Landscape, Irrigation and Lawn Sprinkler Industry Benefit Trusts

SUMMARY PLAN DESCRIPTION 2014

Administered by:

Southern California Pipe Trades Administrative Corporation

www.scptac.org

HEALTH & WELFARE PLAN

Landscape, Irrigation & Lawn Sprinkler Industry Health & Welfare Plan

This Summary Plan Description (referred to in this booklet as "SPD") describes the benefit plan which is made available through the collective bargaining agreement in effect between your employer and your union under the Landscape, Irrigation and Lawn Sprinkler Industry Health and Welfare Plan (referred to in this SPD as "the Plan"). The health and welfare benefits offered under the Plan are administered by the Southern California Pipe Trades Administrative Corporation (referred to in this SPD as "Trust Fund Office").

Employer contributions for the health and welfare benefits described in the enrollment materials and in this SPD are based on hours worked by active employees under a collective bargaining agreement. These Employer contributions finance the benefits offered by the Plan on a monthly basis.

The Trustees reserve the right to change the eligibility rules, reduce the benefits, or eliminate the Plan, in whole or in part, as may be required by the circumstances.

To obtain maximum benefits from the Plan, study this SPD carefully and keep it in a safe and convenient place. If you have any questions, do not hesitate to call the Trust Fund Office at (800) 595-7473, or write to the following address:

Board of Trustees
Landscape, Irrigation & Lawn Sprinkler Industry Health & Welfare Plan and Trust
c/o: Southern California Pipe Trades Administrative Corporation
501 Shatto Place, 5th Floor
Los Angeles, California 90020

All questions about this Plan which are not answered in this SPD and all requests for information about the Plan must be referred to the Trust Fund Office or to the Board of Trustees at the telephone number and address indicated above. No participating Employer, Employer association, Union, or any individual employed thereby has any authority in this regard.

Aviso A Los Participantes Del Idioma Español

Este folleto contiene informes importantes acerca de sus beneficios del Plan de Salud y Bienestar, si tiene dificultad al comprendiendo cualquier parte de los informes, por favor llame a la oficina administrativa al (800) 595-7473 o visite la oficina ubicada en 501 Shatto Place, 5th Floor, Los Angeles, CA 90020. La oficina está abierta Lunes, Martes, Miércoles, y Viernes de 8:00 a.m. a 4:00 p.m. y Jueves de 8:00 a.m. a 6:00 p.m. Un representante que habla Español estará disponible para ayudarle.

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I. Definitions

Unless the context or subject matter otherwise requires, as determined by the Board of Trustees, the words and terms used in this SPD have the same meaning as in the Trust Agreement. Here are some commonly used words in this booklet.

Trust Agreement

This refers to the Restated Agreement and Declaration of Trust Providing For the Landscape, Irrigation and Lawn Sprinkler Industry Health & Welfare Plan.

Collective Bargaining Agreement

The term "Collective Bargaining Agreement" means one or more Collective Bargaining Agreements in force and effect between the Union, as defined below, and an Employer, also defined below, together with any modifications, supplements or amendments. Collective Bargaining Agreement also means any other collective bargaining agreement between the Union and an Employer that requires contributions to the Trust.

CPMCA

The term "CPMCA" means the California Plumbing and Mechanical Contractors Association, a membership corporation organized under the laws of the State of California.

Union

The term "Union" means Southern California Pipe Trades District Council No. 16 of the United Association and its Local Union No. 345 ("Local Union") and all their affiliates within the United Association ("Local Unions").

Employer

The term "Employer" means: (1) an employer bound to a Collective Bargaining Agreement with the Union or to another written agreement (either through CPMCA or otherwise); and (2) Local Unions affiliated with the United Association who are obligated by a written agreement to contribute to the Trust Fund on behalf of certain paid Employees of the Union.

Employee

The term "Employee" means: (1) those persons employed by any Employer and on whose behalf payments are required to be made to the Plan pursuant to a Collective Bargaining Agreement or other written, signed agreement; provided, however, any Employer employing an Employee who has a direct or indirect ownership of a 10% or more interest in said Employer (if a Corporation), must contribute to the Fund a total of 160 hours per month on such Employee at the rate in effect at the time the contributions were made; and (2) paid Employees of the Union affiliated with the United Association of Journeyman and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada, provided the Local Unions contribute to the Trust Fund on behalf of each covered Employee a total of 160 hours per month at the rate in effect under the Local Union's Collective Bargaining Agreement at the time contributions are made. The term Employee does not include any person who has a direct or indirect interest in a sole proprietorship or a partnership and who is an Employer.

Eligible Employee

"Eligible Employee" means an Employee who has satisfied the Eligibility Rules established by the Board of Trustees.

Trust Fund, Plan, Fund

The terms "Trust Fund," "Plan," or "Fund" mean the Landscape, Irrigation and Lawn Sprinkler Industry Health & Welfare Fund and related Trust Agreement provided for in the Collective Bargaining Agreement between the Employer and the Union and shall

mean generally the monies, insurance policies and other assets in the Trust Fund.

ERISA The term "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

Trustee The term "Trustee" means the Trustee designated in the Trust Agreement together with his or her successors designated and appointed in accordance with the terms of the Trust Agreement.

Beneficiary The term "Beneficiary" means a person designated by a Participant (defined below) or by the terms of the rules and regulations of the Plan who is or may become entitled to a benefit from this Fund.

Participant The term "Participant" means a covered Employee who becomes eligible for benefits of the Plan as described herein.

II. Eligibility Rules

(a) Initial Eligibility

Upon hire or rehire, once your employer has contributed based on 300 hours of employment within a 24-month period, you will be eligible the first of the month following a lag month. This means that you could become eligible after two months, as long as you have 300 hours in your Eligibility Bank (defined below). Once you have established initial eligibility, 150 hours will be deducted from your Eligibility Bank for each month of coverage and additional hours will be credited to your Eligibility Bank each month as you work more hours with your Employer. However, in no event will your Eligibility Bank accumulate any more than 900 hours. In the event that you have 24 consecutive months with no eligibility, the Eligibility Bank will be reduced to zero. The following examples illustrate the foregoing:

Example 1 - Date Coverage Commences				
Month	Hours for which Employer Contributions Received	Eligible	Hours Deducted For Eligibility Month	Eligibility Bank Credit
January	90	No	0	90
February	120	No	0	210
March	90	No	0	300
April (lag month)	70	No	150	220
May	80	Yes	150	150

Example 2 - Date Coverage Commences				
Month	Hours for which Employer Contributions Received	Eligible	Hours Deducted For Eligibility Month	Eligibility Bank Credit
January	120	No	0	120
February	180	No	0	300
March (lag month)	90	No	150	240
April	70	Yes	150	160
May	80	Yes	150	90

(b) Eligibility Bank

Your Eligibility Bank is an account of hours that you work for which Employer contributions are received, less all hours deducted, and subject to the rules described below:

(1) Hours that you work for which Employer contributions are received will be credited to your Eligibility Bank, up to a maximum of 900.

(2) 150 hours will be deducted from your Eligibility Bank for each month during which you are covered for benefits.

(3) The maximum balance in your Eligibility Bank can only be 900 hours after the 150-hour monthly deduction for each month's benefits coverage.

(4) If your Employer contributes for less than 150 hours, but you have sufficient hours in your Eligibility Bank to make up the difference between the actual amount worked and 150 hours, you will continue to be eligible for the month following the lag month.

(5) If the balance in your Eligibility Bank falls below 150 hours, your coverage will terminate on the first of the month following the month in which your Eligibility Bank falls below 150 hours. Any remaining hours in your Eligibility Bank will be forfeited after 24 months with no eligibility. Reinstatement during this 24-month period requires hours that increase your Eligibility Bank balance to at least 300 hours. If your Eligibility Bank balance is forfeited, Employer contributions for at least 300 hours must be received on your behalf as discussed above under "Initial Eligibility."

The Trustees are empowered to create and enforce the rules pertaining to individual eligibility. The Trustees, in exercising their responsibilities, reserve the right to modify the eligibility requirements without prior notice.

Note: *The Eligibility Bank is merely a way for the Plan to account for your initial eligibility and continuing eligibility for benefits. It does not create any vested right to any benefit, contribution, or dollar amount on your behalf under any circumstance at any time, regardless of whether you are a Participant, Dependent or other Beneficiary.*

(c) Termination of Employee Eligibility

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

(1) The last day of a benefit period if coverage for the following benefit period was not established during the applicable earning period; or

(2) The date you enter into full-time military service; or

(3) The date coverage for which you are eligible is eliminated from the Plan.

(d) Military Leave of Absence

If you are on a military leave of absence from your employment, and the period of military leave is less than thirty-one (31) days, you will continue to be eligible for coverage under this Plan during the thirty-one (31) day leave with no self-payment required and no deduction of hours from your Eligibility Bank, provided you are in an eligible status under this Plan at the time your military leave begins.

Upon release from active service, your eligibility will be reinstated in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 described later in the Summary Plan Description.

(e) Dependents

(1) Eligibility for Dependents

Once you, an Eligible Employee, qualify for eligibility (initial and continuing eligibility), Eligible Dependents are also entitled to the benefits provided by the Plan, as long as you remain eligible. Eligible Dependents are defined below and will be covered under the same Medical, Vision, and Dental programs as the Eligible Employee. There are no Life or Accidental Death and Dismemberment Benefits for Dependents.

Dependents acquired by you after the effective date of your own coverage become covered as of the date they become Eligible Dependents. All new Dependents must be enrolled within 30 days of becoming Eligible Dependents, including newborn children. Services, coverage, benefits, and reimbursement, if applicable, can be delayed or denied to Eligible Dependents who are not properly enrolled. You may obtain the necessary forms to enroll newly-acquired Eligible Dependents from the Trust Fund Office.

(2) Definition of Eligible Dependent

Under the Plan, an Eligible Dependent is your (a) legal Spouse or your Registered Domestic Partner; (b) unmarried natural or legally adopted dependent children and/or children under legal guardianship; or (c) your Spouse's or your Registered Domestic Partner's unmarried natural children, legally adopted children, and/or children under legal guardianship.

Appropriate documentation including, but not limited to, an official government-issued marriage certificate, certificate of registered domestic partnership, birth certificate, or adoption certificate must be provided to the Trust Fund Office in order to enroll Eligible Dependents.

Note: Before enrolling an Eligible Dependent, w*e strongly urge you to contact a tax advisor or financial consultant regarding possible tax consequences.*

Eligible Dependent children will be covered up to their 26th birthday. Children will be covered regardless of whether or not they are married; regardless of whether or not they are full-time students; regardless of whether or not they are in custody of or living with either parent; and regardless of whether or not they depend on any support of either parent. You are responsible for providing the Trust Fund Office with documentation to establish a child's eligibility.

(3) Disabled Eligible Dependent Child

If your Eligible Dependent child is totally disabled, as determined by the Board of Trustees, due to a physical or mental handicap on the date the child's coverage would otherwise terminate because of age (but he or she continues to reside with you and be dependent upon you for support), coverage for the child will be continued for up to a maximum of three months if within 31 days of the date that he or she becomes totally disabled you submit to the Trust Fund Office satisfactory proof of the child's incapacity. This extension will continue until the earlier of (1) the end of three months, (2) the day that he or she ceases to be totally disabled or (3) the date you lose eligibility.

Note: *This extension applies or provides coverage only for medical issues directly related to the qualifying child's disability.*

(f) Termination of Dependent Eligibility

Dependent Eligibility will terminate upon the earliest of the following dates:

(1) When the Employee ceases to be eligible; or
(2) The date the individual no longer qualifies as an Eligible Dependent; or
(3) The date the Eligible Dependent enters into full-time military, naval, or air service; or
(4) In the event of legal separation, divorce or termination of a Domestic Partnership (your legal Spouse or Domestic Partner's eligibility will terminate as of the date of dissolution or marriage or Domestic Partnership); or
(5) The date the Trustees terminate coverage for Eligible Dependents.

Note: *When an Eligible Dependent's eligibility terminates, he or she may have the right to elect COBRA continuation coverage, which is described in detail below.*

Important Reminder Regarding Changes in Dependent Status: You must IMMEDIATELY notify the Trust Fund Office in writing when changes in dependent status occur. This includes final dissolution of marriage, legal separation, death of a Dependent, and/or any other event which would make your dependent not eligible for coverage. If you do not immediately notify the Trust Fund Office and claims and/or premiums are paid on behalf of an ineligible Dependent, you and/or the Dependent are responsible for reimbursing the Trust for such claims and/or premiums, including attorney's fees, interest and reasonable collection costs. The Trust may recover these amounts through legal action or otherwise as determined in the sole and absolute discretion of the Board of Trustees or a duly authorized committee thereof. You and/or the Dependent may also be required to reimburse the Trust and/or benefit provider for the value of any benefits provided to an ineligible dependent.

III. Enrollment Rules

When you become eligible, the Trust Fund Office will furnish you with an Enrollment & Beneficiary Form.

The Trust has contracted with Western Growers Assurance Trust (WGAT) to provide medical benefits under the benefit plan. Dental benefits are provided by Golden West Dental and vision benefits are provided by Anthem Blue Cross. Life insurance benefits are provided by Aetna Life Insurance Company. In addition to the Enrollment & Beneficiary Form, you must also complete enrollment forms for WGAT, Golden West, Anthem Blue Cross, and Aetna and any other benefit provider under the Plan. These forms will be provided to you by the Trust Fund Office when you become eligible. In addition, you may obtain enrollment forms from the Trust Fund Office at any time upon request.

You cannot be properly enrolled for benefits until the Trust Fund Office receives the necessary completed forms. Therefore, it is your obligation to contact the Trust Fund Office to make sure that you properly completed the necessary forms.

Note: *A failure to properly and timely enroll may mean that Eligible Employees or Eligible Dependents will not be covered by the Plan or receive benefits.*

IV. HIPAA Enrollment Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that if you fail to enroll for a plan or elected not to enroll your Dependents, you will have the option to enroll under the following circumstances:

(a) When you marry; or
(b) When you have a new Eligible Dependent (either as a result of birth, adoption, or marriage to a person who has children); or
(c) When your legal Spouse or Domestic Partner was covered under another group health plan and lost eligibility, exhausted COBRA continuation coverage, or there was a substantial change in the coverage or cost so that the Spouse or Domestic Partner could no longer be covered.

V. Special Enrollment under Children's Health Insurance Program

Effective April 1, 2009, a special 60-day enrollment period is added for an Eligible Dependent who meets the definition of a "qualifying child" if he or she (1) loses eligibility for Medicaid or Children's Health Insurance Program ("CHIP") coverage under state law or (2) becomes eligible to participate in a premium assistance program under Medicaid or CHIP. You must request enrollment in the Plan within 60 days of loss of Medicaid/ CHIP or of the eligibility determination.

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

VI. Subrogation & Reimbursement

The Plan does not provide coverage or benefits for any medical need caused by an act or omission of a third party. If an Eligible Employee or an Eligible Dependent is injured through the act or omission of a third party and payment is made by that party (or the insurance company), or his or her trustee, representative, parent, child or any successor or representative in interest, the Eligible Employee or Eligible Dependent must do all of the following:

(a) Immediately report the event to the Trust Fund Office, including whether he or she intends to pursue a legal claim against the third party;
(b) Subrogate (meaning transfer and assign) to the Plan any and all of your rights to recover and claims or "causes of actions" the Eligible Employee or Eligible Dependent may have against any third party;
(c) Reimburse the Plan up to the actual benefits paid by the Plan for medical expenses arising from the act or omission of the third party; and,
(d) Cooperate and do everything necessary to enable the Plan to enforce its subrogation and reimbursement under this Section.

The Eligible Employee or Eligible Dependent or any individual or entity acting on his or her behalf (referred to in this section as "Claimant") must reimburse the Plan even if the amount the Claimant recovers from the third party is less than the full amount of the funds expended by the Plan in connection with such medical needs. The reimbursement and subrogation rights

described in this section will have first priority and will apply regardless of whether any amount recovered by the Claimant from a third party are characterized as or deemed to be medical expenses or not. Furthermore, the Plan's rights of subrogation and reimbursement will apply to the proceeds of any source of recovery by the claimant, including, but not limited to, a responsible party or responsible party's insurer (or any form of self-funded protection), no-fault protection, personal injury protection, medical payments coverage, financial responsibility, uninsured or underinsured insurance coverage, workers' compensation, or any individual policy of insurance or protection maintained by the Claimant. The Plan expressly disclaims the application of the "common fund doctrine" or any such doctrines or theories in relation to the Plan's right or subrogation and reimbursement. However, the Board of Trustees may, in their sole discretion, permit the Plan to apportion attorney fees in a fair and reasonable manner.

If the Plan makes a payment or becomes obligated to make a payment arising from an act or omission of a third party, the Claimant hereby consents to the placement of a constructive trust and an equitable lien on the proceeds of any payment, settlement or judgment received by the Claimant from any source in connection with the illness, injury, or medical need.

Eligible Employees and Eligible Dependents agree, on their behalf and on behalf of any Claimant acting on his or her behalf, that the Claimant will hold any funds that are subject to subrogation or reimbursement under this section in trust for the benefit of the Plan. Such trust may not be assigned, amended, dissolved, transferred, merged or terminated until and unless the Plan is reimbursed in full for any and all expenses it has incurred related directly or indirectly to the act or omission of the third party, including, but limited to, the payment of medical expenses or providing of benefits and costs, attorney fees, and expenses it has incurred in securing reimbursement or subrogation. Eligible Employees and Eligible Dependents agree on behalf of themselves and their Claimants that the Claimant will not do anything to impair, release, discharge or prejudice the Plan's rights, actions or attempts under this Section. In this regard, the Plan's rights relating to subrogation and reimbursement will not be limited by any "make-whole" doctrine or "common-fund" doctrine available to Claimant under state or federal law.

You further acknowledge the right of the Board of Trustees to require from you and promptly receive proof of eligibility status, such as marriage licenses, birth certificates, domestic relations decrees or any other proof of eligibility as the Board of Trustees, in its sole discretion, may demand. You agree to promptly furnish such proof to the Board of Trustees and further agree that furnishing such proof satisfactory to the Board of Trustees is a precondition to the payment of any benefits for you or on your behalf or on behalf of your dependents.

If the Trust pays benefits for you or on your behalf or for any person enrolled as a dependent when you or such person are not in fact eligible, you agree to promptly reimburse the Trust in full for any monies so paid. You also agree that the Trustees, in their sole discretion, may deduct or offset any such monies from your future benefits. If the Trust files any legal action against you to recover any such monies, you agree to pay all attorneys' fees and costs of the Trust, whether or not such an action proceeds to judgment.

VII. Other Important Facts

(a) Medical Examination

No medical examination is required. Eligible Employees and their Eligible Dependents will be covered regardless of their physical condition.

(b) Beneficiary Designations

Every Eligible Employee should be certain to designate a beneficiary to receive benefits in the event of his or her death. Beneficiary forms are available from the Trust Fund Office and Local Union office.

If you wish to change your beneficiary, get another blank form from the Local Union or the Trust Fund Office, fill it out completely and send it to the Trust Fund Office. A new form is not necessary for a change in address, but you

must advise the Trust Fund Office of such changes on a Change of Address form available from the Trust Fund Office or the Local Union Office.

(c) Financing

Benefits for Eligible Employees and Eligible Dependents are provided through various providers under contract with the Trust. Funds for this purpose are accumulated from Employer contributions as a result of Collective Bargaining Agreements.

(d) Active Eligible Employees who enter the Uniformed Services

If an Eligible Employee enters the Uniformed Service, the Eligible Employee and his or her Eligible Dependents will be provided continuation of coverage under the Plan and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

(e) Industrial Illness or Injury

Benefits will not be paid for any illness or injury covered by any workers' compensation statute or similar statutory provision. Important items to remember in connection with this include:

(1) If an Eligible Employee or Eligible Dependent suffers an industrial injury or illness and obtains an award before the Workers' Compensation Appeals Board, that award is your total compensation for the injury or illness. The Plan will not provide benefits for expenses in connection with the injury or illness.

(2) If the Eligible Employee or Eligible Dependent elects not to seek a workers' compensation award for an industrial illness or injury, the Plan will not provide benefits for expenses in connection with the illness or injury.

(3) If the Plan provides benefits for the treatment of an industrial illness or injury the Plan will have a lien against any workers' compensation award received to the extent of the benefits provided. The Plan will additionally have the right to subrogation and reimbursement as described in Section V above.

(f) Evidence of Coverage Booklets & Policies

The specific benefits available under the Plan are established under the various Evidence of Coverage booklets and policies issued by the various providers of benefits with which the Plan has contracted for providing health and welfare benefits.

(g) Coordination of Benefits

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

(h) Qualified Medical Child Support Orders (QMCSO)

The Trust is required to provide benefits pursuant to a Qualified Medical Child Support Order (QMCSO). A QMCSO is a judgment or decree by a court of competent jurisdiction (or of a state or local administrative process established under state law and has the force and effect of law under applicable state law) that requires a group health plan to provide coverage to the children of an Eligible Employee pursuant to a state domestic relations law.

(1) If a court has issued an order with respect to the provision of health care coverage for any of the Eligible Employee's Eligible Dependent children, the Trust Fund Office or its designee will determine if the court order is a QMCSO as defined by federal law, and that determination will be binding on the Eligible Employee.

(2) An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or if it requires an Eligible Employee who is not covered by the Plan to provide coverage for a dependent child, except as required by a state's Medicaid-related child support laws.

(3) If an order is determined to be a QMCSO, and if the Eligible Employee is covered by the Plan, the Trust

Fund Office or its designee will notify the parents and each child, and advise them of the Plan's procedures that must be followed to provide coverage of the dependent child(ren). However, no coverage will be provided for any dependent child under a QMCSO unless the applicable Eligible Employee contributions for that dependent child's coverage are paid, and all of the Plan's requirements for coverage of that dependent child have been satisfied, including meeting the applicable rules of the Eligibility Bank, as described above.

For further details regarding QMCSOs, please contact the Trust Fund Office at the following address and telephone numbers:

Landscape, Irrigation & Lawn Sprinkler Industry Health & Welfare Plan
c/o Southern California Pipe Trades Administrative Corporation
501 Shatto Place, 5th Floor, Los Angeles, CA 90020
(213) 385-6161· (800) 595-7473 · Fax: (213) 385-2767

VIII. Family & Medical Leave Act (FMLA)

Under the Family and Medical Leave Act of 1993 (FMLA), an Eligible Employee may be entitled to family or medical leave. If an Eligible Employee is eligible and elects to take FMLA leave, employer contributions to the Plan will continue until the earlier of the end of such leave, or the date the Eligible Employee notifies his or her Employer of an intention not to return to work at the end of the FMLA leave. Such contributions may or may not result in coverage under the Plan, based on the eligibility rules described above. Continued active participation in the Plan while on FMLA leave will be at the Eligible Employee's option.

Note: *The Eligible Employee must contact his or her Employer to determine eligibility for FMLA leave. It is not the role of the Board of Trustees, the Plan or the Trust Fund Office to make this determination or provide any advice regarding FMLA leave.*

IX. Newborns' & Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers offering group insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

X. Women's Health & Cancer Rights Act of 1998

The Women's Health & Cancer Rights Act of 1998 requires that if your health plan provides medical and surgical benefits for a mastectomy, and if you were to need a mastectomy, you would also be covered for:

(a) Reconstruction of the breast on which the mastectomy was performed;

(b) Surgery/reconstruction on the other breast to produce a symmetrical appearance; and
(c) Prostheses and/or physical complications that may arise, including lymph edemas.

XI. COBRA Continuation Coverage

(a) Introduction

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the federal law, you should review this SPD or contact the Trust Fund Office at the address indicated below.

(b) COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse/Domestic Partner, and your Dependent Children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. However, if there are hours left in your Eligibility Bank on the date that you die, such hours will first be exhausted before your eligible survivors are obligated to begin paying for COBRA continuation coverage.

If you are an Eligible Employee, you will become a qualified beneficiary if you lose coverage under the Plan because either one of the following qualifying events happen:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse or Domestic Partner of an Eligible Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happen:

- Your Spouse or Domestic Partner dies;
- Your Spouse or Domestic Partner's hours of employment are reduced;
- Your spouse or Domestic Partner's employment ends for any reason other than his or her gross misconduct;
- Your Spouse or Domestic Partner becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse or Domestic Partner.

Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a Dependent Child.

(c) When COBRA Continuation Coverage is Available

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Trust Fund Office has been notified that a qualifying event has occurred.

After the Plan receives notice of the occurrence of a qualifying event, WGAT will provide all qualified beneficiaries an opportunity to elect COBRA continuation coverage. Any individual wishing to elect continuation coverage must do so within 60 days of the later of the date that the information is sent by WGAT or the date that coverage would otherwise terminate. Any qualified beneficiary who wishes to elect COBRA continuation coverage must timely submit all payments due. A failure to timely remit payment for COBRA continuation coverage is a permitted basis under the law upon which COBRA continuation coverage may be terminated.

(d) Your obligation to give notice of some Qualifying Events

For the other qualifying events such as the divorce of the Eligible Employee and Spouse (or termination of a Domestic Partnership) or a Dependent Child's losing eligibility for coverage as a Dependent Child, you must notify the Trust Fund Office within 60 days after the qualifying event occurs. As soon as you experience a qualifying event, the first step in providing this notice to the Plan is for you to contact the Trust Fund Office. Then, the Trust Fund Office will mail you a form which must be signed, completed and returned to the Trust Fund Office at the address provided on the form. It is your responsibility to make sure that the form is fully completed with all the required information and submitted to the Trust Fund Office within 60 days of the qualifying event. As discussed below, if you do not submit a completed form to the Trust Fund Office within 60 days of the qualifying event, you will lose your eligibility for COBRA continuation coverage resulting from divorce, termination of Domestic Partnership or a Dependent Child's losing eligibility for coverage as a Dependent Child.

The notice and the form, or the information required therein, must be sent to the Trust Fund Office at the following address:

Landscape, Irrigation & Lawn Sprinkler Health & Welfare Plan
c/o: Southern California Pipe Trades Administrative Corporation
501 Shatto Place, 5th Floor, Los Angeles, CA 90020

(e) How COBRA Continuation Coverage is provided

Once the Trust Fund Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Eligible Employees may elect COBRA continuation coverage on behalf of their Spouses or Domestic Partners and parents may elect COBRA continuation coverage on behalf of their Dependent Children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Eligible Employee, the Eligible Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or termination of a Domestic Partnership, or a Dependent Child's losing eligibility as a Dependent Child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Eligible Employee's hours of employment, and the Eligible Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Eligible Employee lasts until 36 months after the

date of Medicare entitlement. For example, if a covered Eligible Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his Spouse or Domestic Partner and Dependent Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Eligible Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

(f) Disability Extension of 18-month period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Trust Fund Office in a timely fashion (meaning no later than 60 days as described in the paragraph that follows), you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

The person eligible for this extension bears the responsibility of notifying the Trust Fund Office of the Social Security determination within 60 days. The first step in providing sufficient notice to the Trust Fund Office of the Social Security determination is to contact the Trust Fund Office listed here. Then, the Trust Fund Office will send you a form which must be filled out by the person eligible for the extension and submitted to the Plan within 60 days of the Social Security determination. If you do not submit a completed form to the Trust Fund Office within 60 days of the Social Security determination you will forego your eligibility of any extension. The completed form or the information required therein, must be accompanied with a photocopy of the entire Social Security Administration determination and submitted to the Trust Fund Office at the following address:

Landscape, Irrigation & Lawn Sprinkler Industry Health & Welfare Plan
c/o Southern California Pipe Trades Administrative Corporation
501 Shatto Place, 5th Floor, Los Angeles, CA 90020

If at a subsequent date, the Social Security Administration determines that an individual described in these provisions is no longer disabled, that individual must notify the Trust Fund Office in writing within 30 days after the date of the subsequent determination that the individual is no longer disabled. The individual must submit within 30 days of the date of the determination, the written determination received from the Social Security Administration stating that the individual is no longer disabled. The address of the Trust Fund Office where the Social Security determination must be mailed is listed in the previous paragraph.

(g) Second Qualifying Event Extension of 18-Month period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the Spouse or Domestic Partner and Dependent Children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse or Domestic Partner and any Dependent Children receiving continuation coverage if the Eligible Employee or former Eligible Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced (or terminates a Domestic Partnership) or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the Spouse (or Domestic Partner) or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

(h) Termination of COBRA Continuation Coverage

COBRA continuation coverage will automatically terminate upon the earliest of:

(1) The date upon which a qualified beneficiary becomes covered under any other group health plan (including a retiree health plan), which does not contain any exclusion or limitation with respect to any pre-existing conditions of the participant; or

(2) The first day of the month for which a timely payment is not received; or

(3) The date on which the qualified beneficiary becomes entitled to Medicare benefits under Title XVII of the Social Security Act; or

(4) The date that the Plan terminates; or

(5) At the end of the last day of the maximum coverage period available to the qualified beneficiary; or

(6) The date the Eligible Employee's employer stops making contributions to the Plan on behalf of its active Eligible Employees, and provides alternative coverage to those Eligible Employees under another Plan.

(i) COBRA Self-Payment Rates

The COBRA continuation coverage self-payment rates are set annually. Information on the rates is available from the Trust Fund Office.

(j) Conversion Coverage

At the end of the applicable COBRA continuation coverage period, you will be allowed to enroll in the individual conversion plan of the health plan, and certain other plans in which you are enrolled.

(k) Compliance with Law

The Board of Trustees has adopted procedures for complying with COBRA based on their interpretation of the law. The Board reserves the right to make any changes they deem appropriate or as required or permitted by law.

(l) Questions & More Information

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Trust Fund Office as follows:

Landscape, Irrigation & Lawn Sprinkler Industry Health & Welfare Plan
c/o Southern California Pipe Trades Administrative Corporation
501 Shatto Place, 5th Floor, Los Angeles, CA 90020

For more information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

XII. HIPAA PRIVACY RULES

The Plan is committed to protecting the privacy of your medical information as required by HIPAA and the rules and regulations adopted thereunder. If the privacy rules under HIPAA are changed or amended, the Plan will follow the revised rules.

(a) Your Rights

When it comes to your health information, you have certain rights**.** This section explains your rights and some of our responsibilities to help you.

(1) Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

(2) Ask us to correct health and claims records
- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

(3) Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

(4) Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

(5) Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

(6) Get a copy of this privacy notice
- You can ask for a paper copy of the Notice of Privacy Practices at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

(7) Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

(8) File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting our Privacy Officer.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

(b) Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

Note: *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

(c) Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

(1) Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

(2) Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

(3) Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

(4) Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

(d) How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

(1) Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

(2) Do research
We can use or share your information for health research.

(3) Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

(4) Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

(5) Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims

- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

(6) Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

(e) Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

(f) Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

(g) Name and Contact Information for Privacy Officer

If you have questions regarding your HIPAA rights or any other information relating to HIPAA, please contact the Trust's Privacy Officer listed below:

Norma Jean Diaz, Privacy Officer
Landscape, Irrigation and Lawn Sprinkler Industry Health and Welfare Plan and Trust
c/o: Southern California Pipe Trades Administrative Corporation
501 Shatto Place, 5th Floor
Los Angeles, California 90020
Telephone: (213) 385-6161 or (800) 595-7473
Fax: (213) 385-2767
info@scptac.org

XIII. Miscellaneous Provisions

(a) The Trade Act of 1974

You may be eligible for special COBRA rights, including an extension to your COBRA continuation coverage, pursuant to the trade adjustment assistance provisions of the Trade Act of 1974, as amended, most recently by the Trade Adjustment Assistance Extension Act of 2011. If you believe that you have been impacted by the Trade Act of 1974, you should contact the Trust Fund Office and explain your situation.

(b) Keep your Plan informed of Address Changes

In order to protect your family's rights, you must keep the Trust Fund Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Trust Fund Office. Change of address information should be sent to:

Landscape, Irrigation & Lawn Sprinkler Industry Health & Welfare Plan
c/o: Southern California Pipe Trades Administrative Corporation
501 Shatto Place, 5th Floor, Los Angeles, CA 90020

(c) Plan Contact Information

Landscape, Irrigation & Lawn Sprinkler Industry Health & Welfare Plan
c/o: Southern California Pipe Trades Administrative Corporation
501 Shatto Place, 5th Floor, Los Angeles, CA 90020

(d) Military Service Rights under USERRA

This section provides information about your rights under the Uniformed Services Employment and Reemployment Act (USERRA).

Congress enacted USERRA to provide protections to individuals who are members of the uniformed services. "Uniformed services" is defined as the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Services, and any other category of persons designated by the President in time of war or national emergency. One of the protections provided by USERRA is that Eligible Employees covered under a group health plan must be given an opportunity to elect to continue coverage for themselves and/or their dependents if they take leave to serve in the uniformed services (hereinafter "military leave").

The maximum period of continuation coverage for health care under USERRA is the lesser of: (1) 24 months (beginning from the date you leave work due to your military leave) or (2) the day after the date you fail to timely apply for or return to a position of employment with an Employer participating in the Trust.

Generally, your right to continuation coverage is governed by COBRA, as described above, with the exceptions noted in this paragraph. First, COBRA generally provides a maximum continuation coverage period of 18 months, while under USERRA this time period is extended by an additional six months, to bring the total period of USERRA coverage to 24 months. Second, under USERRA, if your military leave is less than 31 days, you will continue to be eligible for coverage as provided in Section I above. Third, if you become covered by another group health plan or entitled to Medicare during the USERRA maximum coverage period described above, the continuation coverage elected by Eligible Employees will not be terminated.

XIV. Plan Administration Information

(a) Name of Plan

The name of the Plan is the Landscape, Irrigation and Lawn Sprinkler Industry Health and Welfare Plan. The Plan is administered by the Board of Trustees of the Landscape, Irrigation and Lawn Sprinkler Industry Health and Welfare Fund pursuant to the terms of a Trust Agreement.

(b) Name, Address & Telephone Number of Board of Trustees

Board of Trustees
Landscape, Irrigation & Lawn Sprinkler Industry Health & Welfare Plan
c/o: Southern California Pipe Trades Administrative Corporation
501 Shatto Place, 5th Floor
Los Angeles, CA 90020
Telephone: (800) 595-7473 (213) 385-6161
Fax: (213) 385-2767

(c) Tax Identification Number

The taxpayer identification number assigned to the Fund by the Internal Revenue Service is 95-4418990.

(d) Plan Number

The Plan number assigned to this Plan is 501.

(e) Type of Plan

The Plan may provide any or all of the following benefits: Life and Accidental Death and Dismemberment Insurance, Medical, Dental, Drug, and Vision benefits.

(f) Type of Administration

The Plan is administered by the Board of Trustees with the assistance of the Southern California Pipe Trades Administrative Corporation, a contract administrative manager.

(g) Name, Address & Telephone Number of Plan Administrator

Southern California Pipe Trades Administrative Corporation
501 Shatto Place, 5th Floor
Los Angeles, CA 90020
Telephone: (800) 595-7473 (213) 385-6161
Fax: (213) 385-2767
Web site: www.scptac.org
Email: info@scptac.org

(h) Name & Address of Agent for Service of Process

The Board of Trustees has appointed the Southern California Pipe Trades Administrative Corporation as its agent for service of process. The address is 501 Shatto Place, 5th Floor, Los Angeles, California 90020. Legal papers may also be served on any of the Trustees. The names and addresses of the Trustees are set forth in item (i).

(i) Names & Addresses of Plan Trustees

The Trustees serving as of the date of the printing of this SPD are as follows:

EMPLOYER TRUSTEES

Jason Strauss, Employer Co-Chair
c/o: SCPTAC
501 Shatto Place, 5th Floor
Los Angeles, CA 90020

Charles "Chip" Martin
c/o: SCPTAC
501 Shatto Place, 5th Floor
Los Angeles, CA 90020

UNION TRUSTEE

Vincent Diaz, Union Co-Chair
c/o: SCPTAC
501 Shatto Place, 5th Floor
Los Angeles, CA 90020

(j) Carriers & Providers of Service

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

For Hospital, Medical and Surgical Benefits

Western Growers Assurance Trust
17620 Fitch St.
Irvine, CA 92614
(800) 777-7898

For Dental Benefits

Golden West
Golden West Dental & Vision
Post Office Box 5347
Oxnard, California 93031
(866) 926-8078

For Vision Benefits

Anthem Blue Cross-Blue View Vision
Anthem Blue Cross
Post Office Box 629
Woodland Hills, CA 91365-0629
(866) 723-0515

For Life Insurance Benefits

Aetna Life Insurance
Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
(800) 523-5065

Counsel

Chirag Shah, Esq.
Shah and Associates, APLC
1055 West 7th Street, Suite 1940
Los Angeles, CA 90017

Trust Fund Office

Southern California Pipe Trades Administrative Corporation
Attn: Joel E. Brick, Administrator
501 Shatto Place, 5th Floor
Los Angeles, CA 90020
Telephone: (800) 595-7473 (213) 385-6161
Fax: (213) 383-0725
Web Site: www.scptac.org
Email: info@scptac.org

Auditor

Jeffrey K. Dore
Certified Public Accountant
1501 Westcliff Drive, Suite 250
Newport Beach, CA 92660

(k) Description of Collective Bargaining Agreements

The Plan is funded primarily from Employer contributions. Employers make contributions for bargaining unit Employees as required by the terms of various Collective Bargaining Agreements. Generally, the Collective Bargaining Agreements provide that the Employer will contribute at a specified rate per Employee per month. By signing special agreements some Employers may also make contributions for non-bargaining unit employees in the amounts comparable to what is paid for bargaining unit employees.

Copies of the applicable Collective Bargaining Agreements will be furnished by the Trustees, upon written request addressed to the Trust Fund Office. The Trustees may impose a reasonable charge for these copies. Also, copies are available for examination at the Trust Fund Office upon 10 days advance written request. Copies are also available at the Local Union Office.

(l) Participation, Eligibility & Benefits

For a summary of the Plan provisions concerning Participation and Eligibility, see previous sections. For specific information regarding benefits, please refer to the Evidence of Coverage booklets and other policies provided by the benefits provider or insurance company.

(m) Circumstance Which May Result in Disqualification, Ineligibility or Denial or Benefits

A participant or beneficiary who is eligible for benefits may become ineligible as a result of one or more of the following circumstances:

(1) The Eligible Employee's failure to work the required hours to maintain eligibility (or failure to make a COBRA self-payment, where authorized). See eligibility section of this SPD.

(2) The failure of the Eligible Employee's Employer to report the hours and remit contributions on his behalf to the Trust Fund.

(3) In case of beneficiaries who are Eligible Dependents of an Eligible Employee, they may become ineligible if (a) they are no longer Eligible Dependents or (b) they have attained the disqualifying age. See Eligibility rules for Eligible Dependent set forth in Eligibility section - of this SPD.

(4) Failure of a participant's Employer to sign an agreement with a participating labor organization.

(5) The possible modification or termination of Plan benefits due to financial circumstances requiring the Trustees to take such action.

An Eligible Employee, Eligible Dependent or other beneficiary who is eligible under the terms of this SPD may nonetheless be denied benefits as a result of one or more of the following circumstances:

(1) The failure of the individual to file a claim for benefits within the required time. Please consult the appropriate SPD or contact the insurer or benefits provider directly for time frames within which claims for reimbursement and other such claims must be filed.

(2) The failure of an Eligible Employee or Eligible Dependent to file a complete and truthful benefit application.

(3) Where either the Eligible Employee or Eligible Dependent has other benefits coverage it is possible that benefits payable under this Plan may be reduced or denied due to "coordination of benefits" between the two Plans.

(4) Where the loss for which claim is being made is subject to an exclusion or limitation of the insurance policy or health plan agreement.

(5) The possible modification or termination of Plan benefits due to financial circumstances requiring the Trustees to take such action.

(n) Compliance with ERISA

The Trustees believe that the Benefit Plan fully complies with the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Any omissions or oversights will be resolved in accordance with- ERISA.

(o) Source of Contributions

All contributions are made by the participating Employers. Self-payments are allowed under the Benefit Plan's COBRA Continuation Coverage. A complete list of participating Employers and Unions may be obtained by participants and beneficiaries upon written request to the Trust Fund Office and is available for examination upon 10 days advance written notice at the Trust Fund Office. The Trustees may impose a reasonable charge for the list of participating employers.

Contributions to the Trust Fund for the purpose of providing benefits to eligible individuals are made by the Employer on a monthly basis pursuant to a Collective Bargaining Agreement. Such contributions are supplemented by COBRA self-payments of participants and beneficiaries. Should contributions under the Collective Bargaining Agreements and COBRA self- payments (if any) not provide sufficient funding to maintain the present benefits, the Trustees reserve the right to increase the contribution rate, change the eligibility rules, reduce the benefits, or eliminate the Program entirely, as may be required by the circumstances.

(p) Plan Year

The plan year for this Plan ends on December 31 of each year. Each 12-month period commencing on January 1 consists of an entire plan year for the purposes of accounting and all reports to the United States Department of Labor and other regulatory bodies.

(q) Procedure & Remedies for Redress of Denied Claims

There are detailed procedures for presenting applications or claims for benefits. Please refer to the appropriate booklet provided by insurer or benefits provider from whom you seek benefits. For details about each provider's claims appeal and review procedures, please refer to that organization's Evidence of Coverage booklet or contact that entity directly. You may obtain an Evidence of Coverage booklet and relevant policies free of charge from the Trust Fund Office. A list of contact information for the companies providing benefits through this Trust may be found above in a section entitled "Carriers and Providers of Service."

Note: *Most if not all applications or claims for benefits should be made directly to the benefits provider or insurer. In the rare instance that your claim or application needs to be presented to the Trust Fund Office or the Board of Trustees, the Section below describes procedures for presenting such a claim or application for benefits.*

XV. Claims & Appeals Procedures

No Eligible Employee, Eligible Dependent or other beneficiary shall have any right or claim to benefits under the Plan, except as specified in this SPD or the Plan's Trust Agreement. Any dispute as to eligibility type, amount or duration of benefit under the Plan, or any amendment or modification thereof shall be resolved by the Board of Trustees or the designated insurance carrier or benefits provider and the decision of that entity shall be final and binding upon parties to the dispute, subject to the rights of Eligible Employees, Eligible Dependents and other beneficiaries' rights to bring suit in state or federal court.

(a) Requirements Applicable to All Claims

Eligible Employees, Eligible Dependents and all other beneficiaries must follow the claims and appeal review procedures as follows:

1) Submit a written claim for benefits;
2) Receive notification whether the application is granted or denied;
3) If application is denied in full or in part, file a written request for a review of the application through all levels of appeals with the Trust Fund Office or the appropriate benefits provider or insurance carrier, as applicable; and,
4) Receive notification in writing that the benefits provider or insurance company or Trust has confirmed the denial of the claim.

Finally, if there is a claim for benefits which is denied or ignored, in whole or in part, the Eligible Employee, Eligible Dependent or Beneficiary may file a suit in a state or federal court.

(b) Specific Procedures Based upon Type of Claim

As stated above, in the rare instance that your claim needs to be brought before the Board of Trustees, the Plan has adopted the following claims procedures depending on the nature and type of your claim.

(1) Urgent Care Claim

An "Urgent Care Claim" is a pre-service claim for medical care or treatment that, if the normal pre-service claim standards of the Plan were to be applied, could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. An Urgent Care Claim will generally be decided within 72 hours of the submission of the claim. This time frame may be extended as permitted by law if additional information is necessary to evaluate your claim.

(2) Concurrent Care Claim

In cases where the Plan has previously approved an ongoing course of treatment to be given over a period of time or number of treatments, any reduction in that course will be considered an adverse benefit determination. In the event of such an adverse benefit determination, the Plan will give you notice, sufficient time to appeal a determination and time to receive a decision of the appeal before an interruption of your care. In cases where the Plan has approved an ongoing course of treatment and you seek to extend the treatment beyond what has already been approved by the Plan, if the treatment requested is for urgent care, the decision of the Plan will be made in accordance with the same expedited procedures for determination of Urgent Care claims. If the request is made at least 24 hours before the end of pre-approved treatment, the Plan will notify you of the Plan's decision as soon as possible but no later than 24 hours after receipt of your claim.

(3) Pre-Service Claim

Claims for non-urgent care that require pre-authorization before care is obtained will be decided by the Plan within 15 days of receipt of a completed claim by the Trust Fund Office. This time frame may be extended as permitted by law if additional information is necessary to evaluate your claim.

(4) Post Service Claim

Post-Service Claims are claims for reimbursement for care which you have already received. Post-service Claims will be determined within 30 days from receipt of the claim by the Trust Fund Office. This time frame may be extended as permitted by law if additional information is necessary to evaluate your claim.

(c) Denial of Claim

If an application for a benefit or claim under the terms of the Plan is denied, in whole or in part, the Trust Fund Office shall send a written notice to you. The notice will (1) describe the specific reason or reasons for the denial; (2) reference the specific Plan provisions on which the denial is based, and any additional material or information necessary for you or your representative to perfect the claim; (3) provide an explanation of the reason why such material or information is necessary; and (4) explain the Plan's appeal procedures, including the Plan's expedited appeals procedure for Urgent Care claims, and the applicable time limits for both appeal and determination of the appeal by the Board of Trustees and (5) advise you that you are entitled to file suit in state or federal court after you have completed the appeal process described in this section.

If any internal rule, guideline or Plan procedure was relied upon in making the adverse benefit determination, the rule or guideline will be provided or a statement will be included that the specific rule was relied on and is available to you free of charge upon your request.

If the adverse benefit decision was based upon lack of medical necessity or experimental or similar exclusion, the Plan will provide an explanation of the scientific or clinical judgment made, and will apply it to the terms of the

Plan and your specific medical condition, or will notify you that the information is available free of charge upon request.

(d) Appeals Procedure

If your claim has been denied (adverse benefit determination) you will have 180 days from the denial of the claim to file a written appeal with the Trust Fund Office requesting a review by the Board of Trustees which must contain a written explanation of the basis for the appeal, and may include written comments, documents, records and other information relating to the claim.

You or your authorized representative may request that the Trust Fund Office provide copies of all documents, records, and other information relevant to the claim free of charge. The Board of Trustees will review and consider all comments, documents, records and other information submitted by you, whether or not such information was submitted in connection with the initial determination of your claim. The review by the Board of Trustees will consider all information and documents submitted by the claimant and will not defer to the judgment of the Trust Fund Office in deciding the appeal.

When the decision of the Trust Fund Office is based on medical judgment, the Board of Trustees will consult with an expert in the relevant field with appropriate training and experience who did not participate in the original determination by the Trust Fund Office. The Board of Trustees will disclose the identity of each expert consulted by the Plan, whether such expert was relied upon or not in making the final decision on appeal.

At the time of filing the written appeal, you or your authorized representative may request a formal hearing before the Board of Trustees.

(1) Procedure for Appeal of Urgent Care Claim

Appeals of adverse benefit determinations involving Urgent Care claims may be submitted orally or in writing by telephone, facsimile or any other expeditious manner, so long as all information necessary to review the appeal is provided.

(2) Time Limits for Deciding Appeal

- *Urgent Care Claim* will generally be decided within 72 hours of appeal.
- *Pre-Service Claim* will generally be decided within 30 days of appeal.
- *Post-Service Claim* will generally be decided at the next regularly scheduled meeting of the Board of Trustees following receipt of the appeal, unless the appeal arrives within 30 days of the next regularly scheduled meeting of the Board of Trustees, in which case it will be reviewed and decided at the following meeting of the Board of Trustees.

If special circumstances require an extension of time for processing the appeal, you will be given a notice in writing by the Trust Fund Office prior to beginning of the extension period, explaining the special circumstances requiring an extension of time and indicating the date by which the Trustees expect to render a final decision on the appeal. The Trust Fund Office will notify you or your authorized representative of the Board of Trustees' decision in writing not later than 5 days after the determination is made.

(e) Denial of Appeal

If your appeal has been denied in whole or in part by the Board of Trustees, you will be advised by the Trust Fund Office in writing of the specific reason or reasons for the denial, including any specific Plan provision upon which the denial is based. If your appeal is denied you are entitled to have, free of charge, all documents, records and other information relevant to your claim for benefits returned. You will also be advised of the Plan' voluntary appeals procedures, if any, along with the information required in connection with such a voluntary appeal

procedure. If applicable, the notice will also include the specific rule, guideline, or protocol relied on by the Board of Trustees in making the decision, and will either include a copy of the document or will advise you that a copy is available free of charge. If the Board's decision is based either in whole or in part on a medical judgment, the notice will explain the basis for the judgment or will contain a statement that the explanation is available free of charge to you.

In the event an appeal is denied by the Board of Trustees, you will be entitled to review all relevant information relied upon by the Board of Trustees in deciding the appeal, as well as any document, record, or other information which was submitted, considered, or generated in the course of making the benefit determination, whether or not it was relied upon in deciding the appeal.

Note: *The decision of the Board of Trustees, with respect to a request for reconsideration, shall be final and binding upon all parties, including you and any person acting on your behalf.*

(f) Disability & Other Claims

Claims other than those discussed above must be approved or denied by the Trust Fund Office within 90 days of receipt of such claim, unless an extension of time for processing the claim is necessary due to matters beyond the control of the Trust Fund Office. If such an extension of time is required, you will be notified in writing within 90 days of the date the claim is received, stating the circumstances requiring the extension of time and the date you can expect to receive a decision, which will not be longer than 180 days. You or your representative may voluntarily consent to a longer extension of time.

If your claim is denied, the Trust Fund Office will notify you in writing. The notice will explain in detail the reasons for denial with specific reference to the Trust provisions upon which the denial is based, a description of any information or material necessary to perfect the claim and an explanation of the right to appeal.

(g) Review Procedures for Disability & Other Claims

If your claim is denied by the Trust Fund Office, the following review procedures apply:

(1) Appeal

You must file a request for review with the Trust Fund Office within 180 days of your receipt of the denial notice. Failure to file a request within the 180-day period will constitute a waiver of your right to appeal the denial or to take any other action with respect to it, although the Board of Trustees may consider an appeal submitted up to one year from the date of the denial notice provided that good cause is shown for the delay. An appeal shall be in writing, shall state in clear and concise terms the reason or reasons for disputing the denial, and shall be accompanied by any pertinent documentary material not already furnished to the Trust.

(2) Notice of Trustee Decision

You will be advised of the Trustees' decision in writing as soon as practicable but generally no later than sixty (60) days after receipt of your request for review by the Trust Fund Office. Should there be special circumstances, the time may be extended for the processing of such request for review for a period not to exceed 120 days after receipt of a request for review. You will be notified of the extension prior to the end of the original 60 day period. The decision on review shall be in writing and shall include a specific reason for the decision with specific references to the pertinent provisions of the Trust on which the decision is based.

Note: *Other than timeframes, the rules described above governing appeals regarding your opportunity to submit written comments, access to documents, records and other relevant information, non-deference to the initial determination, review by independent reviewing fiduciary, and medical judgment (including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigation, or not medically necessary or appropriate), and access to the identity of the medical or vocational experts relied upon by the*

Board of Trustees will be applicable to disability and other claims.

(h) Right to Bring Civil Action if Appeal Denied

If you are dissatisfied with the final decision of the Board of Trustees, you have a right to bring a civil action under section 502(a) of ERISA in either state or federal court. No action may be filed by any person against the Plan, the Trustees, or any of the Trustees' agents more than 180 days after you are given written notice of the denial of an appeal by the Board of Trustees. Unless you are otherwise expressly advised in writing, the 180-day period shall not be extended even if the Board of Trustees again considers the appeal after the initial denial. This 180-day limitation shall apply to all legal and equitable actions arising out of, or relating to, a claim for benefits including, but not limited to, any legal or equitable action under ERISA to the extent the claim relates to the provision of benefits or rights under the Plan.

XVI. Statement of ERISA Rights

As a participant covered under this Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Trust Fund 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.
- Obtain, upon written request to the Trust Fund Office, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Trust Fund Office is required by law to furnish each Participant with a copy of this summary financial report.
- Continue health care coverage for the Eligible Employee, the Eligible Employee's Spouse or Domestic Partner or Eligible Dependents if there is a loss of coverage under the plan as a result of a qualifying event. Eligible Employees, their Spouses or Domestic Partners and Eligible Dependents may have to pay for such coverage.
- Review this SPD/Plan document and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

  Note: *This requirement will apply only through December 31, 2014. After that, the Plan will not issue a certificate of credible coverage because the federal law known as the Affordable Care Act eliminates such exclusionary periods of coverage for preexisting conditions starting with the first Plan Year beginning on or after January 1, 2014.*

(a) 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, the 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.

(b) Enforce your Rights

If your claim for a Plan 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 donot receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Trust Fund Office 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 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, 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 lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

(c) Assistance with your Questions

If you have any questions about your Plan, you should contact the Trust Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Trust Fund Office, you should contact the nearest office of the Employee Benefits Security Administration, United States Department of Labor, which is located at 1055 East Colorado Boulevard, Suite 200, Pasadena, CA 91106-2341. You may also contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, United States Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

This Summary Plan Description is required by federal law. Of necessity, many of the substantive Plan provisions mentioned in this SPD have been set forth in summary or capsulate form. It is not to be considered the contract of insurance. All statements made in this SPD are subject to the complete terms of the coverages as set forth in the master service agreements issued by the providers and/or insurance companies, and all amendments to those respective documents. Please refer to the master policies and agreements for a complete and detailed description of the coverages.

All questions with respect to Plan participation, eligibility for benefits or the nature and amount of benefits, or with respect to any matter of Trust Fund or Plan administration, should be referred to the Trust Fund Office:

Landscape, Irrigation & Lawn Sprinkler Industry Health & Welfare Plan
c/o: Southern California Pipe Trades Administrative Corporation
501 Shatto Place, 5th Floor, Los Angeles, CA 90020
(213) 385-6161 (800) 595-7473 Fax: (213) 385-2767

The only parties authorized to answer questions concerning the Trust Fund and Plan are the Board of Trustees and the Trust Fund Office. No participating employer, employer association or labor organization, nor any individual employed thereby, has any authority in this regard.

Southern California Pipe Trades Administrative Corporation

501 Shatto Place, 5th Floor | Los Angeles | CA 90020

(800) 595-7473 | Outside US (213) 385-6161 | Fax (213) 383-0725

Administered by:

Southern California Pipe Trades Administrative Corporation

www.scptac.org