to seek the necessary information to make a final determination.

B) Notice of Decision on Your Claim

If your claim for benefits is denied, in whole or in part, the Fund Office will provide you with a written notice that (1) states the specific reason(s) for the denial, (2) refers to the specific Plan provisions on which the denial is based, (3) describes any additional material or information that might help your 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 lawsuit under Section 502(a) of ERISA.

C) Appealing a Benefit Denial

If your claim for benefits is denied, in whole or in part, you may request that the Board of Trustees review the benefit denial. The Board of Trustees has delegated the responsibility to decide appeals to its Appeals Committee. (In some cases, the Board of Trustees may decide to consider an appeal; in other cases, the Appeals Committee may delegate the responsibility to consider an appeal to a subset of the Committee.) All appeals must be in writing and must be received by the Fund Office within 180 calendar days after you receive the written notice of the denial from the Fund Office. Failure to file a timely written appeal shall constitute a complete waiver of your right to appeal, and the decision of the Fund Office will be final and binding.

In presenting your appeal, you can submit written comments, documents, records, and other information about your claim. You are also entitled to receive reasonable access to and copies of all documents, records, and other information relevant to your claim upon request and free of charge. Personal appearances on appeals are at the discretion of the Appeals Committee.

Your written appeal should state the specific reasons why you believe the denial of your claim was in error. You should also submit any documents or records that support your claim. This does not mean that you are required to cite all of the Plan provisions that apply or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefits or other relief you are claiming. The Appeals Committee can best consider your position if it clearly understands your claims, reasons, or objections.

The review of the Appeals Committee will consider all comments, documents, records, and other information you submit, whether or not it was submitted to or used by the Fund Office in its determination. The Appeals Committee will also not afford deference to the initial decision by the Fund Office.

The Fund Office 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.

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 Fund Office receives the appeal. 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 you before the beginning of the extension. Such an extension may only last until the third meeting following receipt of the appeal.

D) Notice of Decision on 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.

If your appeal is denied, in whole or in part, you will receive a written decision that will include: (1) the specific reason(s) for the denial; (2) the specific Plan provisions on which the denial is based; (3) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your appeal and (4) a statement of your right to bring a lawsuit under Section 502(a) of ERISA.

E) Decision on Appeal is Final and Binding

The decision of the Appeals Committee is final and binding on all parties, including anyone claiming a benefit on your behalf.

Once a final decision is made, there is no right to re-file the same appeal or to request reconsideration. If such an appeal or request for reconsideration is filed, the Appeals Committee may refuse to consider it.

The Board of Trustees and, by delegation, the Appeals Committee, has complete discretion and authority to determine all matters relating to appeals including, but not limited to, eligibility for benefits, the amount of benefits to which individuals are entitled, the standard of proof required for any claim, and the application and interpretation of the Plan. The Board of Trustees has the ultimate authority to hear any appeal. It has generally delegated this authority to the Appeals Committee to decide appeals. However, the Board of Trustees has the right and authority to hear any appeal. In such a case, the rights and procedures set forth herein shall apply equally to the Board of Trustees.

If the Appeals Committee denies your appeal, and you decide to seek judicial review, the Appeals Committee's decision will be subject to limited judicial review to determine only whether the decision was arbitrary and capricious. Generally, 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 before the decision on your appeal. No legal action may be commenced against the Trust, the Plan, or the Trustees more than two years after a claim has been denied on appeal.

F) Right to be Represented

In making a claim or appeal, you may be represented by any authorized representative. If your representative is not an attorney or court-appointed guardian, you must designate the representative by a signed written statement. However, neither you nor your representative has a right to an in-person hearing or appearance before the Trustees or the Appeals Committee.

G) Any Adverse Decision May Be Appealed

The recipient of any written correspondence from the Fund Office that could be interpreted as adversely affecting the recipient's interest may appeal to the Appeals Committee for a review of the content of that correspondence. Such a request for review must be in writing and made within 180 calendar days after receiving the correspondence from the Fund Office. Such appeals will be processed in the same manner as appeals from determinations on benefit applications.

SECTION 10. IMPORTANT NOTICES

A) No Assignment of Benefits

You may not pledge your benefit as security for a loan or any other purpose. You may not assign your benefit to any other individual, entity, or party. Also, as a welfare benefits plan, the Christmas Bonus Fund does not recognize Qualified Domestic Relations Orders and will not pay benefits to a former Spouse or any alternate payee under a Qualified Domestic Relations Order.

B) Erroneous Payments

Every effort will be made to ensure accuracy in paying your benefits. However, if an error is discovered, regardless of how long ago it occurred, and it is determined that the Fund has paid any benefits you are not entitled to, you are obligated to reimburse the Fund for the erroneous payments. The Trustees have the right to seek repayment from you through any legal means, including the right to reduce future benefit payments to the extent permissible under ERISA.

C) 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 erroneous amounts paid by the Fund, and you will be liable for all costs of collection, including attorneys' fees. 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 payment made because of fraud or misrepresentation.

SECTION 11. INFORMATION REQUIRED BY ERISA

The following additional information concerning the Plan is provided to you per the Employee Retirement Security Act of 1974 (ERISA). The terms in this section are generally as defined in ERISA unless capitalized.

A) Name and Type of Plan

The name of the Plan is the Southern California Pipe Trades Christmas Bonus Plan. It is a multiemployer welfare benefit plan.

B) Identification Numbers

The Fund's Internal Revenue Service tax identification number is 95-4349805. The Plan number is 501.

C) Plan Year

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

D) Plan Sponsor, Named Fiduciary, and Administrator

The Plan is maintained pursuant to a collectively bargained labor-management trust. The Board of Trustees is the Plan sponsor, the Plan administrator, and the named fiduciary under ERISA.

E) Board of Trustees

The Board of Trustees consists of Employer and Union representatives, selected by the Employers and the Unions, per 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	(800) 595-7473
Southern California Pipe Trades Christmas Bonus Fund	(213) 385-6161
501 Shatto Place, Suite 500	www.scptac.org
Los Angeles, CA 90020	info@scptac.org

F) Fund Office

The Board of Trustees has designated the Southern California Pipe Trades Administrative Corporation to perform the daily business functions of the Plan. You may contact the Fund Office at:

Southern California Pipe Trades Administrative Corporation	(800) 595-7473
Attention: CEO/Administrator	(213) 385-6161
501 Shatto Place, Suite 500	www.scptac.org
Los Angeles, CA 90020	info@scptac.org

G) Agent for Service of Legal Process

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

Southern California Pipe Trades Christmas Bonus Fund
Attention: CEO/Administrator
501 Shatto Place, Suite 500
Los Angeles, CA 90020

Service of legal process may also be made upon a plan trustee or the plan administrator.

H) Source of Contributions and Identity of any Organization Through Which Benefits are Provided

All contributions to the Fund are made by Employers per their Collective Bargaining Agreements or per the terms of a Participation Agreement. The Collective Bargaining Agreements and Participation Agreements require that contributions be made to the Fund at fixed rates per hour of work.

Upon written request, the Fund Office will provide you with a complete list of Employers and Unions that are parties to a Collective Bargaining Agreement and their addresses. The Fund Office will also provide information about whether a particular employer is obligated to contribute to the Fund on behalf of employees working under a Collective Bargaining Agreement or Participation Agreement and the address of any such employer.

The Fund's assets are held in trust by the Board of Trustees. Custody of the Fund's assets is with U.S. Bank, N.A. Benefits are provided directly from the Fund's assets, which are accumulated under the provisions of the Trust Agreement. The assets are used

exclusively for providing benefits to participants' beneficiaries per the provisions of the Plan and for paying the reasonable administrative expenses of the Fund.

All types of benefits provided by the Plan are outlined in this SPD.

I) Collective Bargaining Agreement

Contributions to the Fund are made per Collective Bargaining Agreements between Employers and District Council No. 16 of the United Association or affiliated local unions of District Council No. 16 or the United Association. The United Association local unions affiliated with District Council No. 16 are 78, 114, 230, 250, 345, 364, 398, 403, 460, 484, 582, and 761. Upon written request, the Fund Office will provide you with a copy of the applicable Collective Bargaining Agreement. The Collective Bargaining Agreement is also available for examination at the Fund Office. The following are the employer associations with whom District Council No. 16 has a bargaining relationship which requires contributions to this Fund:

i) California Plumbing & Mechanical Contractors Association (CPMCA);
ii) Airconditioning, 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 this Plan will continue indefinitely, but the Board of Trustees reserves the right to change or discontinue the Plan at any time. The Trustees may terminate the Plan 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 become due. The Plan may also be terminated if no individuals living can qualify as participants or beneficiaries under the Plan or if there are no longer any Collective Bargaining Agreements requiring contributions to the Fund. The Trustees have the complete discretion to determine when and if the Fund should be terminated.

If the Plan is terminated, the Trustees will: (i) pay the expenses of the Fund incurred up to the date of termination as well as the expenses in connection with the termination; (ii) arrange for a final audit of the Fund; (iii) give any notice and prepare and file any reports required by law; and (iv) apply the assets of the Fund per the law and the Plan, including amendments adopted as part of the termination, until the assets are distributed. Under no circumstances will any portion of the Fund revert to the benefit of an Employer, any employer association, or the Union.

Upon termination of the Plan and Fund, the Trustees will promptly notify the Union, any employer association, Employers, and all other interested parties. The Trustees will continue as Trustees to wind up the affairs of the Plan.

K) Actions of Trustees

The Trustees have complete discretion and authority over the standard of proof for any inquiry, claim, or appeal and over the application and interpretation of the Plan and trust. No legal proceeding may be filed in any court or before an administrative agency against the Plan or its Trustees unless all review procedures with the Trustees have been exhausted. No legal action may be commenced against the trust, the Plan, or the Trustees more than two years after a claim has been denied.

L) Right to Amend

The Trustees have the complete discretion to amend or modify the Plan or trust and any of their provisions, in whole or in part, at any time.

M) ERISA Rights

As a Participant in the Southern California Pipe Trades Christmas Bonus Fund, you have 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

a) Examine, without charge, at the plan administrator's office and 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 Employee Benefits Security Administration.
b) 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 an updated summary plan description. The plan administrator may make a reasonable charge for the copies.
c) Receive a summary of the Plan's annual financial report. The plan administrator must furnish each Participant with a copy of this summary annual report.

ii) Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, must 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.

iii) Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits 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 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.

iv) Assistance with Your Questions

If you have any questions about your Plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the 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 Benefit Security Administration.

IMPORTANT	**None of the benefits described in this SPD/Rules & Regulations are guaranteed by any insurance contract.There is no liability on the part of the Board of Trustees or any individual or entity to provide payment over and above the amounts in the Fund collected for such purpose.**

SECTION 12. DEFINITIONS

Accumulation Period

The twelve-month period starts on November 1 of each year and ends on the following October 31.

Appeals Committee

A subset of the Board of Trustees empowered to review any claims as described in Section 9.

Beneficiary

A Beneficiary is a person designated by you or by the Plan to receive benefits when you die.

Board of Trustees

All of the Trustees established as one body per the Trust Agreement.

Calendar Year

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

Collective Bargaining Agreement
Any and all negotiated labor agreements between a Contributing Employer, or employer association acting on behalf of Employers, and Southern California Pipe Trades District Council No. 16 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada ("United Association"), or any local union affiliate of the District Council that requires contributions to the Southern California Pipe Trades Christmas Bonus Fund. It also refers to an agreement, to which the United Association is a party, requiring contributions to the Fund.

Contributing Employer
An Employer signed to a Collective Bargaining Agreement or Participation Agreement, or an Employer that assigns its bargaining rights to an employer association signed to a Collective Bargaining Agreement, that requires contributions to the Fund.

Covered Employment
Work by an Employee under a Collective Bargaining Agreement.

Distributable Amount
The Distributable Amount is the sum of (1) the contributions received by the Fund during the Accumulation Period on an accrual basis; plus (2) any income earned during the Accumulation Period; minus (3) any investment losses experienced during the Accumulation Period; minus (4) the administrative costs paid during the Accumulation Period; minus (5) a small amount held in reserve.

Employee
An Employee is anyone employed by a Contributing Employer in a position for which the Employer contributes to the Fund under a Collective Bargaining Agreement. Employees may also include an Employer or someone employed by an organization signatory to a Participation Agreement.

Employer
See Contributing Employer.

ERISA
Employee Retirement Income Security Act of 1974, as amended. See Section 11(M), page 8, for an explanation of your ERISA rights.

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

Fund Office
Southern California Pipe Trades Administrative Corporation
501 Shatto Place, Suite 500
Los Angeles, CA 90020

(800) 595-7473
(213) 385-6161
www.scptac.org
pension@scptac.org

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 permitting a Contributing 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 not covered by a Collective Bargaining Agreement.

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

Plan Year
January 1 through December 31 of each year.

Retirement Fund
The Southern California Pipe Trades Retirement Fund.

SPD
Summary Plan Description. This document. A summary of the provisions of, and benefits available under, the Southern California Pipe Trades Christmas Bonus Fund.

Spouse
Any person to whom a Participant was legally married at the time of the Participant's death.

Trust Agreement
The written document titled "Restated Agreement and Declaration of Trust Continuing the Southern California Pipe Trades Christmas Bonus Fund" under which the Fund has been established and maintained, and to which this Plan has been adopted and any amendments thereto.

Trustees
Employer and Union representatives who oversee the Fund.

Union(s)
Southern California Pipe Trades District Council No. 16 of the United Association of Journeymen and Apprentices of the Plumbing and Pipefitting Industry of the United States and Canada, AFL-CIO ("United Association"), and its affiliated local unions, and such other unions which have or may in the future become parties to and agree to be bound by the Trust Agreement.

SECTION 13. TRUSTEES

The following is a list of the Trustees as of the publication date of this SPD. The members of the Board of Trustees may change from time to time. If you want a current listing of the Trustees, contact the Fund Office.

A) Employer Trustees

RYAN CAVANAUGH
Murray Company
5995 Plaza Drive
Cypress, CA 90630

ROBERT FELIX
All Area Plumbing/ACCO Engineered Systems, Inc.
6446 E. Washington Blvd.
Commerce, CA 90040

JASON GORDON
Prime SC Mechanical, Inc.
7392 Earl Circle
Huntington Beach, CA 92647

JEFF HACHEY
H.L. Moe Company, Inc.
526 Commercial Street
Glendale, CA 91203

ADAM KAPLAN
Sierra Commercial Plumbing, Inc.
4645 Industrial Street, Unit C
Simi Valley, CA 93063

CHIP MARTIN
CPMCA
1735 Flight Way, Suite 204
Tustin, CA 92782

JOHN MODJESKI
University Mechanical & Engineering Contractors
1168 Fesler Street
El Cajon, CA 92020

JEFF STEVANUS
Southland Industries
12131 Western Avenue
Garden Grove, CA 92841

BRYAN SUTTLES
Suttles Plumbing
2267 Agate Court
Simi Valley, CA 93065

STEVE VALOT
Pan-Pacific Mechanical
18250 Euclid Street
Fountain Valley, CA 92708

LAWRENCE VERNE
Verne's Plumbing, Inc.
8561 Whitaker Street
Buena Park, CA 90621

PIP ZAIDE
Allegiant Mechanical, Inc.
7776 Westminster Blvd.
Westminster, CA 92683

B) Union Trustees

DAVID BALDWIN
U.A. Local No. 403
3710 Broad Street
San Luis Obispo, CA 93401

STEVEN BERINGER
U.A. Local No. 230
6313 Nancy Ridge Drive
San Diego, CA 92121

SHANE BOSTON
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1955 N. Ventura Avenue
Ventura, CA 93001

BEN CLAYTON
U.A. Local No. 250
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Gardena, CA 90248

RODNEY COBOS
District Council No. 16
501 Shatto Place, Suite 400
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JEREMY DIAZ
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1111 W. James M. Wood Blvd.
Los Angeles, CA 90015

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Burbank, CA 91505

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1430 Huntington Drive
Duarte, CA 91010

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223 S. Rancho Avenue
Colton, CA 92324

BILL STEINER
U.A. Local No. 398
8590 Utica Avenue, Suite 200
Rancho Cucamonga, CA 91730

SASHA STEVENS
U.A. Local No. 114
93 Thomas Road
Buellton, CA 93427