Supplemental Summary Plan Description / Plan Rules & Regulations

of the

Landscape, Irrigation and Lawn Sprinkler Industry

HEALTH & WELFARE FUND

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SECTION 1. INTRODUCTION

The Landscape, Irrigation and Lawn Sprinkler Industry Health and Welfare Fund ("Fund" or "Plan") was established in 1993 through the negotiating efforts of the Union and Employers in the plumbing and sprinkler fitting industry in Southern California. Union and Employer Trustees manage the Fund.

A) This Supplemental Summary Plan Description

This Supplemental Summary Plan Description/Plan Rules and Regulations ("Supplemental SPD"), along with the Western Growers Assurance Trust ("WGAT") Summary Plan Description and other documents issued by insurers and benefit providers described in this Supplemental SPD, copies of which have been provided to you and are available upon request, constitute the Plan document of the Landscape, Irrigation and Lawn Sprinkler Industry Health and Welfare Plan. This Supplemental SPD applies on and after January 1, 2020. It is very important that you read this Supplemental SPD and other documents carefully to understand how the Plan works. Please keep this Supplemental 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 be sure to read all Plan communications and keep them with this Supplemental SPD.

B) Purpose of the Plan

The Plan was created to provide medical, dental, prescription drug, vision, life, 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. The Plan pays claims only for benefits provided under the Plan. The Plan does not pay benefits for work-related illnesses and injuries.

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 Supplemental SPD. The Board of Trustees has the authority to decide all questions concerning rights and benefits described in this Supplemental SPD, and not provided through insurers and benefit providers, including, but not limited to, questions about eligibility for participation in the Plan, rights to benefits, and the definition of any Plan term. The Board of Trustees also has the authority to make any factual determinations on these matters.

No individual Trustee, Employer, or Union representative has 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 Board of Trustees has the authority to determine if you have satisfied the eligibility rules required for benefits and the type of benefits to which you may become eligible. The insurer of a particular benefit will determine if you have a valid claim for its benefits and to what extent the benefits will be paid. The determination will include claims for hospital, medical, prescription drugs, dental, vision, life, accidental death or dismemberment claims. Details of the insured benefits are contained in the WGAT Summary Plan Description and other insurer policies and documents reference in paragraph (A) above.

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. Keep in mind that in all matters communicated to you, verbal or written, the Board of Trustees will have the ultimate authority and discretion to interpret the Plan documents and make an independent determination about your entitlement to benefits.

NOTE	**If you have any questions regarding eligibility, benefits, or procedures, contact the Fund Office.** **Landscape, Irrigation and Lawn Sprinkler Industry Health and Welfare Fund** **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**

NOTE	**Capitalized terms are defined in Section 12, page 25.**

Aviso A Los Participantes Del Idioma Español

Este folleto contiene informes importantes acerca de sus beneficios del Plan de Salud y Bienestar, si tiene dificultad al comprendiendo cualquier parte de los informes, por favor llame a la oficina administrativa al (800) 595-7473 o visite la oficina ubicada en 501 Shatto Place, Suite 500, Los Angeles, CA 90020. La oficina está abierta Lunes, Martes, Miércoles, y Viernes de 8:00 a.m. a 4:00 p.m. y Jueves de 8:00 a.m. a 6:00 p.m. Un representante que habla Español estará disponible para ayudarle.

SECTION 2. ENROLLMENT

A) Enrolling Yourself

When you become eligible, the Fund Office will send you an Enrollment Form.

In addition to the Enrollment Form, you must also complete enrollment forms for Western Growers Assurance Trust ("WGAT"), Dental Health Services, Anthem Blue Cross Blue View Vision, and Hartford, and any other benefit provider under the Plan. These forms will be provided to you by the Fund Office when you become eligible. You may obtain all forms at any time from the Fund Office or the Fund Office website at www.scptac.org.

You cannot be enrolled for benefits until the Fund Office receives the necessary completed forms.

B) Enrolling an Eligible Dependent

Eligible Dependents are covered under the same medical, prescription drug, vision, and dental programs as you are. There are no life or accidental death or dismemberment benefits for Eligible Dependents.

In order to enroll Eligible Dependents, you must complete an Enrollment Form and provide required documents.

If required documentation is not submitted by the 60-day deadline, coverage will not be retroactive. These dates may be further limited by the Plan's providers of benefits.

You may obtain all forms from the Fund Office or the Fund Office website at www.scptac.org.

C) Designating a Beneficiary

In order to designate a life insurance Beneficiary(ies), you must complete both a Hartford Life Insurance Beneficiary form and a WGAT enrollment card.

You may obtain all forms from the Fund Office or the Fund Office website at www.scptac.org.

D) Required Documents

In order 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) A certified copy of the Domestic Partnership registration; or
iii) A certified copy of the birth certificate; or
iv) A copy of the document placing the child for adoption or finalizing the adoption; or
v) A copy of the death certificate; or
vi) A copy of the final divorce decree; or
vii) 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 as listed above within 60 days of the date of marriage or Domestic Partnership registration. If the enrollment form and required documents are not received within 60 days of the date of marriage or Domestic Partnership, coverage will not be retroactive to the date of marriage or Domestic Partnership. 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 within 60 days of the date of birth or placement of adoption, or the eligibility date of your child will be delayed. You must notify the Fund Office immediately if there is a delay in obtaining a copy of the certified birth certificate or adoption documents.

iii) Death Certificates

A copy of the death certificate should be submitted to the Fund Office no later than 60 days of the death of any person covered by the Plan. If the Fund Office is not notified, COBRA 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 any benefits paid on their behalf after the date of divorce or dissolution of partnership.

F) Change of Address

If you want to change your address, you must complete a Change of Address Form and return it to the Fund Office. 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.

IMPORTANT	**If there is a change in your family status, such as marriage, divorce, dissolution or death, or a change in status of an Eligible Dependent or Beneficiary, or if your address changes, notify the Fund Office as soon as possible, but no later than 60 days after the change.**

SECTION 3. ELIGIBILITY

A) Establishing and Re-establishing Eligibility

You become eligible to participate in the Plan based on hours credited to your Eligibility Bank by Contributing Employer contributions to the Plan. Employers make contributions to the Plan on behalf of Employees working in employment covered by a Collective Bargaining Agreement.

You and your Eligible Dependents become eligible for benefits after you have worked, and your Employer has paid for, 300 hours in Covered Employment within 24 consecutive months. If you lose eligibility it will be reinstated after you have worked, and your Employer has paid for, 300 hours in Covered Employment within 24 consecutive months.

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.

B) Maintaining Eligibility

Hours paid for on your behalf by a Contributing Employer will be credited to your Eligibility Bank. The maximum hours that may be credited to your Eligibility Bank is the amount that will provide six months of eligibility (i.e., 900 hours).

Hours will be deducted from your Eligibility Bank for each month of eligibility. This charge, called the Monthly Deduction Amount, is 150 hours.

If your Eligibility Bank balance falls below the Monthly Deduction Amount, 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 hours will be forfeited.

Example 1 - Date Coverage Commences

Month	Hours for which Employer Contributions Received	Eligible?	Hours Deducted For Eligibility Month	Eligibility Bank Balance
January	90	No	0	90
February	120	No	0	210
March	90	No	0	300
April	70	No	150	220
May	80	Yes	150	150

Example 2 - Date Coverage Commences

Month	Hours for which Employer Contributions Received	Eligible?	Hours Deducted For Eligibility Month	Eligibility Bank Balance
January	120	No	0	120
February	180	No	0	300
March	90	No	150	240
April	70	Yes	150	160
May	80	Yes	150	90

Example 3 - Date Coverage Terminates

Month	Hours for which Employer Contributions Received	Eligible?	Hours Deducted For Eligibility Month	Eligibility Bank Balance
January	120	No	0	120
February	180	No	0	300
March	90	No	150	240
April	70	Yes	150	160
May	80	Yes	150	90
June	0	No	0	90

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.**

C) Suspension & Termination of Eligibility

i) When Coverage is Terminated

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 3(B), page 4); or
2) The last day of the month in which the maximum months permitted for COBRA coverage have been reached; or
3) The date a 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 3(E), page 8); or
7) The effective date on which the Board of Trustees terminate the Plan or modify the Plan resulting in the loss of your eligibility.

ii) Rescissions of Coverage

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. The Fund must provide 30-days' notice to each Participant who would be affected by the rescission before a rescission can occur.

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 disqualifying event and COBRA is not elected and/or the full COBRA premium is not paid by the Employee or ex-Spouse for coverage. In these circumstances the Fund may terminate coverage, retroactively, without notice. Prospective termination is not a rescission.

D) Dependent Eligibility

i) Who are Eligible Dependents?

Your Eligible Dependents may be:

1) Your Spouse; or
2) Your Domestic Partner; and/or
3) Your or your Spouse's or your Domestic Partner's:
   a) natural child; and/or
   b) legally adopted child; and/or
   c) child placed for adoption; and/or
   d) child placed under legal guardianship .

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

You will be required to 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 coordination of benefit rules will apply. (See Section 7, page 17.)

iii) When Eligible Dependent Coverage Starts

Once you have provided the required documentation as stated in Section 2(D) by the 60-day deadline as stated in Section 2(E), your Eligible Dependent(s) coverage starts on the later of the following dates:

1) The date you become eligible;
2) The date the child is born, or the earlier of the date a child is placed with you for adoption or the adoption is finalized or legal guardianship is established; or
3) Your date of marriage or Domestic Partnership registration, unless more than 60 days has passed since the date of marriage or registration, in which case the first of the month after the date the Fund Office receives your marriage certificate or Domestic Partnership registration.

If required documentation is not submitted by the 60-day deadline, coverage will not be retroactive. These dates may be further limited by the Plan's providers of benefits.

iv) Special Enrollment Rules

1) The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that if you fail to enroll for a plan or elected not to enroll your Dependents, you will have the option to enroll under the following circumstances:
   a) When you marry; or
   b) When you have a new Eligible Dependent (either as a result of birth, adoption, or marriage to a person who has children); or
   c) When your legal Spouse or Domestic Partner was covered under another group health plan and lost eligibility, exhausted COBRA continuation coverage, or there was a substantial change in the coverage or cost so that the Spouse or Domestic Partner could no longer be covered.
2) There is a special 60-day enrollment period for an Eligible Dependent who meets the definition of a "qualifying child" if he or she (1) loses eligibility for Medicaid or Children's Health Insurance Program ("CHIP") coverage under state law or (2) becomes eligible to participate in a premium assistance program under Medicaid or CHIP. You must request enrollment in the Plan within 60 days of loss of Medicaid/CHIP or of the eligibility determination.

   The Fund Office cannot answer questions concerning your rights under state-sponsored programs. The state of California or the state of your residency can assist you with Medicaid or CHIP eligibility questions.

v) When Dependent Coverage Terminates

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

1) The date your eligibility terminates for reasons other than your death (see also Section 3(D)(vi) below); or
2) The end of the month in which 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
3) The first of the month after you submit an application to dis-enroll your dependent; or
4) The end of the month in which your child is adopted by another person; or
5) The date of death of the dependent; or
6) The effective date on which the Board of Trustees terminate the Plan or modify the Plan resulting in the loss of your eligibility.

Eligibility may be extended under COBRA Continuation Coverage. (See Section 4, page 8)

IMPORTANT	**No benefits are payable after the loss of Eligible Dependent status. You will be required to refund any benefit payments or insurance premiums incurred after the date coverage should have been terminated due to loss of eligibility. It is the responsibility of the Participant to report any changes in Eligible Dependent status.**

vi) Surviving Eligible Dependents of Deceased Participants

In the event of the Participant's death, Eligible Dependents will remain eligible for benefits until the Eligibility Bank is depleted. When the Eligibility Bank is depleted, Eligible Dependents may continue coverage only under COBRA. (See Section 4, page 8)

vii) Qualified Medical Child Support Order (QMCSO)

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

A QMCSO is a court order or administrative notice that meets certain legal requirements. 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) 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 4, page 8)

i) USERRA Continuation Coverage

USERRA continuation coverage is generally the same as COBRA coverage and will be provided for the lesser of (a) 18 months from the end of the month during which your Qualified Uniformed Service begins or (b) the period beginning at the end of the month during which 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 a period of 30 days or fewer, the continuation coverage is provided at no cost. If your Qualified Uniformed Service is for 31 or more days, you may be charged you up to 102% of the full cost of coverage, as with COBRA.

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

1) 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.

2) 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 Office and WGAT in writing that you are leaving to perform Uniformed Service and that you elect to continue your medical coverage and/or that you elect to freeze your Eligibility Bank. Within 60 days after receipt of that notice, the Fund Office will provide you with specific information regarding the cost of USERRA continuation coverage, if you so elect.

If you do not give advance notice of your leave for Uniformed Service to the Fund Office, your coverage will be terminated as of the last day of the month during which 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.

SECTION 4. EXTENDING ELIGIBILITY – COBRA CONTINUATION COVERAGE

You may be able to extend eligibility by paying for COBRA continuation coverage if you experience a Qualifying Event.

COBRA applications and election forms will be sent to you if the Fund Office is aware that you are eligible.

A) What is COBRA Continuation Coverage?

Federal law (the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA) requires that most group health plans (including this Plan) give Employees and their families the opportunity to continue their health care coverage when there is a

"Qualifying Event" that would result in a loss of coverage under the Plan. Depending on the type of Qualifying Event, "Qualified Beneficiaries" can include the Employee covered under the group health plan, a covered Employee's eligible Spouse, and eligible child(ren) of the covered Employee. Neither a Domestic Partner nor the Domestic Partner's children are Qualified Beneficiaries under COBRA, but may be covered if the Participant is a Qualified Beneficiary.

Before making a decision to purchase COBRA, review the costs and benefits available through the Covered California marketplace. You may also be eligible for special enrollment in an employer-provided plan in which your Spouse or Domestic Partner participates.

You, your eligible Spouse, and your eligible child have the option of electing one or both of the following COBRA Plans:

i) Medical coverage – Provides coverage for medical only.
ii) Dental and vision coverage – Provides coverage for dental and vision.

Death, accidental death or dismemberment 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:

i) A reduction in your Eligibility Bank to a level below the Monthly Deduction Amount due to layoff (see Section 3(B), page 4);
ii) Reduced hours;
iii) Voluntary termination;
iv) Disability;
v) Retirement; or
vi) Any other reason except gross misconduct.

If you do not elect COBRA coverage, your eligible Spouse and eligible children 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:

i) A reduction in your Eligibility Bank to a level below the Monthly Deduction Amount (see Section 3(B), page 4) due to layoff, reduced hours, voluntary termination, disability, retirement, or any other reason except gross misconduct.
ii) Your death; or
iii) Your divorce; or
iv) Cessation of your Domestic Partnership.

Note that neither a Domestic Partner nor the Domestic Partner's children are Qualified Beneficiaries 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:

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

E) How Long will Continuation Coverage Last?

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. 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:

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

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

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

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	18 months after date of Qualifying Event*
2. Termination of covered Participant's employment	Participant, Spouse and eligible children	18 months after date of Qualifying Event*
3. Death of covered Participant	Spouse and eligible children	36 months after the date of Qualifying Event
4. Divorce of covered Participant	Spouse	36 months after date of Qualifying Event
5. Eligible child's loss of that status	Affected eligible child	36 months after date of 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	Later of 18 months from the Qualifying Event or 36 months from the date of the Participant's Medicare entitlement

* Continuation periods on lines 1, 2, and 3 begin after the Eligibility Bank, if any, is exhausted.

F) Disability

An 11-month extension of coverage may be available if any of the Qualified Beneficiaries is disabled. This would result in a maximum period of continuation coverage of 29 months. The disability has to have started at some time before the 60th day of continuation coverage and must last at least until the end of the 18-month period of continuation coverage. In order to be considered disabled under the terms of the Plan, the Qualified Beneficiary must be determined to be disabled by the Social Security Administration (SSA). If any Qualified Beneficiary was determined to be disabled by the SSA prior to the beginning of continuation coverage, you must notify the Fund Office of that fact within the first 60 days of continuation coverage. If any Qualified Beneficiary becomes disabled within the first 60 days of continuation coverage, you must notify the Fund Office of that fact within 60 days of the SSA's determination and before the end of the first 18 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 11-month disability extension if one of them qualifies.

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

G) Duty to Notify the Fund

i) Divorce or Dissolution of Domestic Partnership

Coverage for a Spouse or Domestic Partner ends on the date of divorce or dissolution of 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 be required to reimburse overpayments. Moreover, COBRA coverage will not be offered to the former Spouse.

Neither a Domestic Partner nor the Domestic Partner's children are Qualified Beneficiaries under COBRA, but may be covered if the Participant is a Qualified Beneficiary.

ii) 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 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.

iii) 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 and other benefits, if applicable, may not be offered.

H) How Is Continuation Coverage Elected?

To elect continuation coverage, you must complete the election form(s) provided by the Fund Office and by WGAT and return them within 60 days, according to the directions on the form. Each Qualified Beneficiary has a separate right to elect continuation coverage.

I) How Much Does Continuation Coverage Cost?

You are required to pay the entire cost of continuation coverage. The amount you will 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.

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

i) Your First Payment

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

However, you must make your first payment for continuation coverage no later than 45 days from the date of your timely election. 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 45 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 14. 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.

ii) Periodic Payments for Continuation Coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments are due by the 1st day of the 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.

iii) Grace Period for Periodic Payments

Although periodic payments are due on the dates shown above, you will be given a grace period until 30 days after the 1st of the month of coverage 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 July 1st. If payment is not received by July 30th, your coverage will be terminated.

iv) Form of Payment

All payments must be made by check, cashier's check, or money order. Cash is not accepted for COBRA payments.

K) For More Information

If you have any questions about vision or dental coverage under COBRA, please contact the Fund Office at:

Landscape, Irrigation and Lawn Sprinkler Industry Health and Welfare Fund
Attention: Eligibility Department
501 Shatto Place, Suite 500
Los Angeles, CA 90020

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

If you have any questions about hospital, medical, and prescription drug coverage under COBRA, please contact Western Growers Assurance Trust at:

Western Growers Assurance Trust
17620 Fitch Street
Irvine, CA 92614

(800) 777-7898
www.wgat.com

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.

SECTION 5. CARRIERS & PROVIDERS OF SERVICE

The insurance carriers and providers of service for this Plan are:

A) For hospital, medical, and prescription drug benefits

Western Growers Assurance Trust
17620 Fitch Street
Irvine, CA 92614
(800) 777-7898
www.wgat.com

For complete details regarding these benefits, see the WGAT Summary Plan Description and other documents provided by WGAT.

B) For dental benefits

Dental Health Services
3833 Atlantic Avenue
Long Beach, CA 90807
(562) 595-6000
www.dentalhealthservices.com

For complete details regarding these benefits, see the Combined Evidence of Coverage and Disclosure Form.

C) For vision benefits

Anthem Blue Cross Blue View Vision
PO Box 629
Woodland Hills, CA 91365-0629
(866) 723-0515
www.anthem.com/ca

For complete details regarding these benefits, see the Anthem Blue Cross Life and Health Insurance Company Certificate of Insurance".

D) For life or accidental death or dismemberment insurance benefits

The Hartford Life
PO Box 14299
Lexington, KY 40512-4299
(800) 523-2233
gbdcustomerservice@thehartford.com

For complete details regarding these benefits, see the Hartford "Your Benefit Plan" booklet.

IMPORTANT	**No health care provider is an agent or representative of the Plan or of the Board of Trustees. The Fund does not provide medical services itself, nor does it control or direct the provision of health care services and/or supplies by anyone else. You choose the providers you want to see for treatment; the Fund does not require you go to any particular provider to secure treatment or supplies. The Fund makes no representation or guarantee of any kind that any provider will furnish health care services or supplies that are error-free or that the provider you select is competent to treat your condition. This applies to any and all health care providers, including 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.**

SECTION 6. CLAIMS AND APPEALS

Most claims and appeals will be filed with the particular insurer that provides the benefit at issue. For example, if your claim involves medical treatment, hospitalization or prescription drugs, your claim and any subsequent appeal will be filed with the Western Growers Assurance Trust. If your claim involves dental services, your claim and any subsequent appeal will be filed with Dental Health Services. If your claim involves vision care, your claim and any subsequent appeal will be filed with Anthem Blue Cross Blue View Vision. If your claim involves the payment of a death, accidental death or dismemberment claim, your claim and any subsequent appeal will be filed with The Hartford Life.

If your claim or appeal involves any other Plan rule or any disagreement in how the Plan is being administered, including eligibility to participate in the Plan or any decision rendered by the Fund Office or the Board of Trustees, you will file a claim with the Fund Office and an appeal with the Fund's Board of Trustees' Appeals Committee.

IMPORTANT	**All applications or claims for benefits should be made directly to the benefits provider or insurer. In the rare instance that your claim or application needs to be presented to the Fund Office or the Board of Trustees, this section describes procedures for presenting such a claim or application for benefits.**

A) Processing Claims with the Fund Office

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 in order 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 prior to 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 prior to 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 prior to 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 prior to 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 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.

B) 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 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 such rule, guideline, protocol, or other criterion 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 a SSA disability determination.

If the adverse determination is based on a medical judgment, 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.

C) Appeals Procedure

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

IMPORTANT	**Most appeals should be made directly to the benefits provider or insurer. In the rare instance that your appeal needs to be presented to the Fund's Board of Trustees, this section describes procedures for presenting such an appeal.**

i) 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 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, with the exception of 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 your 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 have the opportunity to submit written comments, documents, records, and other information relating to your claim for benefits or objection to 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 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, 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.

ii) Timing of Appeals Committee Decisions

The Appeals Committee (or a subset thereof if so 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 prior to the beginning of the extension. Such an extension may only last until the third meeting following receipt of the appeal.

iii) 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.

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 Office.

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 Office.

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

If the decision is based on a medical judgment, 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.

iv) 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, and 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(s), the Board of Trustees will be substituted for the Appeals Committee in this appeal procedure and will have the full discretion in deciding an appeal as set forth in this paragraph.

If the Appeals Committee denies the appeal, and 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 prior to 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.

IMPORTANT	**No legal action may be commenced against the Fund or the Trustees more than two years after the claim has been denied on appeal.**

v) 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

vi) 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 7. COORDINATION OF BENEFITS

Medical, vision, and prescription drug benefits are coordinated with those provided for the Eligible Employees and Eligible Dependents by any other group hospital, medical benefit, or service plan. The necessary information will be provided by the insurer of benefits provider if this provision applies to your particular claim or situation.

See the WGAT Summary Plan Description for details regarding hospital, medical, and prescription drug coordination of benefits.

SECTION 8. 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, by reason 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 insurer or benefits provider may conditionally pay benefits, once you provide written acknowledgment stating that you will reimburse the insurer or provider if your claim against the third party results in a recovery, for such illness or injury while the claim is being adjudicated and may cover such benefits to the extent recovery against the third party is unsuccessful. The necessary information will be provided by the insurer of benefits provider if this provision applies to your particular claim or situation.

See the WGAT Summary Plan Description for details regarding third party liability involving hospital, medical, and prescription drug benefits.

SECTION 9. 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 him or her 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 the payment of 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 that you are not entitled to, you are obligated to reimburse the Fund for the erroneous payments including attorney's fees, interest, and reasonable collection costs. 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

The use of the services of any hospital, physician, or other provider of health care, whether designated by the Fund or otherwise, is your voluntary act. Nothing in this Supplemental 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.

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

SECTION 10. INFORMATION REQUIRED BY ERISA

The following additional information concerning the Plan is provided to you in accordance with 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 Landscape, Irrigation and Lawn Sprinkler Industry Health and Welfare Plan. It is a multi-Employer health and welfare benefit plan. It provides medical, prescription drug, vision, dental, death, and accidental death or dismemberment benefits.

B) Identification Numbers

The Fund's Internal Revenue Service tax identification number is 95-4418990. 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 maintained pursuant 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, 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 Landscape, Irrigation and Lawn Sprinkler Industry Health and Welfare Fund 501 Shatto Place, Suite 500 Los Angeles, CA 90020	(800) 595-7473 (213) 385-6161 www.scptac.org 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 Attention: Joel Brick 501 Shatto Place, Suite 500 Los Angeles, CA 90020	(800) 595-7473 (213) 385-6161 www.scptac.org 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:

Landscape, Irrigation and Lawn Sprinkler Industry Health and Welfare Fund
Attention: Joel Brick
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 in accordance with the terms of a Participation Agreement, which require that contributions be made to the Fund; and
ii) Self-payment for COBRA continuation coverage as described in Section 4, page 8.

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. The assets are used exclusively for providing benefits to participants and beneficiaries in accordance with 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 for active Employees are set forth in this Supplemental SPD.

I) Collective Bargaining Agreement

Contributions to the Fund are made in accordance with 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 numbers 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 primary Collective Bargaining Agreement under which most contributions are made to this Fund is the Agreement between District Council 16 and the California Plumbing & Mechanical Contractors Association (CPMCA).

J) Plan Termination

It is intended that this Plan will continue indefinitely, but the Board of Trustees reserves the right to change and/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 there are no individuals living who 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 in accordance with 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 for the purpose of winding 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 Landscape, Irrigation and Lawn Sprinkler Industry 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

1) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2) 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.

3) 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, spouse, or dependents if there is a loss of coverage under the Plan as a result of 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 who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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 which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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.

SECTION 11. 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. Pursuant to HIPAA, these rules give you greater control over who may have access to the information in your medical records. Health plans, such as this Plan, cannot share Protected Health Information ("PHI") under many circumstances without written authorization.

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, to fulfill its coverage responsibilities, and to provide benefits under the Plan, and to obtain or provide reimbursement for the provision of health care. Payment may include, but is not limited to, the following: determining coverage and benefits under the Plan, paying for or obtaining reimbursement for health care, adjudicating subrogation of health care claims or coordination of benefits, billing and collection, making

claims for stop-loss insurance, determining medical necessity and performing utilization review. For example, the Fund will disclose the minimum necessary PHI to medical service providers for the purposes of payment.

b) Health Care Operations are certain administrative, financial, legal, and quality improvement activities of the Fund that are necessary to run 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 to do so.

b) The Fund may disclose your PHI to a public health authority for certain public health activities, such as: (1) reporting of a disease or injury, or births and deaths, (2) conducting public health surveillance, investigations, or interventions; (3) reporting known or suspected child abuse or neglect; (4) ensuring the quality, safety or effectiveness of an FDA-regulated product or activity; (5) notifying a person who is at risk of contracting or spreading a disease; and (6) notifying an Employer about a member of its workforce, for the purpose of workplace medical surveillance or the evaluation of work-related illness and injuries, but only to the extent the Employer needs that information to comply with the Occupational Safety and Health Administration (OSHA), the Mine Safety and Health Administration (MSHA), or State law requirements having a similar purpose.

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

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

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

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

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

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

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

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

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

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

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

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

o) The Fund may disclose your PHI if you are in 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.

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:

a) The Fund will provide you with access to your PHI. The Fund will generally require you to complete and execute a "Request for Protected Health Information Form" and will provide you with access to PHI consistent with the request form, or as otherwise required by law.
b) The Fund may provide your personal representative or attorney with access to your PHI in the same manner as it would provide you with access, but only upon receipt of documentation demonstrating that your personal representative or attorney has authority under applicable law to act on your behalf.
c) Unless otherwise permitted by law, the Fund will not use or disclose your PHI to someone other than you unless you sign and execute an authorization form. You can revoke an authorization form at any time by submitting a cancellation of authorization form to the Fund. The cancellation of authorization form revokes the authorization form on the date it is received by the Fund.
d) The Fund will disclose your PHI to the Fund's Board of Trustees only in accordance with the provisions of the Fund's Privacy Policy and the provisions of the Plan.

iii) Individual Rights

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

a) You have a right to request that the Fund restrict use or disclosure of your PHI to carry out payment or health care operations. The Fund is not required to agree to a requested restriction.
b) You have a right to receive confidential communications about your PHI from the Fund by alternative means or at alternative locations, if you submit a written request to the Fund in which you clearly state that the disclosure of all or part of that information could endanger you.
c) You have a right of access to inspect and copy your PHI that is maintained by the Fund in a "designated record set". A "designated record set" consists of records or other information containing your PHI that is maintained, collected, used, or disseminated by or for the Fund in connection with: (1) enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for the Fund, or (2) decisions that the Fund makes about you.
d) You have a right to amend your PHI that was created by the Fund and that is maintained by the Fund in a designated record set, if you submit a written request to the Fund in which you provide reasons for the amendment.
e) You have a right to receive an accounting of disclosures of your PHI, with certain exceptions, if you submit a written request to the Fund. The Fund need not account for disclosures that were made more than six years before the date on which you submit your request, or any disclosures that were made for treatment, payment or health care operations.

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 a paper copy of the notice that is currently in effect to you 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 prior to issuing the revised notice.

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

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:

Landscape, Irrigation and Lawn Sprinkler Industry
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 any person for filing a complaint.

vii) For More Information About Privacy

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

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:
    1) Birth or placement of a child for adoption or foster care;
    2) To care for your child, Spouse, or parent with a serious health condition; or
    3) Your own serious health condition; or
    4) A "qualifying exigency" as defined in applicable regulations arising out of 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 is able to 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 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:

1) 48 hours following vaginal deliveries; or
2) 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:

1) All stages of reconstruction of the breast on which the mastectomy was performed;
2) Surgery and reconstruction of the other breast to produce symmetrical appearance; and
3) 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 network provider, and in accordance with Plan limits.

SECTION 12. DEFINITIONS

Appeals Committee
A subset of the Board of Trustees empowered to review any claims as described in Section 6(C).

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

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

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

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

Collective Bargaining Agreement
Any and all negotiated labor agreements between a 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 Landscape, Irrigation and Lawn Sprinkler Industry 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.

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

Domestic Partner
A person whom with 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 that is substantially similar to a domestic partnership recognized in California.

Eligibility Bank
The Eligibility Bank is funded by contributions received 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 3, page 4.

Eligible Dependent
The Participant's Spouse or Domestic Partner, if timely enrolled, or children up to and through age 25, who satisfy requirements of the Plan.

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.

Fund
The Landscape, Irrigation and Lawn Sprinkler Industry Health and Welfare Fund created by the Trust Agreement establishing that Fund.

Fund Office
Landscape, Irrigation and Lawn Sprinkler Industry Health and Welfare Fund
c/o 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

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

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

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 who are not covered by a Collective Bargaining Agreement.

Plan
The benefits, rules, and other provisions described in this Supplemental SPD.

Plan Year
January 1 through December 31 of each year.

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 of the requirements of ERISA, 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.

Supplemental SPD
Supplemental Summary Plan Description. This document. A description of the provisions of, and benefits available under, the Landscape, Irrigation and Lawn Sprinkler Industry Health and Welfare Fund.

Spouse
Any person to whom a Participant is legally married under the laws within the jurisdiction in which the marriage took place.

Trust Agreement
The written document titled "Restated Agreement and Declaration of Trust Continuing the Landscape, Irrigation and Lawn Sprinkler Industry Health and 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 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.

USERRA
Uniformed Services Employment and Reemployment Rights Act of 1994.

WGAT
Western Growers Assurance Trust
17620 Fitch Street
Irvine, CA 92614

(800) 777-7898
www.wgat.com

SECTION 13. TRUSTEES

The following is a list of the Trustees as of the publication date of this Supplemental 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

WALTER SCOTT BAKER
Murray Company
18414 South Santa Fe Avenue
Rancho Dominguez, CA 90221

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

JOHN FEIKEMA
California Spectra Instrumentation, Inc.
21818 S. Wilmington Avenue, Suite 402
Carson, CA 90810

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

JASON GORDON
Xcel Mechanical Systems, Inc.
1710 W. 130th Street
Gardena, CA 90249

CHIP MARTIN
CPMCA
3500 West Olive, Suite 860
Burbank, CA 91505

JOHN MODJESKI
University Mechanical & Engineering Contractors
1290 N. Hancock Street, Suite 100
Anaheim, CA 92807

BRYAN SUTTLES
Suttles Plumbing
2267 Agate Court
Simi Valley, CA 93065

LAWRENCE VERNE
Verne's Plumbing, Inc.
8561 Whitaker Street
Buena Park, CA 90621

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

B) Union Trustees

DAVID BALDWIN
U.A. Local No. 403
3710 Broad Street
San Luis Obispo, CA 93401

SHANE BOSTON
U.A. Local No. 484
1955 N. Ventura Avenue
Ventura, CA 93001

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

MIKE HARTLEY
U.A. Local No. 230
6313 Nancy Ridge Drive
San Diego, CA 92121

GREG LEWIS
U.A. Local No. 761
1305 North Niagara Street
Burbank, CA 91505

MICHAEL LOPEZ
U.A. Local No. 114
93 Thomas Road
Buellton, CA 93427

ANTHONY NOVELLO
U.A. Local No. 582
1916 W. Chapman Avenue
Orange, CA 92868

RICARDO PEREZ
U.A. Local No. 345
1430 Huntington Drive
Duarte, CA 91010

AL POWERS
U.A. Local No. 364
223 S. Rancho Avenue
Colton, CA 92324

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

WILLIAM STEINER (seated February 10, 2021)
U.A. Local No. 398
8590 Utica Avenue, Suite 200
Rancho Cucamonga, CA 91730