

Summary Plan Description / Plan Rules & Regulations

of the

Southern California Pipe Trades

HEALTH & WELFARE FUND (Active Plan)



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SECTION

1. INTRODUCTION

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

A) This Summary Plan Description

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

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

B) Purpose of the Plan

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

C) Role of the Board of Trustees

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

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

D) Role of the Fund Office

The Board of Trustees has authorized the Fund Office to respond in writing to your written questions. As a courtesy, the Fund Office may also respond informally to questions by telephone, email, or in person at the Fund Office. However, such information and answers are not binding upon the Board of Trustees and cannot be relied upon in any dispute. Remember that in all matters communicated to you, verbal or written, the Board of Trustees will have the ultimate authority and discretion to interpret the Plan documents and make an independent determination about your entitlement to benefits.

NOTE

If you have any questions regarding eligibility, benefits, or procedures, contact the Fund Office.

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

Toll-Free: (800) 595-7473 / Outside U.S.: (213) 385-6161
Website: www.scptac.org / Email: info@scptac.org

Contact health@scptac.org for questions relating to:

- Annual Coordination of Benefits Form
- Change of Address Form
- HRA Form and claims
- Injury and Third Party Liability Form
- Specialty Medication
- Therapy related Prescriptions
- Weekly Disability Benefit

NOTE

Capitalized terms are defined in Section 24, page 68.

SECTION**2. SUMMARY OF PLAN BENEFITS**

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

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

SUMMARY OF PLAN BENEFITS

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

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

SUMMARY OF PLAN BENEFITS

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

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

SUMMARY OF PLAN BENEFITS

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

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

SUMMARY OF PLAN BENEFITS

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

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

SUMMARY OF PLAN BENEFITS

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

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

SUMMARY OF PLAN BENEFITS

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

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

SUMMARY OF PLAN BENEFITS

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

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

SECTION

3. ENROLLMENT

A) Enrolling an Eligible Dependent

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

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

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

B) Dis-enrolling a Dependent

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

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

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

C) Designating a Beneficiary

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

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

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

D) Required Documents

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

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

NOTE

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

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

i) Marriage or Domestic Partnership Documents

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

ii) Birth, Adoption, or Guardianship Documents

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

iii) Death Certificates

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

iv) Divorce or Dissolution Documents

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

F) Change of Address

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

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

IMPORTANT

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

SECTION 4. ELIGIBILITY

A) Establishing and Re-establishing Eligibility

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

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

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

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

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

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

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

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

EXAMPLE

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

EXAMPLE

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

B) Maintaining Eligibility

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

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

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

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

EXAMPLE

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

C) Suspension & Termination of Eligibility**i) When Coverage is Suspended**

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

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

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

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

ii) When Coverage is Terminated

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

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

b) Special Rules for Owners and Bargaining Unit Alumni

Under the terms of the Collective Bargaining Agreement:

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

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

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

D) Dependent Eligibility

i) Who are Eligible Dependents?

Your Eligible Dependents may be:

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

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

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

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

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

ii) Dual Coverage

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

iii) When Eligible Dependent Coverage Starts

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

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

iv) When Dependent Coverage Terminates

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

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

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

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

v) Surviving Eligible Dependents of Deceased Participants

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

a) Surviving Spouses or Domestic Partners

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

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

b) Children

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

vi) Qualified Medical Child Support Order (QMCSO)

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

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

E) Reciprocal Contributions

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

i) Incoming Reciprocity

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

ii) Outgoing Reciprocity

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

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

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

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

IMPORTANT

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

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

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

i) Return to Work Under the Temporary Waiver Program

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

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

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

iii) Return to Work Resulting in Suspension of Pension Benefit

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

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

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

v) Return to Work at Age 70½

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

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

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

vii) Reinstatement upon Return to Covered Employment

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

G) Eligibility Under USERRA

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

i) USERRA Continuation Coverage

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

ii) Cost of Coverage

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

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

a) Exhaust Eligibility Bank, Elect USERRA Upon Return

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

b) Exhaust Eligibility Bank, Elect USERRA Immediately After

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

c) Freeze Eligibility Bank, Elect USERRA

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

d) Freeze Eligibility Bank, Waive USERRA

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

iv) Notice Requirements

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

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

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

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

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

i) Definition of Transitioning Employee

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

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

These special eligibility rules are not available to:

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

ii) Methods by which Transitioning Employees May Become Eligible

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

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

a) Employer Lump Sum

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

1) Category I

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

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

2) Category II

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

b) Negative Bank

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

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

1) Category I Employees

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

2) Category II Apprentices

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

iii) Hours Requirement for Transitioning Employees

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

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

iv) Employer's Minimum Contribution Requirement

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

v) Subsidized Self-Pay and COBRA for Transitioning Employees

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

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

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

vii) Special Benefit Provisions for Transitioning Employees

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

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

SECTION

5. EXTENDING ELIGIBILITY

You may be able to extend eligibility as follows:

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

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

A) COBRA Continuation Coverage

i) What is COBRA Continuation Coverage?

a) Introduction

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

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

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

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

NOTE

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

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

b) Rights of Covered Participant

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

A Qualifying Event includes:

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

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

c) Rights of Eligible Spouse

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

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

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

d) Rights of Eligible Child

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

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

ii) How Long will Continuation Coverage Last?

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

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

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

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

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

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

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

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

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

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

IMPORTANT

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

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

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

Maximum Periods of COBRA Continuation Coverage

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

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

iv) Disability

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

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

v) Duty to Notify the Fund

a) Divorce or Dissolution of Domestic Partnership

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

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

b) Ineligible Dependent

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

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

c) Death

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

vi) How Is Continuation Coverage Elected?

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

vii) How Much Does Continuation Coverage Cost?

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

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

a) Your First Payment

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

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

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

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

b) Periodic Payments for Continuation Coverage

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

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

c) Grace Period for Periodic Payments

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

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

EXAMPLE

Your Periodic COBRA Payments

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

d) Form of Payment

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

e) Payments

Payments for continuation coverage should be sent to: Southern California Pipe Trades Administrative Corporation
Attention: Eligibility Department
501 Shatto Place, Suite 500
Los Angeles, CA 90020

ix) For More Information

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

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

B) Subsidized Self-Pay Program

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

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

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

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

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

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

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

C) Survivor Premium Program Coverage

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

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

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

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

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

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

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

D) Extended Coverage in Case of Total Disability

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

EXAMPLE

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

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

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

SECTION

6. HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

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

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

A) Active Participant Eligibility

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

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

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

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

B) Loss of Eligibility

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

EXAMPLE

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

EXAMPLE

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

EXAMPLE

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

C) Benefit Amount

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

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

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

D) Forfeitures

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

E) HRA Opt-Out Feature

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

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

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

F) Reimbursable Expenses

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

NOTE

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

i) Examples of eligible expenses are as follows:

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

ii) Examples of ineligible expenses are as follows:

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

G) Claims Procedures

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

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

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

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

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

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

H) COBRA Continuation Coverage and Your HRA

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

i) COBRA Coverage for Participants

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

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

ii) COBRA Coverage for Eligible Spouses and Children

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

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

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

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

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

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

COBRA without HRA COBRA

EXAMPLE

Your eligible child turns age 26 and therefore loses coverage under the Plan. The child chooses to pay for COBRA coverage but not for HRA COBRA coverage. The child then suffers an Injury, the treatment for which is not entirely covered by the Plan or any other source. The child may not claim reimbursement from the HRA Allowance because the child did not pay for HRA COBRA coverage.

COBRA with HRA COBRA

EXAMPLE

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

I) HRA COBRA Premiums

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

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

J) Election of Additional Contributions from Eligibility Bank

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

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

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

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

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

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

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

K) Death of Participant

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

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

L) Family and Medical Leave Act (FMLA)

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

M) Uniformed Service Leave

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

SECTION 7. PLAN BASICS

A) Calendar Year Deductible

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

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

The Calendar Year Deductible does not apply to the following:

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

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

B) Out-of-Pocket Maximum

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

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

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

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

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

EXAMPLE

You have surgery on July 1, 2025, in an in-network Hospital; the billed amount is \$5,000, the Blue Shield of California PPO Network Rate is \$4,000, and you are responsible for the 5% Coinsurance amount of \$200.

- The \$200 Coinsurance that you pay applies toward your individual and family in-network Out-of-Pocket Maximum for 2025.

EXAMPLE

You have surgery on November 4, 2025, in an out-of-network surgery center; the billed amount is \$5,000, the Allowable Charge is \$1,350, and you are responsible for the 10% Coinsurance amount of \$135 plus the amount over the Allowable Charge of \$3,650 (\$5,000 - \$1,350).

- The \$135 Coinsurance that you pay applies toward your individual and family out-of-network Out-of-Pocket Maximum for 2025.
- The \$3,650 does not apply toward your Out-of-Pocket Maximum.

EXAMPLE

You buy a hearing aid from an in-network Durable Medical Equipment supplier on December 28, 2025; the billed amount is \$1,700, the Blue Shield of California PPO Network Rate is \$1,500, the Allowable Charge is \$1,000, and there is a \$50 Deductible. Because the Allowable Charge is less than the Blue Shield of California PPO Network Rate, you are responsible for the remaining \$500 (\$1,500 - \$1,000) and the Deductible.

- The \$50 Deductible you pay applies to your individual and family in-network Out-of-Pocket Maximum for 2025.
- Because the Fund Allowable Charge is \$1,000 per hearing aid, the \$500 does not apply to your Out-of-Pocket Maximum.

C) Preferred Provider Organization (PPO) Network

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

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

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

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

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

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

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

IMPORTANT

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

IMPORTANT

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

D) When Claims are Paid

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

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

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

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

E) What the Plan will Pay

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

i) Blue Shield of California PPO Network Providers

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

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

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

ii) Out-of-network Providers

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

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

iii) Continuity of Coverage

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

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

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

F) Out-of-Area Services

Benefits will be provided for Covered Services received outside of California within the United States, Puerto Rico, and U.S. Virgin Islands. The Southern California Pipe Trades Health and Welfare Fund, the "Fund", calculates the Participant's copayment either as a percentage of the allowable amount or a dollar copayment, as defined in this SPD. When Covered Services are received in another state, the Participant's copayment will be based on the local Blue Cross and/or Blue Shield plan's arrangement with its providers. See the BlueCard Program section in this SPD.

Blue Shield of California has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of California, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program.

When you access Covered Services outside of California you may obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Plan"). In some instances, you may obtain care from non-participating healthcare providers. The Fund's payment practices in both instances are described in this SPD.

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

When you require Covered Services while traveling outside of California:

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

The participating Physician or Hospital will verify your eligibility and coverage information by calling BlueCard Eligibility at 1-800-676-BLUE. Once verified and after services are provided, a claim is submitted electronically and the participating Physician or Hospital is paid directly. You may be asked to pay for your applicable copayment and Plan Deductible at the time you receive the service.

You will receive an Explanation of Benefits which will show your payment responsibility. You are responsible for the copayment and Plan Deductible amounts shown in the Explanation of Benefits.

Prior authorization is required for all Inpatient Hospital Services and notification is required for Inpatient Emergency Services. Prior authorization is required for selected Inpatient and Outpatient Services, supplies and Durable Medical Equipment. To receive prior authorization from the Southern California Pipe Trades Health and Welfare Fund, the out-of-area provider should call the customer service number noted on the back of your identification card.

i) BlueCard Program

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

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

Whenever you access Covered Services outside of California and the claim is processed through the BlueCard Program, the amount you pay for Covered Services, if not a flat dollar copayment, is calculated based on the lower of:

1. The billed covered charges for your Covered Services; or
2. The negotiated price that the Host Plan makes available to Blue Shield of California.

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price the Fund uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Plan to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

Claims for Covered Services are paid based on the Allowable Amount as defined in this SPD.

ii) Non-Preferred Provider

If you do not see a participating provider through the BlueCard Program, you will have to pay for the entire bill for your medical care and submit a claim form to the local Blue Cross and/or Blue Shield plan or to the Fund for payment. The Fund will notify you of its determination within 30 days after receipt of the claim. The Fund will pay you at the Non-preferred provider benefit level. Remember, your copayment is higher when you see a non-preferred provider. You will be responsible for paying the entire difference between the amount paid by the Southern California Pipe Trades Health and Welfare Fund and the amount billed.

Charges for Services which are not covered, and charges by non-preferred providers in excess of the amount covered by the Plan, are the Participant's responsibility and are not included in copayment calculations.

iii) Care for Urgent Care and Emergency Services Outside the United States

Benefits will also be provided for covered urgent and emergent services received outside of the United States, Puerto Rico, and U.S. Virgin Islands. If you need urgent care while out of the country, call the BlueCard Worldwide Service Center at either the toll-free BlueCard Access number (1-800-810-2583) or collect (1-804-673-1177), 24 hours a day, seven days a week. In an emergency, go directly to the nearest hospital. If your coverage requires precertification or prior authorization, you should also call the Fund at the customer service number noted on the back of your identification card. For inpatient hospital care, contact the BlueCard Worldwide Service Center to arrange cashless access. If cashless access is arranged, you are responsible for the usual out-of-pocket expenses (non-covered charges, Deductibles, and Copayments). If cashless access is not arranged, you will have to pay the entire bill for your medical care and submit a claim to the BlueCard Worldwide Service Center.

When you receive services from a physician, you will have to pay the doctor and then submit a claim.

Before traveling abroad, call your local Customer Service office for the most current listing of providers world-wide or you can go on-line at www.bcbs.com.

IMPORTANT

No health care provider is an agent or representative of the Plan or the Board of Trustees. The Fund does not provide medical services itself, nor does it control or direct the provision of health care services or supplies by anyone else. The Plan makes no representation or guarantee of any kind that any provider will furnish health care services or supplies that are error-free or that the provider you select is competent to treat your condition. This applies to any healthcare providers, including both Blue Shield of California PPO network providers and out-of-network providers under the terms of the Plan, and all entities (and their agents, employees, and representatives) that contract with the Fund to offer health-related services or supplies. Nothing in this Plan restricts the ability of a provider to disclose alternative treatment options.

G) No Surprise Billing

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

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

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

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

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

SECTION 8. QUARTERLY STATEMENT

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

Quarterly Statement Schedule

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

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

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

SECTION

9. MEDICAL BENEFITS

Benefits are listed in alphabetical order.

Acupuncture

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

Allergy Testing

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

Allergy Treatment

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

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

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

Ambulance/Air Ambulance

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

- A) The Plan will pay for the following:
- i) Ground ambulance transportation to a Hospital in the area of an emergency;
 - ii) Ground ambulance service between a Hospital or Extended Care Facility in connection with a confinement;
 - iii) Ground ambulance service to the air ambulance;
 - iv) Transportation from one Hospital to another for Medically Necessary specialized care (i.e., to a pediatric facility required for the patient's condition); and
 - v) Air ambulance service to a medical facility.
- B) The Plan will not pay for the following:
- i) The use of a ground ambulance or air ambulance due to lack of other transportation or for personal preference, such as your desire to use your own Physician, your desire to be near home and family, or your desire to be treated at a different facility; or
 - ii) Stand-by time charged by any ambulance; or
 - iii) Chartered aircraft instead of air ambulance unless a bona fide air ambulance is not available; or
 - iv) More than one air ambulance charge per Illness or Injury; or
 - v) Transportation from a nursing facility to a Hospital or vice versa for tests, X-rays, scans, etc.; or
 - vi) EMS (Emergency Medical Service) with no transport.

Anesthesia

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

IMPORTANT

Effective January 1, 2021, for emergency care, or certain out of network care at an in-network facility, you are protected from receiving a surprise bill from a provider for the following services:

- Emergency care at a out-of-network facility (hospital or freestanding emergency facility) or from an out-of-network provider at an in-network emergency facility.
- Any type of medical care from an out-of-network provider at an in-network hospital or ambulatory surgical center (unless you sign a consent form).
- Emergency transportation for an out-of-network air ambulance provider.

You should never be asked to consent to balance billing in an emergency situation, by resident doctors in the hospital, or by intensive care physicians. For more information on the No Surprises Act you may visit www.cms.gov/nosurprises.

NOTE

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

Bariatric Surgery

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

Cardiac Rehabilitation

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

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

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

Chemotherapy

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

Chiropractic Care

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

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

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

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

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

Colonoscopy/Sigmoidoscopy (Screening)

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

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

Dependent Child Special Disability Benefit

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

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

This benefit has the following additional exclusions and limitations:

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

Dialysis (Renal)

A) Physician's office:

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

B) Hospital services:

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

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

Durable Medical Equipment

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

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

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

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

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

Emergency Services by Out-of-Network Providers

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

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

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

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

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

IMPORTANT

Effective January 1, 2021, for emergency care, or certain out-of-network care at an in-network facility, you are protected from receiving a surprise bill from a provider for the following services:

- **Emergency care at a out-of-network facility (hospital or freestanding emergency facility) or from an out-of-network provider at an in-network emergency facility.**
- **Any type of medical care from an out-of-network provider at an in-network hospital or ambulatory surgical center (unless you sign a consent form).**
- **Emergency transportation for an out-of-network air ambulance provider.**

You should never be asked to consent to balance billing in an emergency situation, by resident doctors in the hospital, or by intensive care physicians. For more information on the No Surprises Act you may visit www.cms.gov/nosurprises

Family Planning

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

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

Genetic Testing

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

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

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

Hearing Aid Benefit

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

EXAMPLE

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

Home Health Nursing

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

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

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

Home Intravenous (IV) Therapy

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

Hospice

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

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

Hospital

A) Introduction

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

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

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

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

B) Inpatient

- i) Blue Shield of California PPO Network Hospital

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

- ii) Out-of-Network Hospital

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

NOTE

A fully itemized bill is required from the facility.

C) Outpatient

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

- i) Blue Shield of California PPO Network Hospital

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

- ii) Out-of-Network Hospital

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

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

NOTE

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

Immunizations

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

Laboratory

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

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

Medical Supplies

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

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

Mental Health

A) Introduction

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

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

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

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

B) Adult Day Health Care Center (ADHC)

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

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

C) Inpatient Hospital

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

D) Outpatient – Office

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

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

E) Partial Hospitalization

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

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

F) Residential Treatment Center

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

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

Midwife Services

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

Non-prescription and Over-the-counter Drugs

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

Nutritional Counseling

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

Occupational Therapy

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

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

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

Opioid Drug Testing

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

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

Pain Management

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

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

Physical Examinations – Adults 18 and Over

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

A physical examination includes, but is not limited to:

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

Physical Therapy

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

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

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

Physician or Psychiatrist Visits/Professional Services

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

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

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

Radiation Therapy

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

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

Radiology

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

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

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

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

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

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

Sleep Study

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

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

Specialty Medication

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

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

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

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

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

Speech Therapy

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

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

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

Substance Use Disorder

A) Introduction

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

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

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

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

B) Inpatient Hospital

i) Blue Shield of California PPO Network Hospital

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

ii) Out-of-Network Hospital

The Plan will pay 90% of the Allowable Charge, up to a maximum of \$1,215 per day, except where the Plan determines that the services rendered are due to an Emergency Medical Condition.

C) Outpatient – Office

i) Blue Shield of California PPO Network Provider

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

ii) Out-of-Network Provider

The Plan will pay 100% of the Allowable Charge.

D) Partial Hospitalization

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

i) Blue Shield of California PPO Network Facility

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

ii) Out-of-Network Facility

The Plan will pay 90% of the Allowable Charge, up to a maximum of \$1,215 per day.

E) Residential Treatment Center

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

i) Blue Shield of California PPO Network Facility

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

ii) Out-of-Network Facility

The Plan will pay 90% of the Allowable Charge, up to a maximum of \$1,215 per day.

F) Laboratory Testing

i) Blue Shield of California PPO Network Provider

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

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

Surgery

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

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

Temporomandibular Joint Dysfunction (TMJ)

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

There are two exceptions to this:

A) Physiotherapy

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

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

B) Plaster molds

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

Transplants

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

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

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

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

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

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

Well-Child Services – Children through age 17

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

SECTION
10. PRESCRIPTION DRUG BENEFITS

A) Benefit Limitations

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

Table with 3 columns: Tier, Amount Submitted, Plan Pays. Rows show tiers 1, 2, and 3 with corresponding amount ranges and reimbursement percentages.

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

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

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

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

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

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

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

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

B) Claim Requirements

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

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

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

IMPORTANT

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

SECTION

11. VISION BENEFITS

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

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

A) Other Plan Rules

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

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

B) Claims and Appeals Procedures

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

SECTION

12. DENTAL BENEFITS

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

A) Enrollment

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

i) Initial Enrollment

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

ii) Changing Plans

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

B) Benefit Options

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

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

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

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

C) Benefit Limitations

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

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

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

D) Claims Procedures

Dental claims are processed by MetLife PPO or DeltaCare USA.

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

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

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

DeltaCare USA
Claims Department
P.O. Box 1810
Alhambra, CA 91803

E) Appeals Procedures

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

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

F) Option Comparison

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

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

SECTION

13. WEEKLY ACCIDENT AND SICKNESS BENEFIT

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

The day of disability on which benefits begin is:

For an Accident: First day

For an Illness: Eighth calendar day

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

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

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

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

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

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

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

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

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

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

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

SECTION 14. DEATH BENEFITS

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

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

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

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

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

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

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

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

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

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

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

NOTE

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

SECTION

15. ACCIDENTAL DEATH / DISMEMBERMENT BENEFITS

A) Accidental Death or Dismemberment

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

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

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

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

B) Accidental Death or Dismemberment Exclusions and Limitations

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

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

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

SECTION

16. PROCESSING CLAIMS FOR BENEFITS

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

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

**Providers should send
medical claims to:**

**Blue Shield of California
P.O. Box 272540
Chico, CA 95927-2540**

**You should send your
HRA or prescription
claims to:**

**Southern California Pipe Trades
Health & Welfare Fund
Claims Department
501 Shatto Place, Suite 500
Los Angeles, CA 90020**

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

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

Claims submitted for medical or prescription benefits are post-service claims. These claims involve the payment or reimbursement for services that have already been provided. A provider may call Blue Shield of California to ask if a particular procedure is covered by the Plan.

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

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

Follow these guidelines for prompt claims processing:

- i) Make sure you submit the Plan’s Annual Coordination of Benefits Form, available from any local Union office, the Fund Office, or the Fund Office website at www.scptac.org. A fully completed Annual Coordination of Benefits Form is required once every Calendar Year.
- ii) In case of any injury, submit the Plan’s Injury and Third Party Liability Form.
- iii) Submit the provider’s fully itemized bill, which must include the following:
 - a) Participant’s name and the last four digits of their Social Security Number or Blue Shield ID number;
 - b) Patient’s name, date of birth, and the last four digits of their Social Security Number or Blue Shield ID number;
 - c) Diagnosis or diagnosis code number (ICDA);
 - d) Date(s) of service;
 - e) Procedure codes (e.g. CPT); and
 - f) Charge for each service.
- iv) Submit a prescription claim receipt from a Pharmacy, which must include the following:
 - 1) Name of Patient;
 - 2) Name of medication;
 - 3) Date dispensed;
 - 4) Name, address, and phone number of Pharmacy;
 - 5) Name of prescribing Physician;
 - 6) Prescription number;
 - 7) National Drug Code (NDC) number; and
 - 8) Cost of Prescription Drug.

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

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

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

Dental claims should be sent to:	DeltaCare USA Claims Department P.O. Box 1810 Alpharetta, GA 30023 MetLife PPO MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282
Vision claims should be sent to:	Vision Service Plan Attention: Claims Services P.O. Box 495918 Cincinnati, OH 45249-5918

B) Timely Filing

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

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

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

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

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

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

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

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

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

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

E) Processing Claims

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

i) Urgent Care Claim

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

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

ii) Pre-Service Claim

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

iii) Post-Service Claim

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

iv) Concurrent Care Claim

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

v) Disability Claim

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

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

F) Notice of Denial of Claim

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

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

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

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

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

SECTION

17. APPEALS PROCEDURE

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

A) Appealing a Benefit Denial

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

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

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

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

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

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

B) Timing of Appeals Committee Decisions

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

Post-Service Claims Appeals. Most claims will be post-service claims appeals. The Appeals Committee will meet at least once each quarter to review pending appeals. The decision of the Appeals Committee will be made by the meeting immediately following the date the appeal is received by the Fund Office. If the appeal is received during the 30 days preceding the meeting, the decision will not be made until the second meeting following receipt of the appeal. The time for processing an appeal may be extended in special circumstances by written notice to you before the beginning of the extension. Such an extension may only last until the third meeting following receipt of the appeal.

C) Notice of Decision on Appeal

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

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

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

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

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

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

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

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

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

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

D) Decisions on Appeal are Final and Binding

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

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

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

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

E) Right to Authorized Representative

In making a claim or appeal, you may be represented by an authorized representative. If your representative is not an attorney or court-appointed guardian, you must designate the representative by a signed written statement. A parent of a minor child is assumed to be the authorized representative of the child for purposes of filing a claim for benefits or appealing a denial of a claim. However, neither you nor your representative has a right to an in-person hearing or appearance before the Trustees or the Appeals Committee.

F) Other Appeals

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

SECTION

18. COORDINATION OF BENEFITS

A) General Rules

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

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

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

B) Benefit Reduction

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

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

C) Which Plan Pays First – Coordination of Benefits

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

- i) If you and your Eligible Dependent are employed and have coverage:
 - a) The plan covering the Patient as an employee is the primary payer.
 - b) The plan covering the Patient as a dependent is the secondary payer.
- ii) If your Spouse/Domestic Partner is retired and has medical coverage:
 - a) The plan providing active coverage is the primary payer.

- b) The plan providing retiree coverage is the secondary payer.
- iii) If you are retired and using your Eligibility Bank to maintain coverage under the Active Plan and your Spouse/Domestic Partner is actively employed with coverage:
 - a) The plan providing coverage for an active employee is the primary payer.
 - b) The plan covering the Participant using the Eligibility Bank is the secondary payer.
- iv) If the Patient is a child who is employed and has medical coverage:
 - a) The plan covering the child as an employee is the primary payer.
 - b) The plan covering the child as a dependent is the secondary payer.
- v) If the Patient is a minor child whose parents both have coverage and are living together:
 - a) The plan covering the parent whose birthday falls earlier in the year is the primary payer for the child.
 - b) The plan covering the parent whose birthday falls later in the year is the secondary payer for the child.

EXAMPLE

Father's date of birth: October 3, 1984

Mother's date of birth: April 20, 1985

The plan covering the mother of the child is the primary payer. The plan covering the father of the child is the secondary payer.

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

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

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

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

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

D) Coordination of Benefits with Medicare

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

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

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

- ii) If the Participant is actively employed with medical coverage and the Spouse is retired with coverage, and both are eligible for Medicare:
 - a) Plan providing active coverage is the primary payer.
 - b) Medicare is the secondary payer.
 - c) Plan providing retiree coverage is the third payer.
- iii) If the Participant is retired and using their Eligibility Bank to maintain coverage under the Active Plan and is eligible for Medicare:
 - a) Plan using Eligibility Bank is the primary payer.
 - b) Medicare is the secondary payer.

IMPORTANT

Once you retire, to get full benefits under the Plan, you must enroll in both Medicare Parts A and Part B before you become eligible for Medicare. Medicare is the primary payer of your benefits once your Eligibility Bank is exhausted.

Medicare is considered by this Plan to be the primary payer of benefits for Pensioners and their eligible Spouses who are eligible for Medicare whether or not they are enrolled in the Medicare Program. This means that if you do not enroll in Medicare as soon as you qualify, this Plan will not pay for benefits that Medicare would have paid had you been enrolled in Medicare.

E) Medicare Part D

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

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

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

SECTION 19. THIRD PARTY LIABILITY

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

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

The Plan has a right to first reimbursement of any recovery from a third party, any insurance policy, or any uninsured motorist coverage, even if you are not otherwise made whole and without regard to how the recovery is categorized. The Plan's right to reimbursement will not be affected, reduced, or eliminated by the make-whole doctrine, comparative fault or regulatory diligence, or the common fund doctrine. Nor shall the Plan's right to reimbursement be reduced by costs or attorney's fees. Without waiving its rights herein, the Plan may, at its sole discretion, agree to reduce the full amount to which it is entitled under this provision to contribute to reasonable attorney's fees and costs incurred by you in collecting a recovery from the third party.

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

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

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

SECTION

20. EXCLUSIONS & LIMITATIONS

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

A) Medical

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

- 1) A claim for a service or procedure not expressly covered by the Plan;
- 2) Any claim for treatment, services, or supplies, including any additional information requested, that is not filed within 12 months from the date the expense is incurred (60 months for HRA claims);
- 3) Services that are not reasonably necessary for the care or treatment of bodily Injuries or Illness as determined by the Fund, except for routine vision benefits, dental benefits, or routine physical examinations expressly covered by the Plan;
- 4) Any services or procedures that are Experimental Treatments or investigational or are not within the standards of generally accepted medical practice, or medical services or supplies, including Prescription Drugs, considered educational, investigational, or experimental. Experimental or investigational means:
 - a) It is a drug or device that cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is furnished; or
 - b) Reliable evidence shows that the drug, device, or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
 - c) Reliable evidence shows that the consensus among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or its efficacy as compared with the standard means of treatment or diagnosis. For this purpose, reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility, or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure;
- 5) Services, prescriptions, medications, and supplies received outside of the United States and its territories unless:
 - a) the services, medications, or supplies were the result of an Accident, urgent care requirement, or life-threatening Emergency Medical Condition or
 - b) the Eligible Participant submits proof of residency in the country where the services were rendered;
- 6) Charges for missed or broken appointments;
- 7) Charges for completion of forms;
- 8) Charges for phone consultations other than telemedicine (e.g., reading of EKGs or fetal monitoring over the phone);
- 9) Hospital or Extended Care Facility charges for personal items such as charges for radio, television, telephone, guest expenses, and other similar items;
- 10) Charges for personal comfort, beautification, or convenience items or services;
- 11) Custodial Care as defined in this SPD except as covered under the Hospice benefit;
- 12) Housekeeping services;

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

B) Third-Party Liability

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

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

C) Other

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

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

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

IMPORTANT

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

SECTION 21. IMPORTANT NOTICES

A) No Assignment of Benefits

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

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

B) Erroneous Payments

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

C) Misrepresentation or Fraud

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

D) No Fund Liability

Using the services of any Hospital, Physician, or other healthcare provider, whether designated by the Fund or otherwise, is your voluntary act. Nothing in this SPD is meant to be a recommendation or instruction to use any provider. You should select a provider or course of treatment based on all appropriate factors, only one of which is coverage by the Plan. Providers are independent contractors, not employees or subcontractors of the Plan. The Trustees make no representation regarding the quality of service or treatment of any provider and are not responsible for any acts of commission or omission of any provider in connection with Fund coverage. The provider is solely responsible for the services and treatments rendered.

Neither the Plan, nor the Board of Trustees, nor any of their designees are engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care, or lack thereof, or over any health care services provided or delivered to anyone by any health care provider. In addition, neither the Plan, nor the Board of Trustees, nor any of their designees, have any liability whatsoever for any loss or Injury caused to anyone by any health care provider because of negligence, failure to provide care or treatment, or otherwise.

SECTION
22. INFORMATION REQUIRED BY ERISA

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

A) Name and Type of Plan

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

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

B) Identification Numbers

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

C) Plan Year

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

D) Plan Sponsor, Named Fiduciary, and Administrator

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

E) Board of Trustees

The Board of Trustees consists of Employer and Union representatives selected by the Employers and Unions under the Trust Agreement that relates to this Plan. If you wish to contact the Board of Trustees, you may do so at:

Board of Trustees
Southern California Pipe Trades Health and Welfare Fund
501 Shatto Place, Suite 500
Los Angeles, CA 90020
(800) 595-7473
(213) 385-6161
www.scptac.org
info@scptac.org

F) Fund Office

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

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

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

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

Contributions to the Fund are made by:

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

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

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

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

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

I) Collective Bargaining Agreement

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

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

J) Plan Termination

It is intended that this Plan will continue indefinitely, but the Board of Trustees reserves the right to change or discontinue the Plan at any time. Assets may also be transferred to a successor fund providing health care benefits. The Trustees may terminate the Plan by a document in writing adopted by a majority of the Union Trustees and a majority of the Employer Trustees if, in their opinion, the Fund is not adequate to carry out its intended purpose or is not adequate to meet the payments due or which may come due. The Plan may also be terminated if no individuals living can qualify as participants or beneficiaries or if there are no longer any Collective Bargaining Agreements requiring contributions to the Fund. The Trustees have the complete discretion to determine when and if the Plan should be terminated.

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

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

K) Actions of Trustees

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

L) Right to Amend

The Trustees have complete discretion to amend or modify the Plan or trust and any of their provisions, in whole or in part, at any time. This means that the Trustees can reduce, eliminate, or modify benefits as well as improve benefits. The Trustees may also modify the length of or eliminate coverage for Participants, Eligible Dependents, and Beneficiaries. The Trustees may also modify any eligibility requirements for coverage.

M) ERISA Rights

As a participant in the Southern California Pipe Trades Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

i) Receive Information About Your Plan and Benefits

- a) Examine, without charge, at the plan administrator's office and other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- b) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The administrator may make a reasonable charge for the copies.
- c) Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

ii) Continue Group Health Plan Coverage

Continue health care coverage for yourself, your spouse, or dependents if coverage under the Plan is lost due to a Qualifying Event. You or your dependents will have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

iii) Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, must do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

iv) Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If the Plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

v) Assistance with Your Questions

If you have any questions about your Plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

N) Preferred Providers and Pre-paid Plans

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

The current PPO network for medical services is: Blue Shield of California
P.O. Box 272540
Chico, CA 95927
(800) 541-6652

The current PPO network for dental services is: MetLife PPO
P.O. Box 981282
El Paso, TX 79998-1282
(800) 942-0854

The current DHMO network for dental services is: DeltaCare USA
P.O. BOX 1810
Alpharetta, GA 30023
(800) 422-4234

The current network for vision services is: VSP
P.O. Box 495918
Cincinnati, OH 45249-5918
(800) 877-7195

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

SECTION

23. OTHER FEDERAL LAWS

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

i) Protected Health Information

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

ii) Use or Disclosure of PHI

The Fund may use or disclose your PHI for treatment, payment, or health care operations without your written authorization.

- a) Payment generally means the activities of a Fund to collect premiums, fulfill its coverage responsibilities, provide benefits under the Plan, and obtain or provide reimbursement for the provision of health care. Payment may include, but is not limited to, the following: determining coverage and benefits under the Plan, paying for or obtaining reimbursement for health care, adjudicating subrogation of health care claims or coordination of benefits, billing, and collection, making claims for stop-loss insurance, determining Medical Necessity and performing utilization review. For example, the Fund will disclose the minimum necessary PHI to medical service providers for the purpose of payment.
- b) Health Care Operations are certain administrative, financial, legal, and quality improvement activities of the Fund that are necessary to run the Fund and to support the core functions of treatment and payment. For example, the Fund may disclose the minimum necessary PHI to the Fund’s attorney, auditor, actuary, and consultant(s) when these professionals perform services for the Fund that requires them to use PHI. Persons who perform services for the Fund are called “business associates”. Federal law requires the Fund to have written contracts with its business associates before it shares PHI with them, and the disclosure of your PHI must be consistent with the Fund’s contract with them. Other examples of business associates are a Fund’s stop-loss insurance carrier, claims repricing services, utilization review companies, prescription benefit managers, PPOs, and HMOs.
- c) Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a Patient; or the referral of a Patient for health care from one health care provider to another. The Fund is not typically involved in treatment activities.

The Fund is permitted or required to use or disclose your PHI without your written authorization for the following purposes and in the following circumstances, as limited by law:

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

- d) The Fund may disclose your PHI to a health oversight agency for oversight activities authorized by law, including (1) audits; (2) civil, administrative, or criminal investigations; (3) inspections; (4) licensure or disciplinary actions; (5) civil, administrative, or criminal proceedings or actions; and (6) other activities.
- e) The Fund may disclose your PHI in the course of any judicial or administrative proceeding in response to an order by a court or administrative tribunal or in response to a subpoena, discovery request, or other lawful process.
- f) The Fund may disclose your PHI for a law enforcement purpose to law enforcement officials. Such purposes include disclosures required by law or in compliance with a court order or subpoena, grand jury subpoena, or administrative request.
- g) The Fund may disclose your PHI in response to a law enforcement official's request to identify or locate a suspect, fugitive, material witness, or missing person.
- h) The Fund may disclose your PHI if you are the victim of a crime and you agree to the disclosure or, if the Fund is unable to obtain your consent because of incapacity or emergency, and law enforcement demonstrates a need for the disclosure, or the Fund determines in its professional judgment that such disclosure is in your best interest.
- i) The Fund may disclose your PHI to law enforcement officials to inform them of your death if the Fund believes your death may have resulted from criminal conduct.
- j) The Fund may disclose PHI to law enforcement officials that it believes is evidence that a crime occurred on the premises of the Fund.
- k) The Fund may disclose your PHI to a coroner or medical examiner for identification purposes. The Fund may disclose your PHI to a funeral director to carry out their duties upon your death or before and in reasonable anticipation of your death.
- l) The Fund may disclose your PHI to organ procurement organizations for cadaveric organ, eye, or tissue donation purposes.
- m) The Fund may use or disclose your PHI for research purposes if the Fund obtains one of the following: (1) documented institutional review board or privacy board approval; (2) representations from the researcher that the use or disclosure is being used solely for preparatory research purposes; (3) representations from the researcher that the use or disclosure is solely for research on the PHI of decedents; or (4) an agreement to exclude specific information identifying the individual.
- n) The Fund may use or disclose your PHI to avoid a serious threat to the health or safety of you or others.
- o) The Fund may disclose your PHI if you are in Uniformed Service and your PHI is needed by military command authorities. The Fund may also disclose your PHI for the conduct of national security and intelligence activities.
- p) The Fund may disclose your PHI to a correctional institution where you are being held.
- q) The Fund may disclose your PHI in emergencies or after you provide verbal consent under certain circumstances.
- r) The Fund may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

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

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

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

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

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

- d) The Fund will disclose your PHI to the Fund’s Board of Trustees only per the provisions of the Fund’s Privacy Policy and the provisions of the Plan.

iii) Individual Rights

You have certain important rights concerning your PHI. You should contact the Fund’s Privacy Officer to exercise these rights.

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

iv) Duties of the Fund

The Fund has the following obligations:

- a) The Fund is required by law to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices with respect to PHI. To obtain a copy of the Fund’s entire Privacy Policy, you should contact the Fund’s Privacy Officer.
- b) The Fund is required to abide by the terms of the notice that is currently in effect.
- c) The Fund will provide you a paper copy of the notice currently in effect upon request.
- d) If a breach of your PHI is discovered, the Fund has certain obligations to provide a notice to you.

v) Changes to Notice

The Fund reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI it maintains, regardless of whether the PHI was created or received by the Fund before issuing the revised notice.

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

vi) Contacts and Complaints

If you believe your privacy rights have been violated, you may file a written complaint with the Fund’s Privacy Officer at the following address:

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

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

You may also file a complaint with the U.S. Secretary of Health and Human Services in Washington, DC. The Fund will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against anyone for filing a complaint.

vii) For More Information About Privacy

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

B) Family and Medical Leave Act (FMLA)

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

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

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

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

C) Women’s Health

i) Pregnancy

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

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

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

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

ii) Women’s Health and Cancer Rights

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

The Plan also provides benefits for the following procedures:

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

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

D) Grandfathered Health Plan

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

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

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

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

SECTION 24. DEFINITIONS

Accident

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

Active Plan

This Southern California Pipe Trades Health and Welfare Plan

Adult Day Health Care Center (ADHC) Program

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

Allowable Charge

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

Appeals Committee

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

Base Contribution

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

Beneficiary

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

Blue Shield of California

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

Blue Shield of California PPO Network Rate

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

Board of Trustees

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

Calendar Year

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

Chiropractor

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

COBRA

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

Coinsurance

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

Collective Bargaining Agreement

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

Contributing Employer

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

Coordination of Benefits Form

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

Covered Employment

Work by an Employee under a Collective Bargaining Agreement.

Covered Services

Services that are expressly listed as covered by the Plan.

Custodial Care

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

Deductible

A Deductible is the amount you must pay before the Plan considers expenses for reimbursement. It can be an annual amount or, in the case of hearing aids, a per-device amount. Not all Out-of-Pocket expenses count toward the Deductible. The Deductible applies separately to each covered person, except that the family Deductible applies collectively to all covered persons in the same family. Separate Deductibles apply to the prescription drug, PPO Dental, and hearing aid benefits.

Dentist

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

Domestic Partner

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

Durable Medical Equipment

Equipment that meets the following criteria:

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

Eligibility Bank

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

Eligible Dependent

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

Emergency Medical Condition

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

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

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

Emergency Services

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

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

Employee

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

Employer

See Contributing Employer.

ERISA

Employee Retirement Income Security Act of 1974, as amended.

Exclusion or Limitation

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

Experimental Treatment

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

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

This Plan does not cover Experimental Treatments.

Explanation of Benefits

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

Extended Care Facility

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

- A) Is approved by and is a participating extended care facility of Medicare;
- B) Has organized facilities for medical treatment and provides 24-hour nursing services under the full-time supervision of a Physician or Registered Nurse;
- C) Maintains daily clinical records on each Patient and has available the services of a Physician under the established agreements;
- D) Provides appropriate methods for dispensing and administering Prescription Drugs;
- E) Has transfer arrangements with one or more Hospitals, a utilization review plan in effect, and operations policies developed with the advice of, and reviewed by, a professional group including at least one Physician; and
- F) Is not an institution that is primarily a place for rest, a place for Custodial Care, a place for the aged, a hotel, or a similar institution.

Fund

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

Fund Office

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

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

Hospice

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

Hospice Care Program

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

Hospital

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

Illness

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

Independent Freestanding Emergency Facility

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

Injury

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

Injury and Third-Party Liability Form

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

Inpatient

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

Medically Necessary/Medical Necessity

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

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

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

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

Medicare

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

Mental Disorder

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

Monthly Deduction Amount

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

Nurse

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

Optometrist

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

Out-of-Pocket (OOP)

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

Out-of-Pocket Maximum

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

Outpatient

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

Partial Hospitalization (for Mental Health and Substance Use Disorders)

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

Participant

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

Participation Agreement

An agreement approved by the Board of Trustees permitting a Contributing Employer, or a related organization, whose participation in the Fund has been approved by the Board of Trustees, to pay contributions to the Plan for Employees not covered by a Collective Bargaining Agreement.

Patient

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

Pensioner

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

Pensioners Health Plan

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

Pharmacy

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

Physician

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

Plan

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

Plan Year

January 1 through December 31 of each year.

Podiatrist

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

Prescription Drugs

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

Psychiatrist

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

Psychologist

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

Qualified Beneficiary

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

Qualified Medical Child Support Order (QMCSO)

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

Qualifying Event

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

Qualifying Payment Amount

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

Registered Physical Therapist

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

Registered Physical Therapist Assistant

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

Residential Treatment Center

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

Special Extension Period

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

SPD

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

Spouse

Any person to whom a Participant is legally married.

Subsidized Self-pay Program

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

Surgery

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

Survivor Premium Program

Coverage available in the Pensioners Health Plan for a Survivor.

Survivor

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

Terminally Ill

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

Totally Disabled

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

Transitioning Employee

See Section 4(H), page 16.

Trust Agreement

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

Trustees

Employer and Union representatives who oversee the Fund.

Uniformed Service and Qualified Uniformed Service

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

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

Union(s)

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

USERRA

Uniformed Services Employment and Reemployment Rights Act of 1994.

Well Child Services

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

Workers' Compensation

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

SECTION

25. TRUSTEES

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

A) Employer Trustees

RYAN CAVANAUGH

Murray Company
5995 Plaza Drive
Cypress, CA 90630

ROBERT FELIX

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

JASON GORDON

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

JEFF HACHEY

H.L. Moe Company, Inc.
526 Commercial Street
Glendale, CA 91203

ADAM KAPLAN

Sierra Commercial Plumbing, Inc.
4645 Industrial Street, Unit C
Simi Valley, CA 93063

CHIP MARTIN

CPMCA
1735 Flight Way, Suite 204
Tustin, CA 92782

JOHN MODJESKI

University Mechanical & Engineering Contractors
1168 Fesler Street
El Cajon, CA 92020

JEFF STEVANUS

Southland Industries
12131 Western Avenue
Garden Grove, CA 92841

BRYAN SUTTLES

Suttles Plumbing
2267 Agate Court
Simi Valley, CA 93065

STEVE VALOT

Pan-Pacific Mechanical
18250 Euclid Street
Fountain Valley, CA 92708

LAWRENCE VERNE

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

PIP ZAIDE

Allegiant Mechanical, Inc.
7776 Westminster Blvd.
Westminster, CA 92683

B) Union Trustees

DAVID BALDWIN

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

STEVEN BERINGER

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

SHANE BOSTON

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

BEN CLAYTON

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18355 South Figueroa Street
Gardena, CA 90248

RODNEY COBOS

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501 Shatto Place, Suite 400
Los Angeles, CA 90020

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U.A. Local No. 78
1111 W. James M. Wood Blvd.
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STEVEN GOMEZ

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6718 Meany Avenue
Bakersfield, CA 93308

ROBERT JAMES

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

GREG LEWIS

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

RICARDO PEREZ

U.A. Local No. 345
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