Summary Plan Description / Plan Rules & Regulations

of the

Southern California Pipe Trades

PENSIONERS & SURVIVING SPOUSES HEALTH FUND

Contents

SECTION 1. INTRODUCTION

The Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund ("Fund" or "Plan") was established in 2011 through the negotiating efforts of District Council No. 16 of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada ("United Association") and Employers in the plumbing and pipefitting industry in Southern California. Union and Employer Trustees manage the Fund.

A) This Summary Plan Description

This Summary Plan Description/Plan Rules and Regulations ("SPD") is the plan document of the provisions of the Southern California Pipe Trades Pensioners & Surviving Spouses Health Plan. It applies to all claims for services rendered on and after January 1, 2019. Prior written material applies only to claims for services rendered prior to January 1, 2019. It is very important that you read this SPD carefully to understand how the Plan works. Please keep this SPD for future reference.

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

B) Purpose of the Plan

The Plan was set up to provide medical, Prescription Drug, and other benefits. The Plan is funded by active union members, whose Employers make contributions on their behalf on a per-hour basis under a Collective Bargaining Agreement or a Participation Agreement, and by premiums paid by Participants and Survivors. The Plan pays claims only for benefits provided under the Plan. The Plan does not pay benefits for work-related Illnesses and Injuries. This Plan does not cover Active Participants, whose benefits are covered under the Southern California Pipe Trades Health & Welfare Fund, which has a separate SPD.

C) Role of the Board of Trustees

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

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

D) Role of the Fund Office

The Board of Trustees has authorized the Fund Office to respond in writing to your written questions. As a courtesy, the Fund Office may also respond informally to questions by telephone, email, or in person at the Fund Office. However, such information and answers are not binding upon the Board of Trustees and cannot be relied upon in any dispute. 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.** **Southern California Pipe Trades Administrative Corporation** **501 Shatto Place, Suite 500** **Los Angeles, CA 90020** **Toll Free: (800) 595-7473 / Outside U.S.: (213) 385-6161** **Website: www.scptac.org / Email: info@scptac.org**

NOTE	**Capitalized terms are defined in Section 19, page 49.**

SECTION 2. SUMMARY OF PLAN BENEFITS

The Plan partners with Blue Shield of California with the goal of lowering and controlling Patient Out-of-Pocket costs while expanding the network of providers available. Blue Shield provides network access and some administrative services only. The Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund determines, administers, and pays Plan benefits. Note that Blue Shield does not administer the Fund's dental or prescription benefits.

	Benefit	Amount
DEDUCTIBLES	Medical services	$250 per person
	Prescription Drugs	$50 per person
	Hearing aids	$50 per device

LIFETIME MAXIMUM BENEFIT (LMB) Effective January 1, 2019	LMB Per Person
	$2,000,000

SUMMARY OF PLAN BENEFITS

Benefit details are listed in alphabetical order in Section 8 beginning on page 22.

TYPE OF SERVICE	BLUE SHIELD OF CALIFORNIA (BSC) PPO NETWORK PROVIDER Plan Pays:	OUT-OF-NETWORK PROVIDER Plan Pays:
ACUPUNCTURE Not to exceed 20 visits per Calendar Year.	80% of the BSC PPO Network Rate	80% of the Allowable Charge
ALLERGY TESTING	80% of the BSC PPO Network Rate	80% of the Allowable Charge
ALLERGY TREATMENT The Plan will pay up to $75 per vial, and no more than a three-month supply, not to exceed four times in any 12-month period and not to exceed $750.	80% of the BSC PPO Network Rate	80% of the Allowable Charge
AMBULANCE	80% of the BSC PPO Network Rate	80% of the Allowable Charge
ANESTHESIA For Pain Management injections, see the Pain Management benefit.	80% of the BSC PPO Network Rate	80% of the Allowable Charge
BARIATRIC SURGERY	NOT COVERED	

SUMMARY OF PLAN BENEFITS

Benefit details are listed in alphabetical order in Section 8 beginning on page 22.

TYPE OF SERVICE		BLUE SHIELD OF CALIFORNIA (BSC) PPO NETWORK PROVIDER Plan Pays:	OUT-OF-NETWORK PROVIDER Plan Pays:
CARDIAC REHABILITATION	**Performed in a Physician's Office**	80% of the BSC PPO Network Rate	80% of the Allowable Charge up to $20 per visit
	Outpatient Hospital or Facility	85% of the BSC PPO Network Rate	80% of the Allowable Charge up to $20 per visit
	Inpatient Hospital or Facility	85% of the BSC PPO Network Rate	80% of the Allowable Charge up to $1,080 per day for all Hospital or facility service
CHEMOTHERAPY		80% of the BSC PPO Network Rate	80% of the Allowable Charge
CHIROPRACTIC CARE Maximum of three visits per week, not to exceed $600 per Calendar Year.		80% of the BSC PPO Network Rate	80% of the Allowable Charge
COLONOSCOPY / SIGMOIDOSCOPY SCREENING Covered once every five years for Patients age 50 and older.		80% of the BSC PPO Network Rate	80% of the Allowable Charge
CONVALESCENT CARE FACILITY / EXTENDED CARE FACILITY / ADULT DAY HEALTH CARE		85% of the BSC PPO Network Rate up to $27 per day	80% of the Allowable Charge up to $27 per day
DIALYSIS (Renal)	**Performed in a Physician's Office**	80% of the BSC PPO Network Rate	80% of the Allowable Charge for supplies
	Performed in a Hospital or Facility	80% of the BSC PPO Network Rate	80% of the Allowable Charge up to $200 per visit for all Hospital or facility services
DURABLE MEDICAL EQUIPMENT		Benefits paid on a rental-to-purchase basis based on monthly eligibility of the Patient	
		80% of the BSC PPO Network Rate	80% of the Allowable Charge
GENETIC TESTING		80% of the BSC PPO Network Rate	80% of the Allowable Charge
HEARING AID A separate $50 deductible per device applies to this benefit, not to exceed one device per ear in a 36-month period.		80% of the BSC PPO Network Rate up to $800 per device	80% of the Allowable Charge up to $800 per device

SUMMARY OF PLAN BENEFITS

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TYPE OF SERVICE		BLUE SHIELD OF CALIFORNIA (BSC) PPO NETWORK PROVIDER Plan Pays:	OUT-OF-NETWORK PROVIDER Plan Pays:
HOME HEALTH NURSING Not to exceed 120 visits per Calendar Year (combined with Skilled Nursing Facility days)		80% of the BSC PPO Network Rate	80% of the Allowable Charge up to $60 per visit
HOME INTRAVENOUS (IV) THERAPY		85% of the BSC PPO Network Rate	85% of the Allowable Charge
HOSPICE CARE PROGRAM In a Hospice Facility or at home		80% of the BSC PPO Network Rate	80% of the Allowable Charge
HOSPITAL	Hospital Inpatient or Hospital Outpatient	85% of the BSC PPO Network Rate	80% of the Allowable Charge up to $1,080 per day
	Emergency Services		80% of the Allowable Charge up to a maximum amount that is reasonable as determined by the Plan using independent third party pricing sources
IMMUNIZATIONS		80% of the BSC PPO Network Rate	80% of the Allowable Charge
LABORATORY	Performed in an Outpatient Laboratory Facility or Physician's Office	80% of the BSC PPO Network Rate	80% of the Allowable Charge
	Performed in a Hospital or Facility	85% of the BSC PPO Network Rate	80% of the Allowable Charge up to $1,080 per day for all Hospital or facility charges
MEDICAL SUPPLIES		80% of the BSC PPO Network Rate	80% of the Allowable Charge
MENTAL HEALTH Treatment for substance abuse is not covered.	Adult Day Health Care Center (ADHC)	85% of the BSC PPO Network Rate up to $27 per day	80% of the Allowable Charge up to $27 per day
	Hospital, Partial Hospitalization, or Residential Treatment Facility	85% of the BSC PPO Network Rate	80% of the Allowable Charge up to $1,080 per day
	Office	80% of the BSC PPO Network Rate	80% of the Allowable Charge

SUMMARY OF PLAN BENEFITS

Benefit details are listed in alphabetical order in Section 8 beginning on page 22.

TYPE OF SERVICE		BLUE SHIELD OF CALIFORNIA (BSC) PPO NETWORK PROVIDER Plan Pays:	OUT-OF-NETWORK PROVIDER Plan Pays:
NON-PRESCRIPTION AND OVER-THE-COUNTER DRUGS		NOT COVERED	
OCCUPATIONAL THERAPY Covered for the treatment of a hand Injury or hand disability only; not to exceed $1,200 per Calendar Year (combined with the Physical Therapy benefit).	**Performed in an Occupational Therapist's Office**	80% of the BSC PPO Network Rate	80% of the Allowable Charge
	Performed in a Hospital or Facility	85% of the BSC PPO Network Rate	80% of the Allowable Charge up to $1,080 per day for all Hospital or facility charges
OPIOID DRUG TESTING Not to exceed once every three months.		80% of the BSC PPO Network Rate	80% of the Allowable Charge

PAIN MANAGEMENT		80% of the BSC PPO Network Rate or 80% of the Allowable Charge, not to exceed:
		• $10,000 per lifetime
		• Facility Fees
		  ○ Hospital: $900 per day; or
		  ○ Surgery Center: $800 per day; or
		  ○ Physician's office/surgical suite: $700 per day
		• Injections
		  ○ $250 per injection
		  ○ Maximum of three surgical injections per day	

PHYSICAL EXAMINATION Once per Calendar Year.		80% of the BSC PPO Network Rate	80% of the Allowable Charge
PHYSICAL THERAPY Prescription required; not to exceed $1,200 per Calendar Year (combined with the Occupational Therapy benefit).	**Performed in a Physical Therapist's Office**	80% of the BSC PPO Network Rate	80% of the Allowable Charge
	Performed in a Hospital or Facility	85% of the BSC PPO Network Rate	80% of the Allowable Charge up to of $1,080 per day for all Hospital or facility charges
PHYSICIAN		80% of the BSC PPO Network Rate	80% of the Allowable Charge
PRESCRIPTION DRUGS Benefits per Calendar Year.		• $50 Prescription Drug Deductible per person • Prescription Drugs are reimbursable at 100% up to $1,200 per person, per Calendar Year	

SUMMARY OF PLAN BENEFITS

Benefit details are listed in alphabetical order in Section 8 beginning on page 22.

TYPE OF SERVICE		BLUE SHIELD OF CALIFORNIA (BSC) PPO NETWORK PROVIDER Plan Pays:	OUT-OF-NETWORK PROVIDER Plan Pays:
RADIATION THERAPY	**Performed in a Physician's Office**	80% of the BSC PPO Network Rate	80% of the Allowable Charge
	Performed in a Hospital or Facility	85% of the BSC PPO Network Rate	80% of the Allowable Charge, up to a maximum of $1,080 per day for all Hospital of facility charges
RADIOLOGY X-rays, CAT/PET/MRI scans, etc.	**Performed in an outpatient Radiology Facility or Physician's Office**	80% of the BSC PPO Network Rate	80% of the Allowable Charge
	Performed in a Hospital	85% of the BSC PPO Network Rate	80% of the Allowable Charge, up to $1,080 per day for all Hospital or facility charges
SKILLED NURSING FACILITY Up to 120 days per Calendar Year (combined with Home Health Nursing visits).		85% of the BSC PPO Network Rate	80% of the Allowable Charge, up to $1,080 per day
SLEEP STUDY	**Physician**	80% of the BSC PPO Network Rate	80% of the Allowable Charge
	Hospital	85% of the BSC PPO Network Rate	80% of the Allowable Charge, up to $1,080 per day
SPEECH THERAPY	**Performed in a Speech Therapist's Office**	80% of the BSC PPO Network Rate	80% of the Allowable Charge, up to $18 per visit
	Outpatient Hospital or Facility	85% of the BSC PPO Network Rate	80% of the Allowable Charge, up to $18 per visit
	Inpatient Hospital or Facility	85% of the BSC PPO Network Rate	80% of the Allowable Charge, up to $1,080 per day for all Hospital or facility charges
SURGERY	**Physician**	80% of the BSC PPO Network Rate	80% of the Allowable Charge
	Anesthesiologist	80% of the BSC PPO Network Rate	80% of the Allowable Charge
	Hospital	85% of the BSC PPO Network Rate	80% of the Allowable Charge up to $1,080 per day

SUMMARY OF PLAN BENEFITS

Benefit details are listed in alphabetical order in Section 8 beginning on page 22.

TYPE OF SERVICE	BLUE SHIELD OF CALIFORNIA (BSC) PPO NETWORK PROVIDER Plan Pays:	OUT-OF-NETWORK PROVIDER Plan Pays:
TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)	NOT COVERED	
TRANSPLANTS Up to $100,000 per covered organ.	**First $100,000**	
	Professional	80% of the BSC PPO Network Rate	80% of the Allowable Charge
	Hospital or Facility	85% of the BSC PPO Network Rate	80% of the Allowable Charge up to $1,080 per day for all Hospital or facility charges
VISION SERVICES – AFTER CATARACT SURGERY	$100 per eye for corrective glasses or contact lenses.	

SECTION 3. ENROLLMENT

This Section applies to Pensioners and their Eligible Dependents. Survivors of Pensioners and Survivors of Active Plan participants should refer to Section 5, on page 12.

A) Enrolling an Eligible Dependent

You must complete an Enrollment Form, including your signature, and provide any required documents, in order to add an Eligible Dependent. Once enrolled, you will receive new plan identification cards which include your Eligible Dependents.

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

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

B) Dis-enrolling a Dependent

You must complete a Disenrollment Form, including all required signatures, and provide any required document, in order to dis-enroll a dependent.

Once dis-enrolled, you may re-enroll your Eligible Dependent at a later date if:

i) You remain enrolled in the Plan;
ii) Your Eligible Dependent maintains Continuous Comparable Coverage during the period your Eligible Dependent is dis-enrolled in the Plan; and
iii) Proof of Continuous Comparable Coverage is submitted to the Plan.

Note that your Eligible Dependent must be enrolled in the Plan within 60 days of losing coverage under the other plan.

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

C) Required Documents

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) An original, filed, domestic partnership registration; or
iii) A copy of the death certificate; or
iv) A copy of the final divorce decree; or
v) A copy of the dissolution of domestic partnership; or
vi) Proof of Continuous Comparable Coverage.

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

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

i) Marriage or Domestic Partnership Documents

You must submit a new Enrollment Form with the appropriate documentation as listed above within 90 days of the date of your marriage or domestic partnership. If the Enrollment Form and the appropriate documentation are not received within 90 days of the date of marriage or domestic partnership, your Spouse/Domestic Partner will never be eligible for coverage under the Plan unless Continuous Comparable Coverage is maintained (see next paragraph). You must notify the Fund Office immediately if there is a delay in obtaining a copy of the certified marriage certificate or the domestic partnership registration.

The 90-day enrollment deadline may be waived if the Fund Office is provided with (1) proof of the Spouse's/Domestic Partner's Continuous Comparable Coverage from the date of marriage/domestic partnership and (2) a completed Pensioners & Surviving Spouses Health Plan Enrollment Form, both within 60 days of losing Continuous Comparable Coverage.

The Spouse/Domestic Partner will not be permitted to enroll in the Plan if the Pensioner is not enrolled.

NOTE	**Survivors of Pensioners and Survivors of Active Plan Participants must provide copies of marriage certificates or domestic partnership documents when they remarry or enter into a new domestic partnership because coverage ends in that event.**

ii) Death Certificate

The Fund Office should be notified within 60 days of the death of a Participant in order to preserve a Survivor's right to COBRA or Survivor Premium Program coverage. A copy of the death certificate should be provided to the Fund Office as soon as it is available. If a death certificate is not provided within 12 months of the date of death, any applicable premium adjustment will be prospective only, not retroactive to the date of death.

iii) Divorce or Dissolution Documents

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

E) Change of Address Form

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

IMPORTANT	**If there is a change in your family status, such as marriage, divorce, dissolution or death, or if your address changes, notify the Fund Office as soon as possible, but no later than 90 days after the change.**

SECTION 4. ELIGIBILITY

This Section applies to Pensioners and their Eligible Dependents. Survivors of Pensioners and Survivors of Active Plan participants should refer to Section 5, on page 12.

A) When a Pensioner May Elect Coverage

You may elect coverage under the Plan if ALL of the following criteria have been met:

i) You are receiving a monthly pension from the Southern California Pipe Trades Retirement Fund based on 12 or more years of Pension Credit; and
ii) You have been eligible for benefits under the Active Plan as a Participant for at least one month during the 24 months prior to your Annuity Starting Date; and
iii) You have been eligible for benefits under the Active Plan as a Participant for at least 60 of the 120 months preceding your Annuity Starting Date; and
iv) You elect coverage at the time of initial retirement; and
v) You pay the applicable monthly Premium timely; and
vi) You timely file a fully completed Enrollment Form.

NOTE	**If you are eligible to participate in the Pensioners and Surviving Spouses Health Fund, but initially elect COBRA Continuation Coverage under the Active Plan, you may not subsequently elect or receive coverage under the Pensioners and Surviving Spouses Plan. Similarly, if you initially elect coverage under the Pensioners and Surviving Spouses Plan you may not subsequently elect or receive COBRA coverage under the Active Plan.**

B) When Eligibility Begins

Eligibility generally begins on the later of:

i) The first day of the month for which you receive a monthly pension benefit; or
ii) The first day of the month in which you lose eligibility under the Active Plan.

C) Continuing Eligibility

You must pay monthly Premiums set by the Board of Trustees. Most Participants fulfill this self-pay obligation by electing to have the Premium amount deducted from their monthly pension benefit. You may also have your monthly Premium deducted from your checking or savings account electronically.

If you do not elect to have the applicable Premium paid automatically, you must personally make payments directly to the Fund in order to retain coverage under the Plan.

Premiums are due by the 20th of the month before the month of coverage, and an additional grace period of 30 days is provided from the beginning of the month of coverage. However, no coverage will be provided until payment is received. If you do not pay by these deadlines, you will lose coverage and will not be permitted to reinstate coverage.

IMPORTANT	**If you fail to pay Premiums timely, you will permanently lose coverage under the Plan.**

D) Dependent Eligibility

i) Who is an Eligible Dependent?

Your lawful Spouse or Domestic Partner is the only Eligible Dependent under this Plan. Your Spouse or Domestic Partner cannot be enrolled in the Plan unless the you are enrolled in the Plan.

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

ii) Dual Coverage

If a person has dual coverage under the Plan as both a Participant and an Eligible Dependent, then the Plan will apply coordination of benefit rules. (See Section 13, page 38.)

iii) When Eligible Dependent Coverage Starts

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

a) The date you become eligible for coverage under the Plan; or
b) The date an individual becomes your Eligible Dependent, so long as the individual is enrolled in the Plan within 90 days of the date of marriage or Domestic Partnership.
c) Within 60 days of losing Continuous Comparable Coverage if your Eligible Dependent was not enrolled at the later of the following dates: the same time you enrolled, or at the time they became your Eligible Dependent.

E) Termination of Eligibility and Re-Enrollment

i) When Pensioner's Coverage Terminates

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

a) The first day of the month following 30 days from the date the Fund Office receives your written request to terminate coverage; or
b) The date you start performing work in the plumbing, heating, and piping industry which is not pursuant to a recognized Collective Bargaining Agreement; or
c) The first day of the month in which your monthly pension benefit from the Southern California Pipe Trades Retirement Fund stops; or
d) The date you return to work for a Contributing Employer in any capacity; or
e) Whenever a Premium is not received timely. In this case you will be barred from establishing eligibility at a later date; or
f) The date the Plan terminates.

In some cases you may be permitted to re-enroll in the Plan. See Section 4(E)(v) below.

ii) When Eligible Dependent Coverage Terminates

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

a) The date your eligibility terminates; or
b) The date your Eligible Dependent no longer qualifies as an Eligible Dependent (e.g., upon divorce); or
c) The date your Eligible Dependent is dis-enrolled upon application by you; or
d) The date of death of your Eligible Dependent; or
e) Whenever a Premium is not received timely; or
f) The date the Plan terminates.

In some cases you may be permitted to re-enroll in the Plan. See Section 4(E)(v) below.

iii) When Survivor Coverage Terminates

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

a) The date your Survivor remarries or enters into a domestic partnership (all benefits paid after the date of remarriage or domestic partnership must be reimbursed to the Fund and legal action may be taken to recover such benefits); or
b) Whenever a Premium is not received timely; or
c) The date the Plan terminates.

iv) Returning to Work for a Contributing Employer

If you are retired and return to work for a Contributing Employer, you must advise the Fund Office of such employment before your employment commences. Your coverage under the Plan will be terminated, including your obligation to pay a Premium to the Plan, effective on the date you return to work for a Contributing Employer as follows:

a) Return to Work Under the Waiver Program

If you return to work under the Temporary Waiver Program, you lose coverage under this Plan but may continue coverage under the Active Plan by paying the same Premium amount you would be required to pay under this Plan.

b) Return to Work Resulting in Suspension of Pension Benefit

If you return to Covered Employment that results in the suspension of your Southern California Pipe Trades Retirement Fund pension benefit, you lose coverage under this Plan but may continue coverage under the Active Plan by paying the full COBRA rate to the Active Plan until such time as you become eligible under the Active Plan on the basis of contributions made to the Active Plan by your Employer for hours worked.

c) Return to Work at Age 65

If you are age 65 to age 70½ and you return to Covered Employment for 39 or fewer hours in a month, you will lose coverage under this Plan but may continue coverage under the Active Plan by paying the same Premium amount you would be required to pay under this Plan for the entire period of your Covered Employment.

d) Return to Work at Age 70½

If you are age 70½ or older and you return to Covered Employment, you lose coverage under this Plan but may continue coverage under the Active Plan by paying the same Premium amount you would be required to pay under this Plan until such time as you become eligible under the Active Plan on the basis of contributions made to the Active Plan by your Employer for hours worked.

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

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

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

If you return to work as an instructor for the Southern California Pipe Trades Apprentice and Journeyman Training Trust Fund, you will lose coverage under this Plan but may continue coverage under the Active Plan by paying the same Premium amount you would be required to pay under this Plan.

In some cases you may be permitted to re-enroll in the Plan. See Section 4(E)(v) below.

v) Re-enrollment after End of Employment

If you were previously enrolled this Plan and you decided to dis-enroll as described in Section 4(E)(i)(a), you and your Eligible Dependent, if any, may be permitted to re-enroll in the Plan if you provide satisfactory evidence of Continuous Comparable Coverage.

If you were previously enrolled in this Plan and returned to work in the plumbing, heating, and piping industry which is not pursuant to a recognized Collective Bargaining Agreement as described in Section 4(E)(i)(b) but did not have your Retirement benefits suspended, you may re-enroll in this Plan when you cease employment, so long as you continue to satisfy all other eligibility requirements to participate in the Pensioners Health Plan, and you notify the Fund Office of the end of your employment and of your intent to re-enroll within 90 days after the end of employment. If you elect not to re-enroll in this Plan and/or timely pay the applicable Premium, you will be barred from establishing eligibility at a later date.

If you were previously enrolled in this Plan and (1) returned to work in the plumbing, heating, and piping industry which is not pursuant to a recognized Collective Bargaining Agreement as described in Section 4(E)(i)(b) and (2) had your Retirement benefits suspended as described in Section 4(E)(i)(c), you may re-enroll in this Plan, so long as you continue to satisfy all other eligibility requirements to participate in the Pensioners Health Plan and only after you have worked enough hours in Covered Employment to earn at least a quarter Pension Credit under the Southern California Pipe Trades Retirement Plan for each calendar quarter in which you worked at least one hour in non-Covered Employment. If this condition is met, coverage must be elected at the time of re-instatement under the Southern California Pipe Trades Retirement Plan. If you elect not to re-enroll in this Plan and/or timely pay the applicable Premium, you will be barred from establishing eligibility at a later date.

If you were previously enrolled in this Plan and you returned to work for a Contributing Employer as described in Section 4(E)(i)(d) and 4(E)(iv), you may re-enroll in this Plan when you cease employment, and upon the exhaustion of any Eligibility Bank in the Southern California Pipe Trades Health & Welfare Fund (if applicable), and further upon the end of your suspension of benefits from the Southern California Pipe Trades Retirement Fund (if applicable), so long as you continue to satisfy all other eligibility requirements to participate in the Pensioners Health Plan, and you notify the Fund Office of the end of your employment and of your intent to re-enroll within 90 days after the end of employment. If you elect not to re-enroll in this Plan and/or timely pay the applicable Premium, you will be barred from establishing eligibility at a later date.

SECTION 5. EXTENDING ELIGIBILITY

You may be able to extend coverage as follows:

- You may be eligible to pay for COBRA continuation coverage if you experience a Qualifying Event.
- A Surviving Spouse or Surviving Domestic Partner may be eligible for a Special Extension Period of up to 3 months.
- A Surviving Spouse or Surviving Domestic Partner may elect to enroll in the Survivor Premium Program.
- If you are Totally Disabled, medical expenses for that disability may be covered for the first three months after your loss of coverage.

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

A) COBRA Continuation Coverage

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

a) Introduction

Federal law (the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA) requires that most group health plans (including this Plan) offer eligible Spouses, who lose coverage due to divorce from, or the death of, the Pensioner, the opportunity to elect a temporary extension of health coverage (called "COBRA Continuation Coverage") in certain instances (called "Qualifying Events") where coverage under the Plan would otherwise end. To receive this continuation coverage, an eligible Spouse must pay timely monthly COBRA Premiums directly to the Fund. COBRA coverage is not available to a Domestic Partner.

Before making a decision to purchase COBRA, an eligible Spouse should review the costs and benefits available through the Covered California marketplace. An eligible Spouse may also be eligible for special enrollment in an employer-provided plan in which his or her new Spouse (if any) participates. COBRA coverage is not available to a Domestic Partner.

b) Rights of Eligible Spouse

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

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

Note that, because Spouses are generally eligible to pay a reduced rate for coverage under the Survivor Premium Program, it only rarely makes sense for a Spouse to elect COBRA coverage.

ii) How Long will Continuation Coverage Last?

COBRA Continuation Coverage for an eligible Spouse may be continued for up to 36 months after the date of divorce or the date of the Pensioner's death.

COBRA Continuation Coverage will end before the 36-month continuation coverage period expires if the eligible Spouse:

a) Fails to pay the required Premium on time; or
b) Becomes covered by another group health Plan (except a Plan that excludes or limits benefits for a pre-existing condition affecting the eligible Spouse, and such exclusion or limitation is enforceable under Health Insurance Portability and Accountability Act (HIPAA); or
c) Becomes entitled to Medicare.

COBRA Continuation Coverage will also end early if such coverage is no longer available under this Plan because the Plan terminates.

iii) Duty to Notify the Fund

a) Divorce or Dissolution of Domestic Partnership

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

If the required notice is not provided within the time allowed, COBRA self-payment will not be permitted, and any applicable Premium adjustment will be prospective only, not retroactive to the date of the event. Note that COBRA coverage is not available to a Domestic Partner.

The Pensioner and/or Spouse/Domestic Partner will be required to refund any monies paid by the Fund after the date of divorce or dissolution of domestic partnership. If the Fund Office determines that a refund is due, it will be offset against any overpaid claims.

No refunds will be made for partial months of coverage.

b) Death

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

If a death certificate is not provided within 12 months of the date of death, any applicable Premium adjustment will be prospective only, not retroactive to the date of death.

No refunds will be made for partial months of coverage.

iv) How Is Continuation Coverage Elected?

To elect continuation coverage, you must complete the election form and return it according to the directions on the form.

v) How Much Does Continuation Coverage Cost?

The amount you can be required to pay for COBRA Continuation Coverage may not exceed 102% of the cost to the group health plan for coverage of a similarly situated person who is not receiving continuation coverage. The required payment for continuation coverage is described in the notices you will receive when you qualify for COBRA coverage.

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

a) Your First Payment

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

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

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

b) Periodic Payments for Continuation Coverage

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

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

c) Grace Period for Periodic Payments

Although periodic payments are due on the dates shown above, you will be given a grace period until the end of the month of the coverage month or 30 days, whichever is greater, to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. Coverage will not be confirmed until payment is received. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

d) Form of Payment

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

e) Payments

Payments for continuation coverage should be sent to:

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

vii) For More Information

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

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

B) Special Extension Period for Survivors

In the event of the Participant's death, coverage for the Survivor, if any, may be provided under this Plan, at no cost for up to three months. This is called the Special Extension Period.

i) Survivors of Participants in this Plan

Special Extension Period coverage for the Survivor of a Pensioner will be provided under this Plan, at no cost, for three months following the month in which the Pensioner died.

ii) Survivors of Participants in the Active Plan

Special Extension Period coverage for the Survivor of an Active Participant in the Active Plan is available under this Plan if, at the time of the Active Participant's death, the number of months in the Active Participant's Eligibility Bank is less than three. The length of the Special Extension Period is the number of months necessary, in combination with the months remaining in the Active Participant's Eligibility Bank, to give the Survivor coverage for three months following the month in which the Active Participant died.

C) Survivor Premium Program

There are two types of Survivors who can qualify for the Survivor Premium Program and choose to continue coverage under this Plan.

i) Survivor of a Deceased Pensioner

a) Surviving Spouse

As of the end of the Special Extension Period, a surviving Spouse may choose to continue coverage either in this Plan through COBRA or through the Survivor Premium Program. If the surviving Spouse elects COBRA, he/she will not be eligible to enroll in this Plan. COBRA is rarely the better option.

b) Surviving Domestic Partner

As of the end of the Special Extension Period, a surviving Domestic Partner may choose to continue coverage in this Plan through the Survivor Premium Program. (A Domestic Partner is not a Qualified Beneficiary under COBRA and therefore does not have the option of electing COBRA coverage in the Active Plan.)

ii) Survivor of a Deceased Active Participant

These benefits are available to a Survivor who was covered in the Active Plan on the Active Participant's date of death.

a) Surviving Spouse

As of the end of the Special Extension Period, a surviving Spouse may choose to continue coverage either in the Active Plan through COBRA or through the Survivor Premium Program. If the surviving Spouse elects COBRA, he/she will not be eligible to enroll in this Plan.

b) Surviving Domestic Partner

As of the end of the Special Extension Period, a surviving Domestic Partner may choose to continue coverage in this Plan through the Survivor Premium Program. (A Domestic Partner is not a Qualified Beneficiary under COBRA and therefore does not have the option of electing COBRA coverage in the Active Plan.)

The Fund Office will provide the eligible Survivor with the Application for the Survivor Premium Program if it has been timely notified of the death. For additional information regarding this category of Survivors, see the SPD for the Active Plan.

iii) Application & Payment

a) Application and Initial Payment Deadlines

If the Fund Office is made aware timely that the Pensioner or Active Participant has died, a COBRA election form and/or a Survivor Premium Program application will be mailed to the Survivor. The complete COBRA election form (if applicable) or Survivor Premium Program application must be returned to the Fund Office within 60 days of the notice.

(A Domestic Partner is not a Qualified Beneficiary under COBRA and therefore does not have the option of electing COBRA coverage, but may participate in the Survivor Premium Program.)

Once the Survivor has made the appropriate election, he/she has 60 days from the loss of coverage, including the Special Extension Period, to pay the Premium due, retroactive to the loss of coverage.

b) Payment Amount

At the time of publication, the Survivor Premium was $140 per month. The Trustees may change the amount from time to time.

c) Timely Premiums

Subsequent Premiums are due by the 20th of the month before the month of coverage and an additional grace period of 30 days is provided from the beginning of the month of coverage. However, no coverage will be provided until payment is received. A Survivor who does not pay within these deadlines will lose coverage and will not be permitted to reinstate coverage.

You may elect to have the Premium amount deducted from your monthly pension check, if any. You may also have your monthly Premium deducted from your checking or savings account electronically. If you do not elect to have the applicable Premium paid automatically, you must personally make payments directly to the Fund in order to retain coverage under the Plan.

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

d) Termination of Survivor Coverage

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

1) The date you remarry or enter into a domestic partnership. All benefits paid after the date of remarriage or domestic partnership must be reimbursed to the Fund. Legal action may be taken to recover such benefits; or
2) Whenever a Premium is not received timely; or
3) The date the Plan terminates.

NOTE	**If you fail to pay Premiums timely, you will permanently lose coverage under the Plan.**

NOTE	**If you are eligible to participate in the Pensioners and Surviving Spouses Health Fund, but initially elect COBRA Continuation Coverage under the Active Plan, you cannot subsequently elect or receive coverage under the Pensioners and Surviving Spouses Plan. Similarly, if you initially elect coverage under the Pensioners and Surviving Spouses Plan you cannot subsequently elect or receive COBRA coverage under the Active Plan.**

D) Extended Coverage in Case of Total Disability

If your eligibility, or your Eligible Dependent's eligibility, terminates while you or he/she is Totally Disabled, medical expense benefits will be available, for that disabling condition only, for three months after the loss of eligibility. This extension is for the disabled individual only. The extension must be requested in writing, and a statement from the attending Physician is required. This benefit is not included in COBRA coverage.

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

SECTION 6. MONTHLY PREMIUM

A) Premium Classifications and Range Classes

The amount of your monthly Premium is determined by the classifications and range classes described below.

i) Premium Classifications

Participants are grouped into the following categories, based on Medicare eligibility, marital or Domestic Partnership status, and the Eligible Dependent's Medicare eligibility. An individual's classification will be evaluated each month.

Classification	Definition
MM	**M**ember (Pensioner) is **M**edicare-eligible; no Eligible Dependent is covered under the Plan
MMSM	**M**ember (Pensioner) is **M**edicare-eligible; covered Eligible Dependent is **M**edicare eligible
MMSN	**M**ember (Pensioner) is **M**edicare-eligible; covered Eligible Dependent is **N**ot Medicare-eligible
MN	**M**ember (Pensioner) is **N**ot Medicare-eligible; no Eligible Dependent is covered under the Plan
MNSM	**M**ember (Pensioner) is **N**ot Medicare-eligible; covered Eligible Dependent is **M**edicare-eligible
MNSN	**M**ember (Pensioner) is **N**ot Medicare-eligible; covered Eligible Dependent is **N**ot Medicare-eligible

ii) Premium Score and Range Class

You are given a score under a combination point system called the "Rule of 100". Your "Rule of 100" score is determined only once, at the time of your initial retirement under the Southern California Pipe Trades Retirement Plan, and is based upon your age plus the number of Pension Credits you had accrued under the Retirement Plan at the time of your initial retirement. For example, an individual who retires at age 65 with 35 Pension Credits will receive a score of 100. An individual who retires at age 60 with 25 Pension Credits will receive a score of 85.

Your score will be reduced by four points for every year (or portion of a year) you worked in the plumbing and pipefitting industry for an Employer that is not signed to a United Association master labor agreement. Years prior to your first year of Pension Credit will not count for this purpose. However, if you return to work in Covered Employment, you can regain points lost for working in non-Covered Employment. In addition to earning points, one point of lost coverage can be restored for working in non-Covered Employment for every two service points earned after returning to Covered Employment. Years prior to a permanent break in service under the Retirement Plan cannot be restored.

If you receive a disability pension at the time of your initial retirement, in determining your score, it will be assumed that you have reached Normal Retirement Age under the Southern California Pipe Trades Retirement Plan (age 65).

NOTE	**Your premium score will be determined once, at the time of your initial retirement under the Southern California Pipe Trades Retirement Plan, and will not later be revised.**

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

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

B) Premium Rates

i) As of the publication date of this SPD, the monthly Premium for eligible Survivors is $140 per month.

ii) The following chart shows the monthly Premium amounts for Pensioners and their Survivors effective from January 1, 2019 through December 31, 2019. For example:

a) If you are Medicare-eligible, but your Eligible Dependent is not Medicare-eligible (MMSN), and you retire at age 65 with 25 Pension Credits (Range Class "C"), your monthly Premium would be $333.

b) If you are unmarried (MM) and retire at age 65 with 35 Pension Credits years of service (range class "A"), your monthly Premium would be $131.

Classification	Range Class						
	A	B	C	D	E	F	G
	100 +	95 - 99	90 - 94	85 - 89	80 – 84	75 - 79	< 75
MM	$131	$131	$131	$131	$150	$174	$201
MMSM	$131	$131	$158	$194	$243	$283	$326
MMSN	$184	$258	$333	$407	$508	$591	$683
MN	$330	$330	$330	$354	$441	$514	$594
MNSM	$330	$330	$333	$407	$508	$591	$683
MNSN	$330	$330	$386	$473	$591	$687	$795

C) Changes to or Refunds of Premiums

i) Changes to Premiums

Premium amounts are subject to change. For example:

a) Premiums may be changed at any time at the discretion of the Board of Trustees.

b) Premiums for Pensioners and Eligible Dependents, and Survivors, are normally reviewed annually and adjusted to reflect changes in the cost of coverage.

c) When a Pensioner or Eligible Dependent turns age 65, the Fund Office will assume that he/she has become eligible for Medicare and will reduce the Premium accordingly. The reduced monthly Premium amount will be effective on the first of the month in which the Pensioner or Eligible Dependent becomes Medicare-eligible.

d) In the case of Medicare eligibility based on a Social Security disability award rather than age, the Premium reduction will begin in the month following the month in which the Pensioner or Eligible Dependent receives written notice of an award of a Social Security disability benefit or in the Social Security disability entitlement month, whichever is later.

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

ii) Refunds of Premiums

In some cases, the Fund will apply a change in Premium retroactively and refund overpaid amounts. In order for a refund to be considered, you must timely advise the Fund Office of any change that may affect your Premium rate, such as:

a) Death of the Pensioner, Spouse, Domestic Partner, or Survivor;

b) Pensioner's divorce, or dissolution of domestic partnership;

c) Pensioner's Spouse's or Domestic Partner's Medicare eligibility; or

d) Survivor's remarriage or new domestic partnership.

Note that:

a) The Fund Office should be notified of a Pensioner's death within 60 days, in order to preserve a Survivor's right to COBRA or Survivor Premium Program coverage.

b) If a death certificate is not provided within 12 months of the date of death, any applicable Premium adjustment will be prospective only, not retroactive to the date of death.

c) If notice of divorce, or dissolution of domestic partnership, or remarriage, or new domestic partnership of a Survivor, or Medicare eligibility, is not provided within 60 days of the event, any applicable Premium adjustment will be prospective only, not retroactive to the date of the event.

d) If the Fund Office determines that a refund is due, it will be offset against any overpaid claims.

e) No refunds will be made for partial months of coverage.

D) Making a Premium Payment

As discussed in Section 4 on page 9, in order to keep coverage under the Pensioners and Surviving Spouses Plan, you must:

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

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

EXAMPLE	**The payment for July 2018 coverage is due no later than June 20, 2018. If payment is not received by July 31st, your coverage will be permanently terminated.**

E) Coverage for Pensioners Eligible for a Retroactive Disability Benefit

If you (1) are awarded a retroactive disability pension under the Southern California Pipe Trades Retirement Fund, (2) you qualify for and elect coverage in the this Plan, and (3) you provide proof of Continuous Comparable Coverage since your most recent month of eligibility in the Southern California Pipe Trades Health & Welfare Fund, you will be eligible under, and pay monthly premiums to, this Plan as of your Annuity Starting Date, and not your earlier "disability entitlement date".

Absent proof of Continuous Comparable Coverage, your eligibility under this Plan will be retroactive to your "disability entitlement date" and you must pay monthly Premiums for the entire retroactive eligibility period.

Your "disability entitlement date", not your Annuity Starting Date, is used to determine whether or not you meet the requirements to be eligible for coverage from the Plan.

Your "disability entitlement date" is usually six months after your Social Security "disability onset date", which is the date the Social Security Administration determines that you first become disabled.

If you are a disabled Pensioner and you pay for COBRA continuation coverage after your Active Plan Eligibility Bank runs out, any retroactive coverage from this Plan shall commence after the end of the COBRA coverage period.

See also Section 11(B), page 34.

SECTION 7. PLAN BASICS

A) Lifetime Maximum Benefit (LMB)

Effective January 1, 2019, you and your Eligible Dependent or your Survivor each have an LMB of $2,000,000.

Before January 1, 2019, the LMB may have been different. See previous SPDs or contact the Fund Office for more information.

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

B) Calendar Year Deductible

You and/or your Eligible Dependent are responsible for the first $250 in amounts otherwise payable by the Plan in a Calendar Year. This is called the Calendar Year Deductible. The Calendar Year Deductible applies separately to you and your Eligible Dependent.

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

The Calendar Year Deductible does not apply to the:
i) Hearing aid benefit – There is a separate $50 per device Deductible.
ii) Prescription Drug Benefit – There is a separate $50 Calendar Year Deductible for Prescription Drugs.

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

C) Preferred Provider Organization (PPO) Network

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

Blue Shield of California (BSC) is a non-profit organization that provides you with an expansive network of doctors, Hospitals and other health care providers and facilities who have agreed to provide services at fixed and generally lower prices. The goal is to provide for the delivery of quality health care services at a reasonable cost.

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

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

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

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

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

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

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

D) When Claims are Paid

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

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

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

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

E) What the Plan Will Pay

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

i) Blue Shield of California PPO Network Providers

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

The Blue Shield of California PPO Network Rate is the amount a participating provider has agreed to accept in payment for specific services. The participating provider cannot charge above the Blue Shield of California PPO Network Rate. In most cases, but not all, the Plan pays 80% of the Blue Shield of California PPO Network Rates.

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

ii) Out-of-Network Providers

If you use an out-of-network provider, the Fund's payment of benefits for Medically Necessary Covered Services will be based on a percentage of an Allowable Charge.

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

IMPORTANT	**No 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. The Plan makes no representation or guarantee of any kind that any provider will furnish health care services or supplies that are error-free or that the provider you select is competent to treat your condition. This applies to any and all health care providers, including both Blue Shield of California PPO network providers and out-of-network providers under the terms of the Plan, and all entities (and their agents, employees and representatives) that contract with the Fund to offer health-related services or supplies. Nothing in this Plan restricts the ability of a provider to disclose alternative treatment options.**

F) Out-of-Area Services

Blue Shield of California has a variety of relationships with other Blue Cross and/or Blue Shield Plans Licensees. Generally, these relationships are called "inter-plan arrangements" and they work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you receive Covered Services outside of California, the claims for these services may be processed through one of these inter-plan arrangements described below.

When you access Covered Services outside of California, but within the United States, the Commonwealth of Puerto Rico, or the U. S. Virgin Islands ("BlueCard® service area"), you will receive the care from one of two kinds of providers. Participating providers contract with the local Blue Cross and/or Blue Shield Plan or licensee in that other geographic area ("Host Blue"). Non-participating providers don't contract with the Host Blue. Blue Shield of California's payment practices for both kinds of providers are described below.

i) Emergency Services

Patients who experience an Emergency Medical Condition while traveling outside of California should seek immediate care from the nearest Hospital. The benefits of this Plan will be provided anywhere in the world for treatment of an Emergency Medical Condition.

ii) BlueCard Program

Under the BlueCard® program, benefits will be provided for Covered Services received outside of California, but within the BlueCard service area. When you receive Covered Services within the geographic area served by a Host Blue, Blue Shield of California will remain responsible for doing what it agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers, including direct payment to the provider.

The BlueCard program enables you to obtain Covered Services outside of California from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will automatically file a claim for the services provided to you, so there are no claim forms for you to fill out. You will be responsible for your Coinsurance and Deductible amounts, if any, as stated in this SPD.

The Fund calculates your share of cost as described in this SPD. Whenever you receive Covered Services outside of California, within the BlueCard service area, and the claim is processed through the BlueCard program, the amount you pay for Covered Services is calculated based on the lower of:

a) The billed charges for Covered Services; or
b) The negotiated price that the Host Blue makes available to Blue Shield of California.

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims as noted above. However, such adjustments will not affect the price Blue Shield of California used for your claim because these adjustments will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, your liability for any Covered Services will be calculated according to applicable law.

To find participating BlueCard providers you can call BlueCard Access® at (800) 810-BLUE (2583) or go online at www.bcbs.com and select "Find a Doctor".

Prior authorization may be required for non-emergency services. To receive prior authorization from Blue Shield of California, the out-of-area provider should call the customer service number noted on the back of your identification card.

iii) Non-participating Providers Outside of California

When Covered Services are provided outside of California and within the BlueCard service area by non-participating providers, the amount you pay for such services will normally be based on either the Host Blue's non-participating provider local payment, the Allowable Charge the Fund pays a Non-Participating Provider in California if the Host Blue has no non-participating provider allowance, or the pricing arrangements required by applicable state law. In these situations, you will be responsible for any difference between the amount that the non-participating provider bills and the payment the Fund will make for Covered Services as set forth in this paragraph.

If you do not see a participating provider through the BlueCard program, you will have to pay the entire bill for your medical care and submit a claim to the local Blue Cross and/or Blue Shield plan, or to the Fund Office, for reimbursement. Blue Shield of California will review your claim and notify you of its coverage determination within 30 days after receipt of the claim. You will be reimbursed as described in the preceding paragraph. Remember, your share of the cost is higher when you see a non-participating provider.

Federal or state law, as applicable, will govern payments for out-of-network Emergency Services. The Fund pays claims for covered Emergency Services based on the Allowable Charge as defined in this SPD.

Prior authorization is not required for Emergency Services. In an emergency, go directly to the nearest Hospital. Please notify Blue Shield of California of your emergency admission within 24 hours or as soon as it is reasonably possible following medical stabilization.

iv) Blue Shield Global® Core

If you are outside of the BlueCard® service area, you may be able to take advantage of "Blue Shield Global Core" when accessing out-of-area Covered Services. Blue Shield Global Core is unlike the BlueCard program available within the BlueCard service area in certain ways. For instance, although Blue Shield Global Core assists you with accessing a network of inpatient, outpatient, and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the provider and submit the claim yourself to obtain reimbursement for these services.

If you need assistance locating a doctor or hospital outside the BlueCard service area you should call the service center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week. Provider information is also available online at www.bcbs.com: select "Find a Doctor" and then "Blue Shield Global Core".

When you pay directly for services outside the BlueCard service area, you must submit a claim to obtain reimbursement. You should complete a Blue Shield Global Core claim form and send the claim form along with the provider's itemized bill to the service center at the address provided on the form to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Blue Shield of California service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week.

v) Special Cases: Value-Based Programs

You may have access to Covered Services from providers that participate in a value-based program. Value-based programs include, but are not limited to, accountable care organizations, episode based payments, patient centered medical homes, and shared savings arrangements.

If you receive covered services through the BlueCard® program under a value-based program inside a Host Blue's service area, you will not be responsible for paying any of the provider incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to Blue Shield of California through average pricing or fee schedule adjustments.

SECTION 8. MEDICAL BENEFITS

Benefits are listed in alphabetical order.

Acupuncture

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, not to exceed 20 visits per Calendar Year.

Allergy Testing

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable.

Allergy Treatment

The Plan will pay up to $75 per vial of antigens, including the charges for the injection, payable at 80% not to exceed a maximum of $750 per Calendar Year. The Plan will pay for up to a three-month supply of antigens, but will do so no more than four times in any 12-month period.

Ambulance/Air Ambulance

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

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

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

Anesthesia

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable. For pain management benefits, see this section, page 27.

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

NOTE	**For pain management services, see this section, page 27.**

Bariatric Surgery

Bariatric Surgery is not a covered benefit under this Plan.

Cardiac Rehabilitation

For cardiac rehabilitation provided by a Blue Shield of California PPO network provider, the Plan will pay 80% of the Blue Shield of California PPO Network Rate.

For cardiac rehabilitation provided by an out-of-network provider, the Plan will pay 80% of the Allowable Charge up to a maximum of $20 per visit.

Cardiac rehabilitation services rendered in an Inpatient Hospital setting will be paid under the Hospital benefit.

Chemotherapy

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% Allowable Charge, whichever is applicable.

Chiropractic Care

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, up to 3 visits per week, with a maximum of $600 per Calendar Year.

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

Colonoscopy/Sigmoidoscopy (Screening)

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, for a screening colonoscopy or sigmoidoscopy once every five years for Patients age 50 and older.

Hospital or Outpatient facility charges will be paid at the Hospital benefit.

Dialysis (Renal)

A) Physician's office
   The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, for services rendered in a professional office.
B) Hospital or facility
   For renal dialysis provided by a Blue Shield of California PPO network provider, the Plan will pay 80% of the Blue Shield of California PPO Network Rate per visit.

   For renal dialysis provided by an out-of-network provider, the Plan will pay 80% of the Allowable Charge up to a maximum of $200 per visit.

Durable Medical Equipment

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, for the Durable Medical Equipment listed below, if Medically Necessary and authorized by a licensed Physician or Podiatrist:

A) Rental of wheelchair, hospital bed, and other durable equipment, not to exceed the purchase price of the item. (The Plan will provide benefits for basic equipment, not for upgraded items such as electric wheelchairs, sports wheelchairs, electric scooters, or electric hospital beds.)
B) Prosthetic devices that improve or maintain the function of an impaired body part.
C) Insulin Pumps.
(Note: The Plan pays for up to $160 per month for supplies.)
D) C-pap devices.
(Note: The Plan pays for up to $150 per 12-month period for supplies.)
E) Foot Orthotics subject to a $200 lifetime maximum benefit.

Benefits paid on rental-to-purchase basis based on monthly eligibility of the Patient.

Replacement or repair of Durable Medical Equipment is permitted no more often than once every 36 months.

See Section 15, page 40 for further Exclusions and Limitations for Durable Medical Equipment.

Emergency Services by Out-of-Network Providers

When a claim for Medically Necessary Emergency Services by an out-of-network provider is received, and the Plan determines that the services rendered are due to an Emergency Medical Condition, the Plan will pay an amount that is reasonable, as determined by the Plan. This amount is calculated using Medicare rates, UCR (usual, customary, and reasonable), or negotiation with the provider.

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

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

Genetic Testing

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, for genetic testing and/or screening deemed Medically Necessary.

Medical Necessity is as determined by the Plan and generally must meet all of the following three criteria:
A) One of the following:
i) Family history suggestive of a heritable condition;
ii) Specific symptoms suggestive of a heritable condition; or
iii) Medical management requires consideration of genetic variants; and
B) Testing will impact treatment or heighten monitoring for early detection of disease; and
C) Evidence-based data supports the validity and utility of the test.

Hearing Aid Benefit

The Plan will pay 80% of the charge after a separate $50 Deductible per device up to a maximum of $800 per device and not to exceed one device per ear in a 36-month period. Replacements will not be covered until 36 months have elapsed from the date the expense was incurred for the existing device.

EXAMPLE	**If a right ear device was dispensed on March 21, 2017, no additional benefits will be allowed until March 22, 2020. If a left ear device is dispensed on October 14, 2017, no additional benefits will be allowed until October 15, 2020.**

Home Health Nursing

For home health nursing provided by a Blue Shield of California PPO network registered nurse, nurse practitioner, licensed vocational nurse, or skilled practical nurse, the Plan will pay 80% of the Blue Shield of California PPO Network Rate.

For home health nursing provided by an out-of-network registered nurse, nurse practitioner, licensed vocational nurse, or skilled practical nurse, the Plan will pay 80% of the Allowable Charge up to a maximum of $60 per day.

The Plan limits home health care benefits to no more than 120 visits per Calendar Year. The 120 visits can be a combination of home health care and Extended Care Facility/Convalescent Care Facility or skilled nursing facility services.

Home Intravenous (IV) Therapy

The Plan will pay 85% of the Blue Shield of California PPO Network Rate or 85% of the Allowable Charge, whichever is applicable.

Hospice

The Plan will pay 85% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, if you have been diagnosed as Terminally Ill and elect, with the approval of a Physician, to be treated by a Hospice Care Program at a Hospice facility or at home.

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

Hospital

A) Introduction

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

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

i) Guest expenses;
ii) Telephone charges;
iii) Chemical dependency or substance abuse treatment or related drug testing; or
iv) Charges by a Hospital for any standby services, including the availability of a "trauma team".

See also Exclusions and Limitations, Section 15, page 40.

B) Inpatient

i) Blue Shield of California PPO Network Hospital
The Plan will pay 85% of the Blue Shield of California PPO Network Rate.

ii) Out-of-Network Hospital
The Plan will pay 80% of the Allowable Charge, up to a maximum of $1,080 per day, except where the Plan determines that the services rendered are due to an Emergency Medical Condition. (See this section, page 24.)

NOTE	**A fully itemized bill is required from the facility.**

C) Outpatient

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

i) Blue Shield of California PPO Network Hospital
The Plan will pay 85% of the Blue Shield of California PPO Network Rate.

ii) Out-of-Network Hospital
The Plan will pay 80% of the Allowable Charge, up to a maximum of $1,080 per day, except where the Plan determines that the services rendered are due to an Emergency Medical Condition. (See this section, page 24.)

NOTE	**For pain management services, see this section, page 27.**

Immunizations

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, based on Blue Shield of California's recommended schedule.

Laboratory

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable.

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

Medical Supplies

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, for the items listed below if Medically Necessary and authorized by a licensed Physician or Podiatrist:

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

Mental Health

A) The Plan will pay for room and board and Medically Necessary services and supplies billed by a Hospital.

   i) Hospital or office visits for mental health care are Covered Services when provided by any of the following professionals practicing within the scope of his/her license in the state in which he/she practices:

      a) Physician;
      b) Psychiatrist;
      c) Psychologist;
      d) Licensed Clinical Social Worker;
      e) Licensed Professional Counselor;
      f) Master Social Worker;
      g) Marriage and Family Therapist; or
      h) Board Certified Behavior Analyst (or ABA therapist under the supervision of a Board Certified Behavior Analyst).

      Group therapy in the Hospital is not a covered benefit.

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

      a) Guest expenses;
      b) Telephone charges;
      c) Chemical dependency or substance abuse treatment or related drug testing; or
      d) Charges by a Hospital or any standby services, including the availability of a "trauma team".

   See also Exclusions & Limitations, Section 15, page 40.

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

   i) Blue Shield of California PPO Network Facility
      The Plan will pay 85% of the Blue Shield of California PPO Network Rate, up to a maximum of $27 per day.
   ii) Out-of-Network Facility
      The Plan will pay 80% of the Allowable Charge, up to a maximum of $27 per day.

C) Inpatient Hospital

   i) Blue Shield of California PPO Network Hospital
      The Plan will pay 85% of the Blue Shield of California PPO Network Rate.
   ii) Out-of-Network Hospital
      The Plan will pay 80% of the Allowable Charge, up to a maximum $1,080 per day, except where the Plan determines that the services rendered are due to an Emergency Medical Condition. (See this section, page 24.)

D) Outpatient – Office Setting
Children under five years of age require a referral by their attending Physician or Psychiatrist for psychiatric care and/or testing.

i) Blue Shield of California PPO Network Provider
The Plan will pay 80% of the Blue Shield of California PPO Network Rate.
ii) Out-of-Network Provider
The Plan will pay 80% of the Allowable Charge.

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

i) Blue Shield of California PPO Network Facility
The Plan will pay 85% of the Blue Shield of California PPO Network Rate.
ii) Out-of-Network Facility
The Plan will pay 80% of the Allowable Charge, up to a maximum $1,080 per day.

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

i) Blue Shield of California PPO Network Facility
The Plan will pay 85% of the Blue Shield of California PPO Network Rate.
ii) Out-of-Network Facility
The Plan will pay 80% of the Allowable Charge, up to a maximum $1,080 per day.

Non-prescription and Over-the-Counter Drugs

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

Occupational Therapy

For occupational therapy, the Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, up to a maximum of $1,200 per Calendar Year. The yearly maximum is combined with Physical Therapy.

Occupational therapy is covered for the treatment of a hand Injury or hand disability only. Services must be rendered by a licensed occupational therapist.

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

Opioid Drug Testing

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable.

The Plan will cover opioid drug testing, per Medicare guidelines, except that the Plan:

A) Does not cover anything related to the treatment of substance abuse; and
B) Will cover opioid drug testing no more than once every three months.

Pain Management

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, up to a maximum of $10,000 per lifetime, for pain management expenses. This includes charges for the Physician and facility, up to $900 per day for a Hospital, $800 per day for a surgery center, or $700 per day for a Physician's office or surgery suite. If an injection is included in the course of treatment, the Plan will, in addition to the above limits, pay up to $250 per injection, not to exceed three injections per day. The Patient will be responsible for any charges in excess of the Blue Shield of California PPO Network Rate or the Allowable Charge.

These limitations apply to both Blue Shield of California PPO network and out-of-network providers.

Physical Examinations

If you incur any of the preventive expenses listed below while undergoing a physical examination authorized and performed by a Physician, the Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable. The Plan covers only one routine physical examination per Calendar Year per person. However, an additional examination will be permitted if a Pap Smear was not performed during a routine physical examination earlier in the Calendar Year.

A physical examination includes, but is not limited to:

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

Physical Therapy

If you incur charges for outpatient physical therapy, by a licensed Physical Therapist, the Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, up to a maximum of $1,200 per Calendar Year. The yearly maximum is combined with Occupational Therapy.

These services require a prescription from your Physician.

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

Physician or Psychiatrist Visits/Professional Services

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable.

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

A) A trauma team in the emergency room; or
B) A "standby" surgeon or anesthesiologist during a surgical procedure.

Radiation Therapy

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable.

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

Radiology

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable.

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

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

The Plan will pay 85% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable, for a maximum of 120 days per Calendar Year. Extended Care Benefits follow Medicare Guidelines which require care to be provided within three days of a four-day inpatient Hospital confinement.

The Plan limits Extended Care Facility/Convalescent Care Facility or skilled nursing facility benefits to no more than 120 visits per Calendar Year. The 120 visits can be a combination of home health care and Skilled Nursing Facility also called and Extended Care Facility/Convalescent Care Facility services.

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

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

Sleep Study

The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable.

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

Speech Therapy

If, as a result of an Illness or Injury, you suffer speech impairment or loss and are referred by a Physician to a qualified speech pathologist, the Plan will pay 80% of the Blue Shield of California PPO Network Rate if a Blue Shield of California PPO network provider is used, or a maximum of $18.00 or billed charges if less, per visit, if an out-of-network provider is used. Speech therapy is not covered for developmental or learning problems or disorders.

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

Substance Abuse
Substance abuse treatment is not covered under the Plan. Acute medical detoxification rendered in a Hospital setting will be paid at the Hospital benefit.

Surgery
The Plan will pay 80% of the Blue Shield of California PPO Network Rate or 80% of the Allowable Charge, whichever is applicable.

Temporomandibular Joint Dysfunction (TMJ)
Treatment for TMJ is not a covered benefit under this Plan.

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

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

B) Artificial parts transplants are limited to:
   i) Joint replacement for functional reasons;
   ii) Skin;
   iii) Heart valves;
   iv) Vascular grafts and patches;
   v) Pacemakers;
   vi) Metal plates; and
   vii) Eye after cataract Surgery.

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

Plan benefits are payable to an organ donor at the Blue Shield of California PPO Network Rate or the out-of-network Allowable Charge, whichever is applicable, up to the maximum benefit limit, incurred by the donor (whether or not the donor is eligible under the Plan), which are directly related to the transplant Surgery only if the organ recipient is eligible under this Plan and provided that such expenses are not payable from any other source including, but not limited to, medical plans, medical research organizations, and charitable organizations. The Blue Shield of California PPO Network Rate or the Allowable Charge for an organ donor is included in the maximum payable in connection with any-organ transplant of $100,000 and is included in your Lifetime Maximum Benefit.

Vision Services – After Cataract Surgery
Routine vision services such as eye exams, fittings, glasses, and contact lenses are not a covered benefit. However, after cataract surgery, the Plan will pay up to $100 per eye for glasses or contact lenses.

SECTION 9. PRESCRIPTION DRUG BENEFITS

A) Benefit Limitations
The Plan's maximum Calendar Year Prescription Drug benefit is $1,200 per person, subject to a separate $50 Calendar Year Deductible.

Subject to the maximum annual benefit, the Plan will reimburse you for 100% of amounts you pay for covered Prescription Drugs, net of any rebates or discounts you receive, and except for the $50 Deductible.

EXAMPLE	**You paid $6,550 for covered Prescription Drugs in 2018. The first $50 you paid was applied to your Prescription Deductible. The next $1,200 you paid was reimbursed at $1,200 ($1,200 x 100%). The remaining $5,300 you paid exceed the Prescription Drug benefit and was not reimbursed. In total, you received $1,200 in Prescription Drug reimbursements.**

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

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

Prescription Drugs dispensed in a provider's office are not a covered benefit under the Plan. Drugs prescribed for off-label use are not a covered benefit under the Plan.

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

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

Prescription Drugs include up to 30 pills annually for the treatment of erectile dysfunction.

B) Claim Requirements

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

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

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

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

C) Medicare Part D

The Pensioners & Surviving Spouses Health Plan Prescription Drug benefit is not "actuarially equivalent" to Medicare Part D, and is therefore not "creditable coverage" under Medicare rules. This means that if you do not sign up for Medicare Part D when you first become eligible you may have to pay a higher premium for your Medicare Part D coverage for as long as you are covered under Medicare Part D. You can avoid this increase in premium by not going more than 63 days without "creditable coverage".

Because Medicare Part D provides better benefits, on average, than this Plan does, and because you may therefore pay a penalty if you do not enroll in Medicare Part D when you are first eligible, you should seriously consider enrolling in a Medicare Part D Prescription Drug plan.

Detailed information about Medicare is available through the "Medicare & You" handbook from Medicare. You are strongly encouraged to study the Medicare handbook. If you have not received a copy, you can download it from www.medicare.gov/publications. You can also obtain more information about Medicare from:

i) www.medicare.gov;
ii) (800) MEDICARE (TTY users should call (877) 486-2048); or
iii) California Health Advocates at (800) 434-0222.

SECTION 10. DENTAL BENEFITS

You may choose to purchase coverage in one of two DeltaCare USA DHMO options at the time you first become eligible for Plan benefits, and thereafter during annual open enrollment periods, as long as you remain eligible under this Plan. You may also elect to purchase DeltaCare USA DHMO coverage for your Spouse/Domestic Partner. However, coverage can only be purchased for your Spouse/Domestic Partner if you purchase coverage.

A) Enrollment

To enroll, you must complete a Dental Enrollment Form. You may obtain a Dental Enrollment Form from any local Union office, the Fund Office, or the Fund website at www.scptac.org.

i) Initial Enrollment

You must enroll no later than 60 days from your initial eligibility date or during annual open enrollment periods.

ii) Changing Plans

Once enrolled, you will be able to change your enrollment during annual open enrollment periods.

B) Benefit Options

i) The DeltaCare USA High DHMO option offers greater benefits for a higher monthly premium.
ii) The DeltaCare USA Medium DHMO option offers lesser benefits for a lower monthly premium.

A more thorough description of these options is available by contacting DeltaCare USA at (800) 422-4234.

C) Premiums

Premiums for DeltaCare USA DHMO coverage are in addition to the normal monthly Premium that you pay for medical and prescription drug coverage under the Plan. Also, unlike the Premiums for medical and prescription drug coverage, the premiums for DeltaCare USA DHMO coverage will not vary based on the number of Retirement Fund Pension Credits you had when you retired, your age at retirement, or your or your Spouse/Domestic Partner's Medicare status.

At the time of publication, monthly premiums for the two DeltaCare USA DHMO options were as follows:

DeltaCare USA DHMO Plan	Pensioner or Survivor	Pensioner and Spouse/ Domestic Partner
High	$17.03	$33.99
Medium	$11.70	$23.25

Monthly premiums for DeltaCare USA DHMO coverage must be deducted from your Southern California Pipe Trades Retirement Fund pension benefit. By signing a Dental Enrollment Form, you authorize this deduction. A Survivor must also have any DeltaCare USA DHMO premium deducted from his/her Southern California Pipe Trades Retirement Fund pension benefit, unless the Survivor is not receiving such a benefit, in which case premium payments must be made by monthly electronic ACH transfer from a bank account, which must be authorized in writing by the Survivor. DeltaCare USA DHMO premiums will not be accepted by check, money order, cash, or any other method.

D) Cancelling Coverage

You may cancel DeltaCare USA DHMO coverage at any time. However, if you cancel coverage, you will not be permitted to re-enroll in DeltaCare USA DHMO coverage until the next open enrollment period. Any cancellation will apply both to you and your Spouse/Domestic Partner, if applicable.

E) Benefit Limitations

See the DeltaCare USA DHMO materials for detailed information regarding DeltaCare USA's rules and benefits.

Both DeltaCare USA options are DHMOs. You must live within the DHMO's service area in order to qualify for benefits. You must use only your assigned Dentist in the DeltaCare USA DHMO network. Before enrolling, you should check that the DeltaCare USA DHMO network operates where you live.

The Plan's rules determine who is an Eligible Dependent for all benefits, including DeltaCare USA DHMO. Some DeltaCare USA DHMO documents may imply that a broader range of persons qualify as Eligible Dependents. Only Spouses and Domestic Partners are covered under the Plan.

F) Claims Procedures

Dental claims are processed by Delta Dental.

Dental claims should be sent to:

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

G) Appeals Procedures

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

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

H) Coverage Comparison

Sampling of Covered Procedures[1]	DeltaCare USA High DHMO Copayment	DeltaCare USA Medium DHMO Copayment
Diagnostic and Preventive Services		
• Cleaning, oral evaluation, X-rays	$0	$0
Basic Services		
• Restorations/fillings (1 – 4 surfaces)	$0	$8 – $ 95
• Root canal (excludes final restoration)	$0	$125 – $365
• Scaling/root planning	$0	$5 – $60
• Perio maintenance	$0	$45
• Oral Surgery (tooth removal/extraction)	$0	$10 – $140
Major Services		
• Crowns	$0	$65 – $395
• Prosthodontics — removable (dentures)	$0	$325 – $445
• Prosthodontics — fixed (pontic/retainer)	$0	$210 – $395
• Implant-supported crowns or prostheses[2]	$0	Not covered
Comprehensive Orthodontics	$0	$2,100

Notes:
1. Refer to each program's benefit summary for more information about covered services, deductibles and maximums.
2. Implant services (implant body, surgical placement or abutment) are not covered.

SECTION
11. PROCESSING CLAIMS FOR BENEFITS

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

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

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

You should send your prescription claims to:	**Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund Claims Department 501 Shatto Place, Suite 500 Los Angeles, CA 90020**

Claims cannot not be submitted by phone. Providers may file electronic claims via Electronic Data Interface ("EDI").
All forms required by the Fund must be completed in full before claims can be processed. Failure to provide all the information necessary to process a claim will result in the delay or denial of benefits.

Claims submitted for medical or prescription benefits are post-service claims. These claims involve the payment or reimbursement for services that have already been provided. A provider may call Blue Shield of California to ask if a particular procedure is covered by the Plan. This will not be treated as a claim for benefits.

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

Claims will be considered submitted upon receipt.

When you receive medical care, follow these steps for prompt claims processing:

i) Obtain the Plan's Claim Form from any local Union office, the Fund Office, or the Fund Office website at www.scptac.org. A fully completed Plan Claim Form is required once every Calendar Year and for each Accident.

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

iii) Submit a prescription claim receipt from a Pharmacy which must include the following:
   a) Name of Patient;
   b) Name of medication;
   c) Date dispensed;
   d) Name, address, and phone number of Pharmacy;
   e) Name of prescribing Physician;
   f) Prescription number;
   g) National Drug Code (NDC) number; and
   h) Cost of Prescription Drug.

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

i) Patient employment status;
ii) Information about any other coverage available to the Patient, including any group medical insurance or plan, including health maintenance organization (HMO), preferred provider organization (PPO), independent physician organization (IPO), or point of service (POS), including reduced charges as a professional courtesy or care provided by an Employer at a reduced or zero charge (i.e., employed by a Hospital or Physician and care received at that facility is at no charge or a reduced rate);
iii) Operative reports;
iv) Laboratory results;
v) X-ray results; or
vi) Detailed information when the claim may be related to an Accident, including but not limited to circumstances surrounding: tripping, slipping, falling, dog bites, foreign objects (in the eye, ear, etc.), being hit by a projectile or another person, automobile Accidents, and bicycle Accidents.

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

Dental claims should be sent to:	**DeltaCare USA** **Claims Department** **P.O. Box 1810** **Alpharetta, GA 30023**

B) Timely Filing

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

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

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

In case of retroactive coverage for Pensioners eligible for a retroactive disability benefit, the 12-month limit for filing claims will be waived with respect to claims incurred during the retroactive eligibility period, and any claims incurred during the retroactive eligibility period must be submitted within 90 days of the date of your Annuity Starting Date in the Retirement Fund, or 12 months from the date of the service, whichever is later. See also Section 6(E), page 18, above.

C) Processing Claims

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

i) Urgent Care Claim

An urgent care claim is a claim that involves emergency medical care needed immediately 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.

D) Notice of Denial of Claim

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

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

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

SECTION 12. APPEALS PROCEDURE

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

A) Appealing a Benefit Denial

If your claim for benefits is denied, in whole or in part, you may request that the Board of Trustees review the benefit denial. The Board of Trustees has delegated the responsibility to decide appeals to its Appeals Committee. (In some cases the Board of Trustees may decide to consider an appeal and in other cases the Appeals Committee may delegate the responsibility to consider an appeal to a subset of the Committee.) All appeals, 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 you receive the written notice of the denial from the Fund Office. Failure to file a timely written appeal will constitute a complete waiver of the right to appeal, and the decision of the Fund will be final and binding.

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

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

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

The Fund Office maintains records of determinations on appeal and Plan interpretations so that those determinations and interpretations may be referred to in future cases with similar circumstances.

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

B) Timing of Appeals Committee Decisions

The Appeals Committee (or a subset thereof if 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.

C) 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.

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

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

Disability Claims Appeals. If your claim pertains to total disability it will be decided in the time period of a post-service claim appeal.

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

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

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

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

D) Decisions on Appeal are Final and Binding

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

Once a final decision is rendered there is no right to re-file the same appeal, or to request reconsideration, 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 Committees' 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.

E) Right to Authorized Representative

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

F) Other Appeals

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

SECTION
13. COORDINATION OF BENEFITS

A) General Rules

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

i) Group insurance or any other arrangement of coverage in a group whether or not insured or self-insured; or
ii) Individual coverage, from a private insurer, including PPOs, HMOs, a Covered California plan, or any other prepaid medical arrangement; or
iii) Medicare.

For any Covered Service under the Plan, you will receive up to the normal benefit.

B) Which Plan Pays First - Coordination of Benefits

Below are several examples of how the Plan's coordination of benefit provisions operate.

i) If you and your Spouse/Domestic Partner are both retired and have coverage:
   a) The plan covering the Patient as a participant/subscriber is the primary payer.
   b) The plan covering the Patient as a dependent is the secondary payer.

ii) If one of you is retired and the other is actively employed:
   a) The plan providing active coverage is the primary payer.
   b) The plan providing retiree coverage is the secondary payer.

iii) If you are retired but using your Active Plan Eligibility Bank, and your Spouse/Domestic Partner is actively employed:
   a) The plan providing coverage for your Spouse/Domestic Partner is the primary payer.
   b) This Plan is the secondary payer because you are retired.

C) Coordination of Benefits with Medicare

i) Overview

Detailed information about Medicare is available through the "Medicare & You" handbook from Medicare. You are strongly encouraged to study the Medicare handbook. If you have not received a copy, you can download it from www.medicare.gov/publications. You can also get more information about Medicare from:

a) www.medicare.gov;
b) (800) 633-4227 (TTY users should call (877) 486-2048); or
c) California Health Advocates at (800) 434-0222.

The following is only a general summary of Medicare benefits. It is NOT a substitute for you own research, based on your particular circumstances. There are four Medicare programs:

- Part A – Hospital Insurance
- Part B – Medical Insurance
  - Part A and Part B constitute "Original Medicare". This is the default Medicare coverage.
  - You may add a Medigap policy (optional insurance to help pay your out-of-pocket costs) and/or Part D Prescription drug insurance to Original Medicare.
- Part C – Medicare Advantage Plans
  - These optional plans replace Original Medicare and are like HMOs or PPOs. They typically include Part A, Part B, and Part D coverage.
- Part D – Prescription Drug Insurance

Part A coverage is usually free. Premiums apply for Parts B, C, and D coverage. If you do not enroll when you are first eligible, there may be a penalty in the form of a higher premium.

If you retire at age 65, you can apply for Medicare as part of your application for Social Security retirement benefits. The Social Security Administration advises people to apply 90 days prior to their 65th birthday. If your application is approved, Medicare will then become effective on the first of the month in which you attain age 65.

ii) Which Plan Pays First

Below are some examples of how the Plan's coordination of benefits provisions apply with Medicare.

a) If you and your Spouse/Domestic Partner are both employed with medical coverage and eligible for Medicare:
   1) The plan providing coverage as an employee is the primary payer.
   2) The plan providing coverage as a dependent is the secondary payer.
   3) Medicare is the third payer.

b) If you are employed with medical coverage and your Spouse/Domestic Partner is retired with medical coverage, and both of you are eligible for Medicare:
   1) The plan providing coverage as an employee is the primary payer.
   2) Medicare is the secondary payer.
   3) The plan providing coverage as a retiree is the third payer.

c) If you are retired and using your Eligibility Bank to maintain coverage under the Active Plan and you are eligible for Medicare:
   1) Medicare is the primary payer.
   2) The Active Plan is the secondary payer because you are retired.

IMPORTANT	**Medicare is the primary payer of your benefits from the date you retire, even if you are using your active Eligibility Bank. Medicare is considered by this Plan to be the primary payer of benefits for people who are eligible for Medicare whether or not they are enrolled in the Medicare program. This means that if you do not enroll in Medicare as soon as you are eligible, this Plan will not pay for benefits that Medicare would have paid for had you been enrolled in Medicare.** **In order to get full benefits under the Plan, Medicare Part A and Part B must be effective prior to your retirement effective date.**

D) Benefit Reduction – Failure to Comply with Coordination of Benefits Rules

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

If your Spouse/Domestic Partner could have been covered as an employee under another plan, with no premium paid by the employee but declined such coverage, the benefit payable will be reduced to 20% of the Blue Shield of California PPO Network Rate or the out-of-network provider Allowable Charge, whichever is applicable.

SECTION 14. THIRD PARTY LIABILITY

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

If any service is provided or medical claims paid in connection to any Illness or Injury caused by a third party, and you recover from a third party, insurance policy, or uninsured motorist coverage, you must reimburse the Plan from the recovered funds for medical claims paid in connection with the Illness or Injury. You must reimburse the Plan from the recovered funds even if the settlement or judgment is less than anticipated and regardless of whether the recovered funds are designated as payment for medical expenses. Upon settlement of the claim or judgment against the third party, insurance company, or uninsured motorist coverage, you will pay the Plan the recovered funds up to the full amount of medical claims paid on your behalf in connection with the Illness or Injury caused by the third party.

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

may, at its sole discretion, agree to reduce the full amount to which it is entitled under this provision to contribute to reasonable attorney's fees and costs incurred by you in the collection of a recovery from the third party.

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

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

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

SECTION 15. EXCLUSIONS AND LIMITATIONS

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

A) Medical

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

1) A claim for a service or procedure not expressly covered by the Plan;
2) Any claim for treatment, services and/or supplies, including any additional information requested, that is not filed;
3) Services that are not reasonably necessary for the care of treatment of bodily Illnesses or Injuries as determined by the Fund, except for routine physical examinations expressly covered by the Plan;
4) Any services or procedures that are Experimental Treatments or investigational in nature or are not within the standards of generally accepted medical practice, or medical services or supplies, including Prescription Drugs, considered educational, investigational, or experimental. A drug, device, medical treatment or procedure is considered experimental or investigational if:
   a) It is a drug or device that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
   b) Reliable evidence shows that the drug, device, or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
   c) Reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis. For this purpose, reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.
5) Services, prescriptions, medications, and supplies received outside of the United States and its territories unless
   a) The services, medications, or supplies were the result of an Accident, urgent care requirement, or life-threatening Emergency Medical Condition or
   b) The Eligible Participant submits proof of residency in the country where the services were rendered;
6) Charges for missed or broken appointments;
7) Charges for completion of forms;
8) Charges for phone consultations other than telemedicine (e.g. reading of EKGs);
9) Hospital or Extended Care Facility charges for personal items such as charges for radio, television, telephone, guest expenses, and other similar items;
10) Charges for personal comfort, beautification, or convenience items or services;

11) Custodial Care as defined in this SPD;
12) Housekeeping services;
13) "Standby" charges (charges in which a Physician is present but is not providing care, treatment or a diagnosis). This includes, but is not limited to, standby charges for an anesthesiologist, pediatrician, or trauma team;
14) Additional charges for "after hours" and weekend services by a Physician;
15) Expenses for travel or transportation, except as provided under ambulance benefits;
16) EMS (Emergency Medical Service) with no transport;
17) Services by a provider who is a family member of the Patient;
18) Vitamins, including prenatal vitamins (prescription and over the counter);
19) Prescription Drugs dispensed in a Physician's office;
20) The Fund will not provide benefits for drugs prescribed for off-label use;
21) Over-the-counter medications and medical supplies, such as gauze, bandages, breast pumps, shoe inserts, and herbal medications;
22) Blood pressure monitors, thermometers, vaporizers;
23) Certain types of Durable Medical Equipment such as cervical traction units, cervical collars, TENS units, hot/cold therapeutic devices, bone growth stimulators, canes, bionicare knee device, humidifiers, and nasal pillows;
24) Replacement or repair of Durable Medical Equipment within 36 months unless otherwise specified not to exceed $150 annually;
25) Electric wheelchairs, electric hospital beds (allowance may be made for standard wheelchair or standard hospital bed);
26) Cosmetic Surgery, except for Medically Necessary treatment resulting from Accidental Injury, functional disorder, or congenital malformation or treatment related to Gender Identity Disorder. (It is suggested, but not required, that the eligible individual's Physician submit the proposed procedure to the Fund prior to the procedure to determine if benefits are available under the Plan);
27) Weight control, such as surgical procedures, diet management, medications, exercise programs, or nutritional training regardless of any medical condition, related or otherwise;
28) Goal-oriented behavior modification therapy for smoking cessation, substance abuse including chemical dependency, drug addiction, and alcoholism, or weight loss;
29) Exercise equipment, tanning booths, whirlpools, swimming pools, saunas, spas, massage therapy, or gym membership;
30) Nutritional counseling regardless of the diagnosis, including, but not limited to, diabetes, hypertension, and obesity;
31) Charges for obtaining, testing, and storing the Patient's blood prior to a medical procedure of any kind;
32) Family Planning (except Prescription Drug benefit for contraceptive drugs and devices);
33) Testing for or treatment of infertility, including artificial insemination and in-vitro fertilization, or any charges associated with direct inducement of pregnancy, any testing during and related to the treatment of infertility or related conditions and/or complications of the treatment;
34) Care or treatment for pregnancy or related conditions and/or complications;
35) Reversal or attempted reversal of an elective sterilization procedure;
36) Care or treatment for substance abuse including chemical dependency and drug addiction;
37) Occupational Therapy (except for the treatment of a hand Injury or hand disability);
38) Physical therapy by any person other than a Registered Physical Therapist or a Registered Physical Therapist Assistant under the supervision of a Registered Physical Therapist;
39) Acupuncture except as provided by a Physician or Licensed Acupuncturist;
40) Care by homeopathic practitioners, naturopathic practitioners, and doctors of oriental medicine (OMD);
41) Treatment for Temporomandibular joint dysfunction (TMJ);
42) Transplant and stem cell transfers (except as noted under Transplant Benefit);
43) Routine vision care including eye examinations, eye glasses, or contact lenses;
44) Any refractive eye surgery, (e.g. Lasik Surgery), regardless of the diagnosis;

B) Third Party Liability

In addition to the Exclusions and Limitations listed elsewhere in this SPD, except as explicitly provided under Third Party Liability (see Section 14, page 39), the Plan will not provide benefits for:

45) Any charges or medical claims for which a third party may be liable or legally responsible, unless payable under the terms of the Plan's Third Party Liability recovery provisions;
46) Any charges paid for or payable by another plan, or insurance;
47) Charges for services, treatments, or supplies for the care and treatment of an Injury or Illness that are in excess of the charges that would have been made in the absence of the benefits provided by the Plan;
48) Any Illness, Injury, or disability covered by any worker's compensation laws;
49) Care or treatment obtained in a federal or state facility, or a facility operated by a government agency, for which you are not required to pay except to the extent benefits are required by law to be paid by the Plan;
50) Conditions caused by an act of war, armed invasion, or insurrection;
51) Care or treatment in any penal institution;

C) Other

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

52) Pay interest on unpaid balance(s);
53) Reissue a benefit payment more than two years after it was first issued;
54) Pay for any charge by a financial institution including but not limited to the deposit or cashing of:
    a) A check upon which a stop payment has been placed, or
    b) A stale-dated check.

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

SECTION 16. 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 or the facility, nor any communication about benefits or payments between representatives of the Plan and a provider or a facility, shall be considered an assignment of the benefit, an assignment of a claim or an appeal, a waiver of this no assignment provision, or a contract with the provider or the facility to pay benefits.

B) Erroneous Payments

Every effort will be made to ensure accuracy in 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. The Trustees have the right to seek repayment from you through any legal means, including the right to reduce future benefit payments for you or your Eligible Dependent by the amount of the erroneous payment.

C) Misrepresentation or Fraud

If you receive benefits as a result of false information or a misleading or fraudulent representation, you will be required to repay all erroneous amounts paid by the Fund and you will be liable for all costs of collection including attorneys' fees. The Trustees reserve the right to reduce future benefit payments by the amount of the payment made because of fraud or misrepresentation.

D) No Fund Liability

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 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 17. 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 Southern California Pipe Trades Pensioners & Surviving Spouses Health Plan. It is a multi-Employer health and welfare benefit plan. It provides medical, Prescription Drug, dental, hearing aid, and other benefits.

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

B) Identification Numbers

The Fund's Internal Revenue Service tax identification number is 27-4271742. The Plan number is 501.

C) Plan Year

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

D) Plan Sponsor, Named Fiduciary, and Administrator

The Plan is maintained 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 Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund 501 Shatto Place, Suite 500 Los Angeles, California 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:

Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund
Attention: Joel Brick
501 Shatto Place, Suite 500
Los Angeles, CA 90020

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

Contributions to the Fund are made by:

i) Employers 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 at fixed rates per hour of work; and
ii) Self-payment as described in Section 5, page 12, and Section 6, page 16.

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

The Fund's assets are held in trust by the Board of Trustees. Custody of the Fund's assets is with U.S. Bank, N.A. Benefits are provided directly from the Fund's assets, which are accumulated under the provisions of the Trust Agreement, except with respect to certain insured dental benefits. 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 Pensioners & Survivors are set forth in this SPD. There is a separate Plan with its own SPD covering benefits for active Employees.

I) Collective Bargaining Agreement

Contributions to the Fund are made 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 following are the employer associations with which District Council No. 16 has a bargaining relationship that requires contributions to this Fund:

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

J) Plan Termination

It is intended that this Plan will continue indefinitely, but the Board of Trustees reserves the right to change 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 Unions.

Upon termination of the Plan and Fund, the Trustees will promptly notify the Union, any employer association, Employers, and all other interested parties. The Trustees will continue as Trustees 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 Southern California Pipe Trades Pensioners & Surviving Spouses Health Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

i) Receive Information About Your Plan and Benefits

a) Examine, without charge, at the plan administrator's office and 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.

b) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The administrator may make a reasonable charge for the copies.

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

ii) Continue Group Health Plan Coverage for a Spouse

Continue health care coverage for a former Spouse if there is a loss of coverage under the Plan as a result of a qualifying event. Your former Spouse will have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

iii) Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people 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.

N) Preferred Providers and Pre-paid Plans

The Board of Trustees may from time to time, in its sole discretion, enter into written agreements with preferred provider (PPO) organizations or prepaid plans, such as health maintenance organizations (HMO). The use of such preferred providers is wholly at your option.

The current PPO network for medical services is:

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

The current DHMO network for dental services is:

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

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

SECTION 18. 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:

Southern California Pipe Trades Pensioners &
Surviving Spouses Health Fund
Attention: Privacy Officer
501 Shatto Place, Suite 500
Los Angeles, CA 90020

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

You may also file a complaint with the U.S. Secretary of Health and Human Services in Washington, DC. The Fund will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against 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) Women's Health and Cancer Rights

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

The Plan also provides benefits for the following procedures:

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

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

SECTION 19. DEFINITIONS

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

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

Active Plan
Southern California Pipe Trades Health & Welfare Plan.

Allowable Charge
The dollar amounts for services that the Plan uses to determine how much it will pay, and how much your out-of-pocket cost will be, when you use an out-of-network provider. These dollar amounts are generally less than the amount the provider bills, and less than the Blue Shield of California PPO Network Rate for in-network providers. For a few types of benefits (orthotics, pain management, home health care, allergy treatment, and hearing aids) an Allowable Charge also applies to Blue Shield in-network providers, instead of the Blue Shield of California PPO Network Rate. Any amount that exceeds the Allowable Charge is not considered by the Plan. You are responsible for the Coinsurance amount, if any, and for any charges that exceed the Allowable Charge, but such amounts may be eligible for reimbursement from your HRA Allowance. When the Plan determines that the services rendered by an out-of-network provider are due to an Emergency Medical Condition, the Plan will pay an amount that is reasonable, as determined by the Plan, that may be in excess of the Allowable Charge. This amount is calculated using Medicare rates, UCR (usual, customary, and reasonable), or negotiation with the provider.

Annuity Starting Date
The date that you are first entitled to receive a benefit from the Southern California Pipe Trades Retirement Plan, although the actual payment may be made at a later date. Usually your Annuity Starting Date is the first of the month after you have met the Retirement Plan's eligibility requirements and have submitted a pension application.

Appeals Committee
A subset of the Board of Trustees empowered to review any claims as described in Section 12.

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

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

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

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

Chiropractor
A person acting within the scope of his/her license, holding the degree of Doctor of Chiropractic (DC), and who is legally entitled to provide chiropractic care in all its branches under applicable laws where the services are rendered.

Claim Form
The form required by the Fund to provide information necessary to process claims. One complete routine Claim Form is required per Patient per Calendar Year; an additional Claim Form is required for any Injury.

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

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

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

Continuous Comparable Coverage
Enrollment, that has not lapsed for more than 60 days, in a plan offering minimum essential coverage under the Affordable Care Act, a Medicare Advantage Plan (HMO, PPO or Private Fee-For-Service plan) or a Medicare Supplemental (Medigap) Plan.

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

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

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

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

Deductible
A Deductible is the amount you must pay before the Plan will consider expenses for reimbursement. Not all Out-of-Pocket expenses count toward the Deductible. The Deductible applies separately to each covered person, except that the family Deductible applies collectively to all covered persons in the same family. Separate Deductibles apply to the prescription drug benefit and the hearing aid benefit.

Dentist
A person acting within the scope of his/her license, holding the degree of Doctor of Dental Surgery (DDS), or Doctor of Dental Medicine (DMD), and who is legally entitled to practice dentistry in all its branches under the laws of the state or jurisdiction where the services are rendered.

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

Durable Medical Equipment
Equipment that meets the following criteria:

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

Eligibility Bank
The Active Plan Eligibility Bank is funded by contributions received from Contributing Employers on an Employee's behalf. Active Plan eligibility is determined by the contributions credited and debited to and from the Eligibility Bank.

Eligible Dependent
The Pensioner's lawful Spouse or Domestic Partner if timely enrolled.

Emergency Medical Condition

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

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

Emergency Services

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

Employee

An Employee is anyone employed by a Contributing Employer in a position for which the Employer 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.

Exclusion or Limitation

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

Experimental Treatment

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

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

This Plan does not cover Experimental Treatments.

Explanation of Benefits

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

Extended Care Facility

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

A) Is approved by and is a participating extended care facility of Medicare;
B) Has organized facilities for medical treatment and provides 24-hour nursing services under the full-time supervision of a Physician or Registered Nurse;

C) Maintains daily clinical records on each Patient and has available the services of a Physician under the established agreements;
D) Provides appropriate methods for dispensing and administering Prescription Drugs;
E) Has transfer arrangements with one or more Hospitals, a utilization review plan in effect and operations policies developed with the advice of, and reviewed by, a professional group including at least one Physician; and
F) Is not an institution that is primarily a place for rest, a place for Custodial Care, a place for the aged, a place for drug addicts, a place for alcoholics, a hotel, or similar institution.

Fund

The Southern California Pipe Trades Pensioners & Surviving Spouses Health Fund created by the Trust Agreement establishing that Fund.

Fund Office

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

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

Hospice

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

Hospice Care Program

A coordinated program of inpatient and home care that treats the Terminally Ill Patient and the family as a unit is a Hospice Care Program. The Plan provides care to meet the special needs of the Patient and the family during the final stages of Terminal Illness and during bereavement.

Hospital

A public or private facility, licensed and operating according to applicable law, that provides care and treatment by Physicians and Nurses on a 24-hour basis for an Illness or Injury through the medical, surgical and diagnostic facilities on its premises. A Hospital also includes Mental Disorder treatment facilities that are licensed and operated according to applicable law. A Hospital is not an institution that is primarily a place for rest, a place for Custodial Care, a place for the aged, a place for drug addicts, a place for people recovering from alcohol dependency, a hotel, or similar institution.

Illness

Any bodily sickness or disease as diagnosed by a Physician. Congenital abnormalities of a newborn child are included in this definition. Pregnancy is considered an Illness.

Injury

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

Inpatient

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

Lifetime Maximum Benefit (LMB)

The total dollar amount payable during your life for benefits issued by the Fund.

Medically Necessary/Medical Necessity

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

Medical Necessity also applies to the type of facility in which the Patient receives care. For example, a hospitalization will not be considered Medically Necessary if the care could be provided at home or in a less expensive facility such as a skilled nursing facility or Outpatient clinic. The Plan does not cover treatments that are not Medically Necessary.

Medical Necessity, when used with respect to genetic testing, generally must meet all of the following three criteria:
A) One of the following:
   i) Family history suggestive of a heritable condition;
   ii) Specific symptoms suggestive of a heritable condition;

iii) Medical management requires consideration of genetic variants; and
B) Testing will impact treatment or heighten monitoring for early detection of disease; and
C) Evidence-based data supports the validity and utility of the test.

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

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

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

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

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

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

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.

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

Pension Credit(s)
The years of service which are accumulated and maintained for Employees.

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

Pharmacy
A licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under applicable law.

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

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

Plan Year
January 1 through December 31 of each year.

Podiatrist
A Podiatrist or chiropodist licensed to practice podiatry or chiropody within the meaning of the license granted by the state in which the podiatrist or chiropodist is practicing.

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

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

Psychiatrist
A Physician who provides care and treatment for a Mental Disorder who is licensed to practice as a psychiatrist in the jurisdiction where the services are provided.

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

Qualified Beneficiary
Qualified Beneficiary means the Pensioner or Spouse who is entitled to elect COBRA coverage after the loss of coverage under the Plan due to a Qualifying Event.

Qualifying Event
A circumstance that permits a Pensioner or Spouse to elect COBRA coverage. Qualifying Events may include, but are not limited to, divorce from the Pensioner or death of the Pensioner.

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

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

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

Special Extension Period
In this Plan, the three month period after the Pensioner's death during which free coverage is offered to a Survivor. In the Active Plan, a period of zero to three months of coverage in this Plan in the event of the Active Participant's death.

Spouse
Any person to whom a Pensioner is legally married.

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

Survivor
A Spouse or Domestic Partner of a deceased Participant who was covered under this Plan or the Active Plan on the Participant's date of death.

Survivor Premium Program
A continuing coverage option offered by this Plan for Survivors at a monthly Premium.

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

Totally Disabled
Wholly prevented by bodily Injury or Illness from engaging in any occupation or employment.

Trust Agreement
The written document titled "Agreement and Declaration of Trust Establishing the Southern California Pipe Trades Pensioners and Surviving Spouses Health Fund" 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.

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

USERRA
Uniformed Services Employment and Reemployment Rights Act of 1994.

SECTION 20. TRUSTEES

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

A) Employer Trustees

WALTER SCOTT BAKER
Kinetic Systems, Inc.
1620 S. Sunkist Street
Anaheim, CA 92806

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

JOHN FEIKEMA (seated February 13, 2019)
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 (seated February 13, 2019)
Xcel Mechanical Systems, Inc.
1710 W. 130th Street
Gardena, CA 90249

KEN GREER (seated February 13, 2019)
Murray Company
18414 South Santa Fe Avenue
Rancho Dominguez, CA 90221

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

JOHN MODJESKI
University Mechanical & Engineering Contractors
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Anaheim, CA 92807

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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

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

RODNEY COBOS (seated May 8, 2019)
District Council No. 16
501 Shatto Place, Suite 400
Los Angeles, CA 90020

JEREMY DIAZ (seated August 23, 2019)
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

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

GREG LEWIS (seated May 8, 2019)
U.A. Local No. 761
1305 North Niagara Street
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MICHAEL LOPEZ
U.A. Local No. 114
93 Thomas Road
Buellton, CA 93427

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1916 W. Chapman Avenue
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Duarte, CA 91010

AL POWERS
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223 S. Rancho Avenue
Colton, CA 92324

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

JEFF THOMAS
U.A. Local No. 403
3710 Broad Street
San Luis Obispo, CA 93401