U.A. LOCAL NO. 447

PIPE TRADES HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION

REVISED July 1, 2014

FOR ACTIVE EMPLOYEES AND DEPENDENTS

IMPORTANT PHONE NUMBERS

Trust Fund Administrative Office	(916) 457-0821
(Outside Sacramento area)	(877) 811-4474
Blue Shield of California	(800) 541-6652
Pre-Certification	(800) 343-1691
Employee Assistance Program (EAP) 24 hour number	(800) 378-1109
Catamaran Prescription Benefits Manager (PBM)	(800) 880-1188
Griffin & Reed Eye Care (LASIK Eye Surgery)	(916) 483-2525
Kaiser Permanente	(800) 464-4000
Medical Eye Services	(415) 362-7771
The Union Labor Life Insurance Company (Life/AD&D)	(866) 795-0680

TRUST WEBSITE

www.pipetradesbenefits.org

Dear Participant:

This booklet summarizes the benefits provided to you by the U.A. Local 447 Health and Welfare Plan. You and your family members should become familiar with the eligibility rules and the different benefits provided under this Plan. Eligible employees and dependents may choose the PPO Self-Funded Medical Plan or the Health Maintenance Organization (HMO) plan through Kaiser Permanente. You may change your medical coverage option once each year during the annual open enrollment period.

Only the full Board of Trustees is authorized to interpret the Plan. The Board has discretion to decide all questions about the Plan, including questions about your eligibility for benefits and the amount of any benefits payable to you. No individual Trustee, employer or union representative has authority to interpret this Plan on behalf of the Board or to act as an agent of the Board.

The Board has authorized the Administrative Office to respond in writing to your written questions. If you have a question about your benefits, you should write to the Administrative Office for a definitive answer.

As a courtesy to you, the Administrative Office also may respond informally to oral questions. However, oral information and answers are not binding upon the Board of Trustees and cannot be relied on in any dispute concerning your benefits.

This booklet details the Pipe Trades PPO Self-Funded Medical Plan, the Pipe Trades PPO Self-Funded Dental Plan, the hearing benefit, the prescription drug program, the vision program, the employee assistance program, the LASIK eye surgery benefit and the Life/AD&D insurance. Benefits offered by Kaiser are described in detail in a separate brochure prepared by Kaiser. The separate brochure, incorporated by reference in this booklet, is available from the Administrative Office and will be provided to you free of charge upon request.

No participating employer has any liability, directly or indirectly, to provide the benefits established by this Plan beyond the obligation stipulated in the Collective Bargaining Agreement or the Trust Agreement. In the event that at any time the Trust does not have sufficient assets to permit continued payments under this Plan, nothing contained in this Plan or the Trust Agreement shall be construed as obligating any participating employer to make benefit payments or contributions other than the contributions for which the participating employer may be obligated by the Collective Bargaining Agreement or Trust Agreement. Likewise, there shall be no liability upon the Trustees, individually or collectively, or upon the Contractor, Employer Association or Local Union to provide the benefits established by this Plan if the Trust does not have assets to make such benefit payments. Please remember that this booklet is only a summary. In the event of any dispute, the official language of the insurance policy or other Plan documents will be controlling. Policies and Plan documents are available for your review at the Administrative Office.

Plan rules and benefits may change from time to time. If this occurs, you will receive a written notice explaining the change. Please be sure to read all Plan communications and keep all amendments with this booklet.

Be sure to inform the Administrative Office if you change your address, change your family status (e.g., if you marry or divorce) or if any of your family members become eligible for another group medical plan.

U.A. LOCAL NO. 447 HEALTH AND WELFARE PLAN
FOR
ACTIVE EMPLOYEES AND DEPENDENTS

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DEDUCTIBLE INFORMATION		
	In-Network	**Out-of-Network**
Maximum of two deductibles per family per year	$100 per person[1,2]	$200 per person[1]
Coinsurance Maximum per person[3]	$5,000	Does not Apply[4]
Annual Maximum	No Annual Maximum on Essential Benefits	

SCHEDULE OF MEDICAL BENEFITS		
Physician Care and Outpatient Services	**In-Network**	**Out-of-Network[4]**
Physician Visits	90% of contract rate, after deductible.	70% of usual & customary, after deductible.
	Pre-Certification not required.	
Diagnostics, X-Ray, Lab	90% of contract rate, after deductible.	70% of usual & customary, after deductible.
Chiropractor	90% of contract rate, after deductible.	70% of usual & customary, after deductible.
	Pre-Certification not required. $1,500 maximum benefit per calendar year.	
Physical Therapy	90% of contract rate, after deductible.	70% of usual & customary, after deductible.
	Pre-Certification not required.	
Durable Medical Equipment (DME)	90% of contract rate, after deductible.	70% of usual & customary, after deductible.
	Not covered unless Pre-Certified.	
Outpatient Specialty Medications/Injectables over $500[5](see page 25)	90% of contract rate, after deductible, when obtained through the PBM Specialty Pharmacy.	Not covered unless obtained through the PBM Specialty Pharmacy.
	Not covered unless Pre-Certified[5].	

1 In-Network deductible does not count towards Out-of-Network deductible. Out-of-Network deductible counts toward the In-Network deductible.
2 Does not apply to the preventive care as defined by the Plan.
3 Not all out-of-pocket expenses count towards the $5,000 maximum. See pages 23 and 25.
4 Only In-Network benefits count toward the $5,000 coinsurance maximum. Charges incurred Out-of-Network will never be paid at 100%.
5 Drugs costing $500 or less are covered through the outpatient prescription benefit. See page 5.

SCHEDULE OF BENEFITS
FOR PARTICIPANTS WHO HAVE SELECTED THE PIPE TRADES PPO SELF-FUNDED MEDICAL PLAN (CONTINUED)

SCHEDULE OF MEDICAL BENEFITS		
Physician Care and Outpatient Services	**In-Network**	**Out-of-Network[1]**
Audiologist	90% of contract rate, after deductible.	70% of usual & customary, after deductible.
Hearing Aids	90% of contract amount, after deductible.	70% of usual & customary, after deductible.
	\$4,000 (\$2,000 per ear) maximum payment. Annual hearing aid maintenance check is required.[2] Adults (18 & over): one aid per ear every 3 years, if necessary as determined by the Plan. Children (under the age of 18): one aid per ear every calendar year, if necessary as determined by the Plan.	
Annual Hearing Aid Maintenance Check[2]	90% of contract amount, after deductible, up to \$30.	70% of usual & customary, after deductible, up to \$30.

[1] Only In-Network benefits count toward the \$5,000 coinsurance maximum. Charges incurred Out-of-Network will never be paid at 100%.

[2] Annual hearing aid maintenance check is required. **If you fail to obtain this annual maintenance check, the Plan will not pay for replacement of hearing aids.**

SCHEDULE OF BENEFITS
FOR PARTICIPANTS WHO HAVE SELECTED THE PIPE TRADES PPO SELF-FUNDED MEDICAL PLAN (CONTINUED)

SCHEDULE OF MEDICAL BENEFITS		
Hospital Inpatient & Outpatient[1]	**In-Network**	**Out-of-Network[2]**
Pre-Certification Requirement: Inpatient, Outpatient and Emergency Admissions	All inpatient non-emergency hospital stays must be Pre-Certified and will not be paid unless Pre-Certified.	
Room & Board, Miscellaneous Hospital Charges, Surgery, Anesthesia	90% of contract rate, after deductible.	70% of usual & customary, after deductible.
Intensive Care	90% of contract rate, after deductible.	70% of usual & customary, after deductible.
Organ/Tissue Transplants[3]	90% of Distinction Facility[3] contract rate, after deductible, if Pre-Certified.	50% of usual & customary, after deductible.
Emergency Room	90% of contract rate, after deductible, if emergency.	70% of usual & customary, after deductible.
Urgent Care Center	90% of contract rate, after deductible.	70% of usual & customary, after deductible.
Home Health	90% of contract rate, after deductible.	70% of usual & customary, after deductible.
	No coverage for Non-Preferred home health care unless Pre-Certified. 100 Visit Maximum Per Year.	
Hospice Inpatient or Outpatient	90% of contract rate, after deductible.	70% of usual & customary, after deductible.
	No coverage unless Pre-Certified, and Re-Certified if services extend beyond six months.	

1 When participants use Network providers and hospitals, sometimes ancillary services such as radiology and anesthesiology are provided by Out-of-Network providers. When this occurs, these ancillary services will be paid at 90% of usual, reasonable and customary charges. The Plan will make every attempt to negotiate a discounted rate through the national provider Network.

2 Only In-Network benefits count toward the $5,000 coinsurance maximum. Charges incurred Out-of-Network will never be paid at 100%.

3 Failure to use a designated Blue Shield Distinction Facility will result in a benefit reduction of 50% of the contract rate (Network Hospital) or 50% of usual & customary (Non-Network Hospital).

SCHEDULE OF BENEFITS
FOR PARTICIPANTS WHO HAVE SELECTED THE PIPE TRADES PPO SELF-FUNDED MEDICAL PLAN (CONTINUED)

SCHEDULE OF MEDICAL BENEFITS		
	In-Network	**Out-of-Network[1]**
Preventive Health Services The In-Network deductible is waived, if you use Network providers for Preventive care as defined by the Plan.		
Well Baby Care From birth to second birthday.	90% of contract rate.	70% of usual & customary, after deductible.
Routine Exam One exam per year ages 2-19 and over 65. One exam every two years ages 20 - 64.	90% of contract rate.	70% of usual & customary, after deductible.
Immunizations • Doctors office • Network pharmacy (flu and shingles[2] only)	90% of contract rate. No charge	70% of usual & customary, after deductible. Not covered
Routine Annual Gynecological Visits and Mammography	90% of contract rate.	70% of usual & customary, after deductible.
Nicotine Replacement Therapy To assist participants in quitting smoking	Covered under pharmacy benefit. Two 12-week treatments per 12 month period. 80% of cost for generics or over-the-counter; 70% of cost for preferred brand; 50% of cost for non-preferred brand.	
Mental/Nervous/Psychiatric Conditions		
Inpatient	90% of contract rate, after deductible.	70% of usual & customary, after deductible.
	Not covered unless Pre-Certified.	
Outpatient Includes family counseling, grief counseling, outpatient counseling, etc.	90% of contract rate, after deductible.	70% of usual & customary, after deductible.

[1] Only In-Network benefits count toward the $5,000 coinsurance maximum. Charges incurred Out-of-Network will never be paid at 100%.

[2] Age 50 and older.

SCHEDULE OF BENEFITS

The information below describes the outpatient Prescription Drug Benefits for Participants covered by the Pipe Trades PPO Self-Funded Medical Plan. Participants who are covered by Kaiser must obtain their prescriptions through Kaiser.

Pipe Trades PPO Participants	
	At Retail PBM Pharmacy, You Pay[1]:
Generic	20% of cost
Preferred Brand	30% of cost
Non – Preferred Brand	50% of cost
Maximum Supply	34 days

The benefits described on this page apply only to outpatient prescription drugs which cost less than $500 per prescription, for a supply of 31 days or less. All medications costing over $500 per prescription for a supply of 31 days or less are covered through the Pipe Trades PPO Self-Funded Medical Plan, subject to deductibles and coinsurance maximums, and not this outpatient prescription drug benefit, and must be Pre-Certified by the Plan and obtained through the mail service pharmacy. No benefits are provided if Pre-Certification is not obtained. See page 25 for more details.

Prescriptions obtained at non-PBM pharmacies (and outside the PBM's Mail Service Pharmacy) are not covered unless in conjunction with emergency services provided out-of-area (i.e. more than 30 miles from the nearest PBM pharmacy). For out-of-area emergency services, benefits are provided at 50% of the cost of the prescription.

[1] Your payment is due at time of purchase. No claim form required.

SCHEDULE OF BENEFITS

SELF-FUNDED EMPLOYEE ASSISTANCE PROGRAM BENEFITS FOR PPO PLAN PARTICIPANTS

SCHEDULE OF EMPLOYEE ASSISTANCE PROGRAM BENEFITS		
Employee Assistance Program (EAP) [1] Treatment of Alcohol or Substance Abuse (In/Outpatient; Pre-Certification required for inpatient)		
	In-Network	**Out-of Network**
Course of treatment that may include Screening, Referral, Detoxification, Residential Recovery facility, and follow-up visits	90% of contract rate, after deductible	70% of usual & customary, after deductible

[1] Only In-Network benefits count toward the $5,000 coinsurance maximum. Charges incurred Out-of-Network will never be paid at 100%.

SCHEDULE OF BENEFITS

PIPE TRADES PPO SELF-FUNDED DENTAL PLAN FOR ALL PARTICIPANTS

Calendar Year Deductible:	$50[1] per person, 3 per family
Calendar Year Maximum:	$3,000 per person over age 18. There is no calendar year maximum for participants age 18 and younger.
Orthodontia Lifetime Maximum:	$5,000 per child

SCHEDULE OF DENTAL BENEFITS		
Dental Service	**In-Network**	**Out-of-Network**
Preventive and Diagnostic Services Cleaning (two per calendar year[2])	90% of contract rate, no deductible.	70% of Usual & Customary, no deductible.
Fluoride Treatments, Exams, X-Rays, Bitewings (once every six months to age 18; once every twelve months ages 18 and over), Panoramic/Full Mouth X-Rays (once every three years)	90% of contract rate, after deductible.	70% of Usual & Customary, after deductible.
Basic Services Restorative: Amalgam, Synthetic Porcelain and Plastic Fillings for the Treatment of Cavities, Scaling and Root Planing, Repairs to Dentures, Partial Dentures and Bridgework, Simple Extractions and Extraction of Impacted Teeth, Oral Surgery	90% of contract rate, after deductible.	70% of Usual & Customary, after deductible.
Major Services Crowns, Full or Partial Dentures, Fixed Bridges	90% of contract rate, after deductible.	70% of Usual & Customary, after deductible.
Orthodontia (Children under age 19 ONLY) Cephalometic, X-Ray, Study Models, Orthodontic Treatment (braces)	90% of contract rate, after deductible.	70% of Usual & Customary, after deductible.
Pre-Certification is required by the Plan prior to work costing $500 or more. **Benefits will not be paid unless Pre-Certification is obtained.**		

1 The $50 deductible will be waived for prophylaxis (cleanings).

2 A third prophylaxis in a twelve month period may be covered if approved in advance by the Plan.

SCHEDULE OF BENEFITS

SELF-FUNDED VISION BENEFITS ADMINISTERED BY MEDICAL EYE SERVICES (MES)
FOR ALL PARTICIPANTS

SCHEDULE OF BENEFITS			
		MES Participating Provider	**Non-Participating Provider**
Vision Exam	Every 12 months	No charge	$40 allowance
Lenses	Every 24 months OR at a 12-month intervals if the prescription change so indicates	No charge for standard lenses	Allowance varies based on lens type
Frames	Every 24 months	No charge for standard frame	$45 allowance
Contact Lenses	Every 24 months OR at 12-month intervals if the prescription change so indicates	Cosmetic or convenience: $150 allowance Medically necessary: Covered in full	Cosmetic or convenience: $100 allowance Medically necessary: $250 allowance

ELIGIBILITY RULES

EMPLOYEES

Initial Eligibility
To become eligible for benefit coverage, you must work at least 375 hours within a six-month period. Your benefit coverage begins on the first of the month two months later, provided your employer has made the required contributions on your behalf.

The following chart shows you how this works.

If you Complete Initial Eligibility Requirement in:	Your Coverage Becomes Effective:
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

For example:
Bob began working in October and by the end of January had completed 375 hours of service. Since he met the eligibility requirements in January, his coverage will begin March 1.

Special Eligibility Rule When Transferring From Provisional Plan
If you are currently covered under the Provisional Plan and you are transferring into this Plan for active employees, you can qualify for coverage the first of the month following the month in which you accumulate 135 hours in reserve, or 135 hours of contributions are made by your employer on your behalf at the required rate. When you become eligible for this Plan you will become covered under Kaiser and will have the option to change to the Pipe Trades PPO Self-Funded Medical Plan at the next open enrollment if you so desire.

Waiver of 375 Hour Requirement for New Bargaining Units
The 375 hour service requirement may be waived for bargaining unit employees who are on the employer's payroll on the effective date of the employer's first collective bargaining agreement providing for contributions to this Plan, if all the following conditions are met:

1. All persons within the bargaining unit have had comparable continuous coverage (no gap for more than 60 days) for at least 18 months prior to the effective date of coverage under the Plan, evidenced by a HIPAA certificate of creditable coverage; and

2. The employer is incorporated and has a place of business that is not a private residence; and

3. The employer has been in business for at least two years prior to the effective date of coverage under the Plan.

Waiver of 375 Hour Requirement for Certain New Hires
The 375 hour service requirement may be waived if your employer is a current contributing employer and you meet all of the following conditions:

1. You have had comparable continuous coverage (no gap for more than 60 days) for at least 18 months prior to the effective date of coverage under the Plan, evidenced by a HIPAA certificate of creditable coverage; and

2. You have been employed in the plumbing and piping industry for a minimum of two years; and

3. Your employer pays a contribution on your behalf equal to the contract rate for 135 hours by the 25th of the month prior to the first month of coverage; and

4. Your employer pays a second contribution by the 15th of the first month of coverage equaling the greater of 135 hours or the actual number of hours worked in the month prior to the first month of coverage; and

5. Thereafter your employer pays contributions on your behalf equal to the actual hours you work each month beginning with the first month of coverage.

Any waiver under this rule must be approved by the Board of Trustees. If a waiver is granted pursuant to this section and you cease to be available for work for a contributing employer within twelve (12) months after your first month of coverage, any hours in your reserve bank may be forfeited.

Coverage may begin on the first day of the following month provided the waiver applications and HIPAA certificate of coverage are submitted to the Plan by the 20th of the month. If not, coverage may begin the first day of the second month. Enrollment forms and proof of dependency must be submitted to the Plan before coverage begins.

Maintaining Eligibility
After qualifying for initial eligibility, you maintain benefit coverage as long as you continue to work at least 135 hours per month and your employer pays the required contributions.

Your Reserve Hour Bank
Hours in excess of the 135 required to maintain eligibility are credited to your reserve hour bank, up to a maximum of 810 hours equivalent to a six month reserve bank. If you work less than 135 hours in any month and have a large enough reserve balance, your reserve hours will be used to maintain your benefit coverage. When hours are deducted from your bank, your balance is reduced.

You may draw upon your hour bank to maintain coverage only while you are:

1. Working or available for work for a contractor who has signed a collective bargaining agreement with a local union affiliated with the United Association of the Plumbing and Pipefitting Industry (U.A.);

2. On vacation;

3. Disabled;

4. Retired; or

5. Newly employed by a city, county or state governmental agency or by the U.A. or any affiliated local union and not yet eligible for coverage under your employer's plan.

The Plan may require evidence that you satisfy these requirements before allowing coverage based on your hour bank. If you do not satisfy these requirements, your reserve hour bank will be cancelled and your hours forfeited.

If your hour bank balance is less than 135 hours and twelve consecutive months pass without an employer contribution made on your behalf, your hour bank will be cancelled and your hours forfeited.

When you retire, you must use your hour bank reserve before converting to the retiree plan. Any remaining hours (less than 135) will be forfeited. When you retire and are eligible for retiree health benefits, your retiree coverage will begin on the first of the month following the month in which your hour bank balance falls below 135 hours. In other words, you will no longer be eligible for subsidized self-pay coverage under the active plan.

The application for retiree health and welfare coverage must be completed and received in the Administrative Office prior to the date your active coverage terminates to ensure continuous health coverage.

Your eligibility for benefits depends on the continuous and up-to-date payment of employer contributions on your behalf. If your employer does not pay a contribution when it is due, those hours of work cannot be credited to your reserve bank.

Termination of Coverage - Employees

Your coverage ends at the end of the month in which you are credited with less than 135 total hours, whether the hours reflect actual employment, your reserve hour bank, or any combination of the two. Your hour bank will be eliminated if you go for 12 months without being covered under this Plan.

If you return to work within one year after losing active coverage, you will be eligible for coverage again on the first of the month after the month in which you again have 135 hours in one calendar month. If you return to work after more than one year without active coverage, you must again meet the initial eligibility requirements, as described on page 9.

If you work for an employer in an area that is not under the jurisdiction of Local 447, your employer is not required to contribute to the Fund on your behalf. Therefore, time spent outside of the Fund's jurisdiction will be treated as a period of unemployment as far as your eligibility for benefits is concerned. If the Fund receives contributions on your behalf for hours worked outside the jurisdiction of Local 447, you will receive pro-rated credit for those contributions, based on the Journeyman contribution to this Plan. There is usually a lag of at least 30 days before this Plan receives reciprocity contributions, which may result in an interruption in coverage and possibly a COBRA notice.

Your coverage can also end:

1. On the last day of the last month in which you meet the eligibility requirements outlined in this booklet;

2. On the date that you enter full-time military service; or

3. On the date this Plan ends.

DEPENDENTS

Your eligible dependents are your legally married spouse and children who meet the following criteria:

1. The child has not reached his/her 26th birthday EXCEPT that before July 1, 2014, the child shall not be an eligible dependent under this Plan if:

    a. The child has reached his or her 19th birthday and
    b. The child is eligible to enroll in an employer sponsored health plan (as defined in section 5000A(f)(2) of the Internal Revenue Code) other than a group health plan of a parent; or

2. The child is permanently and totally disabled at any time during the year, and became disabled while an eligible dependent.

The term "children" includes your natural children, legally adopted children and children placed with you for adoption, stepchildren, and foster children who are placed with you by an authorized placement agency or by court order, judgment or decree. Note: Foster children are not eligible for coverage under the Kaiser medical plan.

The Trustees may require proof of eligibility, such as a birth certificate, marriage certificate, court adoption order/documents showing the child has been placed with you for adoption, Social Security Foster Care Agreement, and/or proof of legal guardianship.

A child will continue to be eligible for dependent coverage if, within 31 days after he or she would otherwise lose dependent status, you give proof satisfactory to the Administrative Office that the child is totally and permanently disabled. The child must have been a covered dependent immediately before the request for continued dependent status.

A court or state administrative agency may issue a Qualified Medical Child Support Order (QMCSO) that requires a group health care plan to provide medical benefits to a participant's child. Contact the Administrative Office for further details about the Plan's rules and procedures for administering QMCSOs. You are entitled to receive a copy of these rules and procedures free of charge.

Initial Eligibility for Dependents

If you have eligible dependents when your coverage becomes effective, coverage for them begins on the same day. If you acquire an eligible dependent after your coverage starts, your dependent's coverage will start on the date you gain the dependent. Immediate coverage is available for each newborn child of an eligible employee and for any minor child placed in the physical custody of an eligible employee for adoption. Failure to enroll a new dependent within 30 days of acquisition (*e.g.*, within 30 days of marriage, birth, adoption or placement for adoption) will result in a delay in the dependent's effective date of coverage, until the next annual open enrollment. Contact the Administrative Office to enroll new dependents.

Termination of Coverage - Dependents
In general, coverage for your dependents ends on the date your coverage ends. However, coverage will also end:

1. On the last day of the month in which your dependent no longer meets the eligibility requirements outlined in this booklet (*e.g.*, the end of the month in which your child turns 26);

2. On the date that your dependent enters full-time military service;

3. On the date that this Plan ends; or

4. On the date that a divorce becomes final.

Survivors' Eligibility for Coverage
In the event of your death, full coverage for your dependents will continue at no charge until the end of the month in which the reserve hour bank is exhausted.

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends, and provided that you declared in writing to the Plan that you declined enrollment due to the existence of other coverage. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

LOSS OF ELIGIBILITY FOR MAKING FALSE STATEMENTS

If the Trustees determine that you submitted false information in connection with a benefit claim, no benefits will be payable to you for the longer of (a) 12 months during which you otherwise would have been covered or (b) the period of time necessary to recover the amount of any erroneous benefits or premium payments made in reliance upon the false statement.

Concealment or omission of material information, such as a divorce or a child's loss of eligibility, is considered a false statement covered by this rule.

If your eligibility is suspended under this rule, you will not be permitted to purchase COBRA continuation coverage.

The Trustees may impose a shorter suspension or no suspension if they, in their sole discretion, determine that the false statement was negligent rather than intentional. If the Trustees, in their sole discretion, determine that a particular family member was solely responsible for the false statement, they may extend coverage to other eligible family members during the period of disqualification. The Trustees may require full restitution of erroneous payments before granting any relief from the suspension rule.

In addition to suspending benefit eligibility, the Trustees may report any false statement to the authorities for criminal prosecution under federal and/or state laws.

EXTENDED COVERAGE

UNEMPLOYMENT

If you are temporarily unemployed but currently available for work (signed on the out-of-work list at Local 447), you may pay a subsidized rate to continue your medical and drug coverage only for up to twelve months after you otherwise would lose eligibility. You must have been covered under the active Plan for at least twelve continuous months immediately prior to being eligible for this subsidized coverage. Contact the Administrative Office for more information about this extended coverage.

EXTENDED COVERAGE UNDER FAMILY AND MEDICAL LEAVE ACT ("FMLA")

Under the federal Family and Medical Leave Act (FMLA), your employer must continue to pay for your health coverage during any approved leave. In general, you may qualify for up to 12 weeks of unpaid FMLA leave each year if:

1. Your employer has at least 50 employees;

2. 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

3. You require leave 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 medical condition, or
    c. your own serious health condition.

Details concerning FMLA leave are available from your employer.

Requests for FMLA leave must be directed to your employer; the Administrative Office cannot determine whether or not you qualify. If a dispute arises between you and your employer concerning your eligibility for FMLA leave, you may continue your health coverage by making COBRA self-payments.

If your employer continues your coverage during an FMLA leave and you fail to return to work, you may be required to repay the employer for all contributions paid to the health plan for your coverage during the leave.

MILITARY SERVICE

You will be eligible to continue coverage in accordance with federal law. If your military leave begins on or after December 10, 2004, you will be eligible to continue coverage for up to 24 months from the date your military leave begins, provided you make monthly payments equal to 102% of the cost of coverage. If you are on military leave for less than 31 days, your employer is required to pay for your medical coverage.

The Plan will continue to cover your dependents if you are deployed for military duty for the length of your deployment, even if your primary medical coverage is provided by the military.

COVERAGE DURING DISABILITY

If you cannot work because of disability, full coverage for you and your dependents will continue during your disability, up to a maximum of four months after the last day of the month in which your disability began. Maintaining your coverage during the first four months of a disability will not draw against any hours accumulated in your reserve bank. You must have been covered as an active for at least twelve continuous months immediately prior to being eligible for this subsidized coverage.

COBRA CONTINUATION RIGHTS

In accordance with federal law, you and/or your spouse or dependent children are entitled to self-pay for a temporary extension of health coverage under certain circumstances.

Qualifying Event	Qualified Beneficiary	Maximum Continuation Period
1. Reduction in covered employee's hours	Employee, spouse and dependent children if covered under Plan	18 months after date of qualifying event
2. Termination of covered employee's employment	Employee, spouse and dependent children if covered under Plan	18 months after date of qualifying event
3. Death of employee covered under Plan	Spouse and dependent children if covered under Plan	36 months after date of qualifying event
4. Divorce of covered employee	Spouse and dependent children if covered under Plan	36 months after date of qualifying event
5. Dependent child's loss of that status under Plan	Affected dependent child if covered under Plan	36 months after date of qualifying event

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

A newborn or adopted child added by the former employee on COBRA is considered a qualified beneficiary. The newborn or adopted child must be added within 30 days of the birth or adoption.

COBRA premium is 102% of the cost for employees who are employed under the labor contract. The Board of Trustees may increase the premium on an annual basis if costs increase to the Plan. You should check with the Administrative Office as to the proper self-payment rate.

For an additional charge and subject to certain notice requirements, the 18-month continuation period shown in the table above may be extended for up to 29 months for any individual (and his or her eligible family members) with a Social Security disability award issued prior to or within a period of up to 60 days following the time of the reduction or termination of employment. Notice of the disability award must be provided to the Administrative Office within 60 days after the latest of the disability determination date, the date of the qualifying event, the date on which the qualified beneficiary loses coverage, or the date on which the qualified beneficiary is informed of the obligation to provide the disability notice, and within the initial 18-month period of COBRA eligibility. The cost for the 11-month extension will be 150% of the cost to the Plan. The 11-month disability extension period will end if the disabled individual recovers before the end of the disability extension period. Contact the Administrative Office for further details about this disability extension.

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Administrative Office. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, or gets divorced, of if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

The maximum continuation period is 36 months, even if more than one event occurs giving rise to COBRA continuation rights. The 18, 29, or 36 month period of COBRA eligibility is reduced by months of free or subsidized coverage provided in the event of unemployment, disability or death.

COBRA continuation coverage will end before the 18, 29, or 36 month continuation coverage period expires if: (1) you or your dependents fail to pay the required premium on time; (2) you or your dependents become covered, after the date of election, by another group health plan (except a plan that excludes or limits benefits for a preexisting condition affecting you or your dependent, and such exclusion or limitation is enforceable under the Health Insurance Portability and Accountability Act); (3) you or your dependents become entitled, after the date of election, to Medicare; (4) your employer ceases to maintain any health plan for active employees; or (5) you or your dependents qualified for the 29-month maximum continuation period based on disability, but are no longer disabled.

Continuation coverage will no longer be available under this Plan if this Plan terminates.

You or your dependents are responsible for notifying the Administrative Office when divorce occurs or when a child loses dependent status. Notice must be given within six months after the later of: (1) the divorce or loss of dependent status, or (2) the actual loss of coverage. If the required notice is not provided within the time allowed, COBRA self-payment will not be permitted.

Within 60 days after the Administrative Office is informed in writing of an event entitling you and/or your spouse or dependent children to COBRA coverage, the office will provide detailed information concerning the coverage available and its cost. The coverage available is “core” medical and prescription drug coverage or “core plus non-core” (the same benefit you had as an active employee). You or your dependents must send the election form to the Administrative Office within 60 days of your loss of coverage or the date of receipt of the notice from the Administrative Office, whichever is later. If you do not send the election form within this 60 days you will lose all rights under COBRA, which may affect your ability to obtain coverage without any pre-existing condition limitation.

Anyone electing COBRA coverage must pay for it retroactive to the date he or she lost coverage under the Plan. Payment for this retroactive coverage is due within 60 days after the date COBRA coverage is elected. Subsequent payments are due on the first day of the coverage month. You are responsible for paying the premium on a timely basis. No bill or notice will be sent. If the premium is not paid within 30 days of the due date, your coverage will be terminated without notice. COBRA, once terminated, cannot be reinstated. No benefit claim will be honored unless the required payment has been received for the period in which the claim was incurred.

If you elect to purchase continuation coverage, coverage for your eligible family members will continue automatically unless your spouse independently declines coverage. Even if you elect not to continue your coverage, your spouse and eligible dependent children may elect continuation coverage. Anyone electing continuation coverage must pay for it.

If your dependents are covered by a regional plan (like a health maintenance organization servicing a limited area) and relocate to another area where your former employer has an active workforce, your dependents may be eligible to elect COBRA coverage under the plan provided for the active employees working in that area. Under no circumstances would such a transfer prolong the 36-month continuation period. Call your former employer for more information.

If your employer ceases contributions to the Fund or withdraws participation in the Fund, employees or dependents will not be offered COBRA. However, if you or your dependents are covered under COBRA when the cessation of contribution or withdrawal occurs, you and your dependents will be able to continue COBRA to the end of the continuation period, *i.e.*, 18, 29 or 36 months. This COBRA continuation will also be terminated if your former employer through which the COBRA was elected has or establishes a plan to cover a class of employees formerly covered under the Plan. Your former employer is required to provide COBRA coverage from that point to the end of your continuation period.

For any questions about your rights under COBRA call the Administrative Office.

CONVERSION OF MEDICAL COVERAGE FOR KAISER PARTICIPANTS ONLY

When group medical insurance coverage ends you and/or your dependents may be entitled to enroll in an individual conversion plan offered by Kaiser. This coverage may cost more and/or provide fewer benefits than your group health coverage. You only have a limited time to apply for this conversion after your coverage through the group plan or COBRA terminates, so you should call Kaiser as soon as possible. Your right to conversion is discussed in the Kaiser brochure available from the Administrative Office.

CERTIFICATE OF FORMER COVERAGE

The certificate of former group health plan coverage provides evidence of your health coverage under the Plan. If you become covered under a new group health plan that excludes coverage for certain medical conditions, you may need to furnish the certificate to the new plan administrator. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

If you or your dependent lose coverage under the Plan, you will be furnished with a certificate of former plan coverage. You may need the certificate if your new plan excludes coverage for pre-existing conditions. If you are entitled to COBRA coverage, the certificate will be mailed when a notice for a qualifying event under COBRA is required and after COBRA coverage stops. You may also request a certificate within 24 months after losing coverage.

INFORM ADMINISTRATIVE OFFICE OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Administrative Office informed of any changes in the addresses of family members. You should keep a copy, for you records, of any notices you send to the Administrative Office.

DISCLOSURE OF PROTECTED HEALTH INFORMATION

DISCLOSURE

The Plan and any Business Associate, as defined below, will disclose your Protected Health Information to the Board of Trustees only to permit the Board of Trustees to carry out plan administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. §§ 160-64). Any disclosure to and use by the Board of Trustees of your Protected Health Information will be subject to and consistent with this section.

RESTRICTIONS ON USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. The Board of Trustees will not disclose your Protected Health Information, except as permitted or required by the Notice of Privacy and the Privacy Rule, as amended, or required by law.

2. The Board of Trustees will ensure that any agent, including any subcontractor, to whom it provides your Protected Health Information, agrees to the restrictions and conditions of the Plan Documents, including this section, with respect to your Protected Health Information.

3. The Board of Trustees will not use or disclose your Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Board of Trustees.

4. The Board of Trustees will report to the Plan any use or disclosure of your Protected Health Information that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.

5. The Board of Trustees will make Protected Health Information available to the Plan Participant who is the subject of the information in accordance with 45 C.F.R § 164.524.

6. The Board of Trustees will make your Protected Health Information available for amendment, and will on notice amend your Protected Health Information, in accordance with 45 C.F.R. § 164.526.

7. The Board of Trustees will track disclosures it may make of your Protected Health Information so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528.

8. The Board of Trustees will make its internal practices, books, and records, relating to its use and disclosure of your Protected Health Information, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 C.F.R. §§160-64.

9. The Board of Trustees will, if feasible, return or destroy all your Protected Health Information, in whatever form or medium (including any electronic medium under the Board of Trustees custody or control), received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Participant who is the subject of the Protected Health Information, when your Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all your Protected Health Information, the Board of Trustees will limit the use or disclosure of any of your Protected Health Information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

AUTHORIZATION

Authorization is required for the use and disclosure of your Protected Health Information for purposes other than the permitted uses and disclosures specified in the Privacy Rule. When your authorization is needed, you will be asked to fill out an authorization form. The signing of the form is completely voluntary, and once signed, may be revoked in writing at any time.

DEFINITIONS

Business Associate means a person or entity who provides certain functions, activities or services to the U.A. Local No. 447 Health and Welfare Plan involving the use and/or disclosure of Protected Health Information.

Protected Health Information means individually identifiable health information that is transmitted or maintained by electronic media or is transmitted or maintained in any other form.

Electronic Protected Health Information shall have the same meaning as the term "electronic protected health information" in 45 CFR Section 160.103.

SECURITY STANDARDS FOR ELECTRONIC PROTECTED HEALTH INFORMATION

1. The Board of Trustees will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan.

2. Adequate separation required by 45 CFR Section 164.405(f)(2)(iii) will be supported by reasonable and appropriate security measures.

3. The Board of Trustees will ensure than any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect the information.

4. The Board of Trustees will report to the Plan any security incident of which it becomes aware promptly upon learning of such security incident.

MEDICAL BENEFITS

YOUR CHOICE OF MEDICAL BENEFIT PROGRAMS

Eligible employees and dependents may choose medical coverage provided through the Pipe Trades PPO Self-Funded Medical Plan, or Kaiser Permanente.

Once you make your plan selection, you can change plans only during the annual open enrollment period. Exception: if you enroll in Kaiser and you move out of that plan's service area or that plan ceases to provide services in your area, you can change programs.

The Pipe Trades PPO Self-Funded Medical Plan is described in the following pages. The Kaiser plan is briefly described below and the benefits are described in the brochure (Evidence of Coverage) prepared by Kaiser, which are available free of charge from the Administrative Office.

KAISER PLAN: GENERAL DESCRIPTION

In order to enroll in Kaiser, you must live within 30 miles of a Kaiser Permanente medical group or facility.

Most covered services will be provided at no charge or will require a copayment. A Kaiser physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat your medical condition. The services and supplies must be provided, prescribed, authorized or directed by your Kaiser physician. For a complete description of your benefits, limitations, exclusions, the services covered, any copayments, the conditions or circumstances under which services may be received or denied, and details on the procedures to be followed for obtaining these services, and for the review of claims for services that are denied in whole or in part, please refer to the Evidence of Coverage brochure provided by Kaiser. The brochure will be provided at no cost to you by Kaiser or the Administrative Office.

When you enroll in Kaiser, you must receive services at facilities associated with Kaiser Permanente. A list of Kaiser facilities will be provided to you without charge by the Administrative Office or Kaiser. If you do not receive services at authorized facilities, you will be responsible for 100% of the charges (except in an emergency, in which case Kaiser will determine how much it will pay). The benefits provided by Kaiser are subject to the terms and conditions of an agreement with the Plan.

BLUE SHIELD PPO

The Plan utilizes Blue Shield of California for PPO, utilization review and case management services for the Pipe Trades PPO Self-Funded Medical Plan.

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.

Out Of Area Programs

Benefits will be provided for Covered Services received outside of California within the United States, Puerto Rico, and U.S. Virgin Islands. The Plan 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 on page 22.

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 Plan's payment practices in both instances are described in this SPD.

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 Plan for payment. The Plan will notify you of its determination within 30 days after receipt of the claim. The Plan 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 Plan 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.

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

When you require Covered Services while travelling 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 and select the "Find a Doctor or Hospital" tab; and,

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 Plan, the out-of-area provider should call the customer service number noted on the back of your identification card.

If you need Emergency Services, you should seek immediate care from the nearest medical facility. The Benefits of this Plan will be provided for Covered Services received anywhere in the world for emergency care of an illness or injury.

Care for Covered 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 Plan 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 and select “Find a Doctor or Hospital” and “BlueCard Worldwide.”

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 section of this booklet). 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 underestimating of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price the Plan 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.

THE PIPE TRADES PPO SELF-FUNDED MEDICAL PROGRAM

Preferred Providers
Under this Plan you are free to use any hospital or doctor. However, the Trustees have negotiated lower charges with certain hospitals, physicians, and other health professionals, called "preferred providers" or "Network providers." The Network of preferred providers is called the "Preferred Provider Organization" or "PPO." Because the Plan saves money when you use a preferred provider, your out-of-pocket costs are less when you use preferred providers.

For your free copy of the listing of preferred providers, call the Administrative Office or visit the Plan's website which links to providers: www.pipetradesbenefit.org.

Obtaining services from a preferred provider does not necessarily mean the services will be covered. Services that are not covered by the Plan are excluded regardless of where or by whom services are provided.

Annual Maximum
Effective July 1, 2014, there will be no annual maximum on Essential Benefits.

Annual Deductible
Each covered person must satisfy an annual deductible (up to two per family) as shown on the Schedule of Benefits, before the Plan begins to pay benefits. Non-covered charges do not count towards the deductible. The deductible does not apply to In-Network preventive services as defined by the Plan.

Charges applied toward the deductible in the last 90 days of a calendar year will be carried over and combined with subsequent covered charges to satisfy the deductible for the following calendar year. Neither charges payable by the Plan nor the percentage of covered charges that you are required to pay may be used to satisfy the deductible.

If two or more eligible members of your family are injured in the same accident, only one deductible will be charged against all covered expenses resulting from the accident, regardless of the number of family members injured.

Annual Coinsurance Maximum
Benefits provided under the Pipe Trades PPO Self-Funded Medical Plan, with some exceptions (see below), will be paid at 100% of covered charges after you have incurred $5,000 in covered expenses in a calendar year, when you use Network providers.

The following do not count towards the $5,000 coinsurance maximum and will not be paid at 100%:

1. Charges because a non-Network provider was used. Benefit reimbursement will not exceed 70% of Usual and Customary charges when non-Network providers are used;

2. Charges for services that are not covered under the Pipe Trades PPO Self-Funded Medical Plan, (e.g. Plan’s dental services, LASIK services);

3. Charges for failure to use a Blue Shield-Designated Facility for organ transplants; and

4. Outpatient prescription drug copays (except for copays associated with specialty medications/injectables costing more than $500 for a supply of 31 days or less, when Pre-Certified by the Plan).

Pre-Certification
Pre-Certification is required for certain services. **Benefits will not be paid if Pre-Certification is not obtained for the services listed below.**

Certification is requested by calling the Plan at (800) 343-1691.

Services that Require Pre-Certification
The services that require Pre-Certification change from time to time, and network providers are made aware of these changes. Call the Plan at (800) 343-1691 if you are concerned about whether a planned service or procedure requires pre-certification.

The following services require Pre-Certification:

1. All inpatient non-emergency hospital stays

2. Non-preferred home health care

3. Non-preferred home infusion/injectable therapy

4. Hospice care

5. Skilled nursing facility

6. Speech therapy

7. Clinical trials for cancer benefits

8. Select injectable drugs administered in the physician office setting

9. Durable medical equipment, including but not limited to motorized wheelchairs, insulin infusion pumps, and Continuous Positive Air Pressure (CPAP) machines.

10. Reconstructive surgery

11. Arthroscopic surgery of the temporomandibular joint (TMJ)

12. Dialysis services

13. Hemophilia home infusion

14. Bariatric surgery and associated services

15. Transplant benefits

16. Specialty medications/injectables costing more than $500 for a supply of 31 days of less.

When you call the Plan for Pre-Certification you will need to provide the following information:

1. Patient's name, address, phone number and date of birth;

2. Participant's Social Security number;

3. The name of the patient's doctor;

4. Basic medical information about the need for the Pre-Certification.

After you call, the Plan may need to talk with your doctors to get more detailed information.

If services are Pre-Certified, remember that you get maximum Plan benefits when you use preferred providers, and Plan benefits are reduced for services of non-preferred providers. An exception may be made by the Plan if the care needed is not available in the preferred provider Network or the non-Network provider agrees to a contract rate. In addition, in certain cases where you use a Network facility and the treating physician is a Network doctor, some Out-of-Network provider charges may be paid at the In-Network benefit level (examples could include anesthesiologists and emergency room physicians).

Services Not Requiring Pre-Certification by the Plan

1. Outpatient physician office visits;

2. Routine laboratory tests and obstetrical ultrasounds;

3. Outpatient visits to specialists other than those listed above as requiring Pre-Certification;

4. Outpatient prescription drugs (other than specialty medications/injectable drugs costing more than $500 per prescription for a supply of 31 days or less);

5. Chiropractic care;

6. Emergency services as defined by the Plan;

7. Mastectomy, lymph node dissection and other procedures as may be exempt from Pre-Certification requirements per applicable law; and

8. Hospital stays of less than 48 hours for a vaginal delivery or less than 96 hours for a cesarean section.

Specialty Medications/Injectable Drugs over $500
Specialty medications (including injectable drugs) costing over $500 per prescription for a supply of 31 days or less are covered under the medical benefit, not the prescription drug benefit. Even though the Plan's specialty drug contract is with a separate provider, the Prescription Benefit Manager (PBM) still administers the specialty medications and injectable drug process in accordance with Plan guidelines. Just like high dollar medical services, specialty medications and injectable medications costing over $500 (high dollar medications) will require Pre-Certification for medical necessity from the Plan.

Without Pre-Certification from the Plan, high dollar medications, also known as specialty drugs (including injectable drugs), costing over $500 for a supply of 31 days or less will not be covered by the Plan.

- Patients should be advised that the Pre-Certification process could take up to five business days and should plan accordingly.

- In the case of specialty medications or injectable drugs costing over $500 for a supply of 31 days or less, the patient or the provider should fax the new prescription to the Fund's Prescription Benefit Manager (PBM) for urgent review or standard review. The PBM will determine whether or not the prescription needs Pre-Certification from the Plan and fax the prescriptions to the Plan for determination of medical necessity and Pre-Certification.

- Based upon review and determination of medical necessity, the Plan will issue the Certification to the Fund's Prescription Benefit Manager (PBM) who will forward the prescription to the Fund's specialty pharmacy to be filled.

- The Fund's specialty pharmacy can send the specialty medication to the participant's home, doctor's office, or infusion center. In some cases, special arrangements can be made in advance for the patient to pick up the medication at a local pharmacy.

- The Plan will process the claims based upon NDC codes and the Fund's specialty drug contract in accordance with Plan guidelines and schedule of benefits.

- When all of the above guidelines are met, the Plan will pay for specialty drugs using the same benefit structure as used on In-Network provider claims up to Plan maximums.

All current Plan provisions and guidelines for medical benefits will apply to specialty medications and injectable drugs costing over $500 for a supply of 31 days or less. If providers refuse to use the Plan's specialty drug program, specialty medications/injectable drugs will be paid at the appropriate percentage (90% or 100%) of the lowest AWP price of the medication minus 10%. Patients should keep in mind that there are many different AWP prices so failure to use the above guidelines could result in much higher out-of-pocket expense.

These guidelines do not apply to chemotherapy medications. However, chemotherapy still requires Pre-Certification from the Plan.

Organ/Tissue Transplants
If you need to have a covered[1] organ or tissue transplant, you must use a Blue Shield Designated Facility, in order to receive maximum benefits. If you fail to use a Blue Shield Designated Facility, your benefits will be reduced to 50% of Usual and Customary (Non-Network hospital) or 50% of the contract rate (Network hospital), and your out-of-pocket coinsurance does not count towards the $5,000 coinsurance maximum.

Blue Shield Designated Facilities have been selected on the basis of a number of factors including patient outcomes, length of time the facility has been performing the specific transplant, re-hospitalization rates and re-transplant rates.

Case Management
The Plan also provides participants with a service called case management. Under many circumstances where continuing care or extensive medical services are required, case managers will work with your doctor to help make sure the services you receive are the most appropriate and cost effective available.

If you have questions about the case management program, you should call the Administrative Office at (916) 457-0821.

MEDICAL BENEFITS

The Plan will pay a percentage of a preferred provider's negotiated rate or a percentage of Usual and Customary charges for a non-preferred provider up to the amounts shown in the Schedule of Benefits charts starting on page 1. The following services and supplies are covered when ordered by a licensed provider, determined to be medically necessary by the Plan, and provided in accordance with Plan rules:

1. Hospitalization;

2. Services and supplies furnished by a hospital;

3. Services provided by a licensed physician or surgeon or other licensed healthcare professional approved by the Plan. However, if more than one operation is performed in the same operative field at one session, payment will not exceed the amount for the operation with the highest limit;

[1] Remember: all organ transplants require Pre-Certification from the Plan. Experimental procedures (see Definitions section) are not covered, and additional exclusions apply (see Exclusions section).

4. When multiple outpatient services are incurred on the same day and services overlap in any respect, the Plan will pay only for the service code that is most inclusive;

5. Services and treatment by a physical therapist, when prescribed in writing by a physician;

6. Anesthetics and their administration;

7. Dental treatment by a physician, dentist or dental surgeon for a fractured or dislocated jaw or for accidental injury to natural teeth including replacement of such teeth, and for cutting procedures in the mouth other than for extractions, repair and care of teeth and gums;

8. Lab and diagnostic services;

9. Genetic testing;

10. Professional local ambulance service to the hospital for confinement therein and emergency transportation by regularly scheduled airline or railroad or by air ambulance from the place you become disabled, to the nearest hospital qualified to provide the special treatment for the injury or sickness;

11. Rental (or purchase, if the cost is less than the rental for the period required) of durable medical equipment such as a wheelchair or hospital bed for therapeutic treatment of a covered illness or non-work related injury, and that is:

    (a) Of no further use when medical needs end,

    (b) Usable only by the patient,

    (c) Not primarily for the comfort or hygiene of the patient, or solely to aid the care giver,

    (d) Not for environmental control,

    (e) Not for exercise,

    (f) Manufactured specifically for medical use,

    (g) Approved as effective and Usual and Customary treatment of a condition as determined by the Plan, and

    (h) Not for prevention purposes;

    Durable medical equipment for non-Medicare retirees and dependents is not covered unless Pre-Certified by the Plan;

12. Artificial limbs or eyes;

13. Orthotics when ordered by your medical doctor and made specifically for your personal use, up to $400 per pair: (a) for adults, no more than one pair every four years; (b) for children up to age 19, no more than one pair for every two full shoe size increases;

14. Charges incurred for prosthetic devices to restore a method of speaking incidental to a laryngectomy. Covered medical expenses will include the initial and subsequent prosthetic devices or installation accessories, as ordered by the physician, but will not include electronic voice producing machines;

15. Wigs, required as the result of a disease or the treatment of a disease which is covered by the Plan, at 90% of cost up to a maximum benefit of $500 every three years;

16. Drugs and medicines while hospital confined;

17. Blood and blood plasma if the blood is not replaced;

18. Charges incurred for the treatment of osteoporosis. Covered expenses will include all Food and Drug Administration (FDA) approved technologies, including bone mass measurement technologies;

19. Pregnancy benefits for:

    (a) Charges in connection with normal pregnancy and delivery for female employees and spouses, but not for dependent daughters, or surrogacy arrangements, and

    (b) Charges in connection with complications of pregnancy are covered in all cases, and

    (c) Charges for any hospital length of stay in connection with childbirth for the mother or newborn child up to 48 hours following a normal vaginal delivery, or 96 hours following a cesarean section. The attending provider of a mother or newborn, after consulting with the mother, is not prohibited from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). The Plan does not require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods;

20. Voluntary sterilization charges by a hospital and/or physician for sterilization of the reproductive system of the employee or dependent spouse;

21. Voluntary termination of pregnancy, for employees and dependent spouses;

22. Eye refractions only if required because of accidental injury to the eyes, within one year of the accident;

23. Chiropractic treatment, as defined in this booklet, up to a maximum payment of $1,500 per calendar year, including x-rays relating to chiropractic treatment and massage therapy provided by a licensed massage therapist as part of a written chiropractic treatment plan;

24. Mastectomy Benefits: If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

    (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 treatment of physical complications of the mastectomy, including lymphedemas.

    These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan.

25. Well-baby exams, well-child exams, from birth to the second birthday and one exam per year from age two through 19, including appropriate laboratory services and routine immunizations. Individuals age 20 through 64 are covered for one routine exam every two years and individuals age 65 and over are covered for one routine exam per year, including appropriate laboratory services and routine immunizations;

26. PAP smears and pelvic exams;

27. Mammography for screening and diagnostic purposes every two years or more frequently based on a physician's recommendation;

28. Home health care is covered as shown in the Schedule of Benefits. Services for non-preferred home health care are covered only when Pre-Certified by the Plan. The Plan will pay for charges for the following home health care services that begin within 14 days of a hospital discharge, are due to the same injury or illness for which the patient was hospitalized, and are provided under a written plan approved by the attending physician instead of hospital confinement:

    (a) Part-time or intermittent skilled nursing care by a registered nurse, or by a licensed vocational nurse under the supervision of a registered nurse, if the services of a registered nurse are not available;

    (b) Part-time or intermittent home health aide services that consist primarily of supportive service under the supervision of a nurse or physical, speech or occupational therapist;

    (c) Physical, occupational or speech therapy; and

    (d) Medical supplies, drugs and medications prescribed by a physician, related pharmaceutical services and laboratory services to the extent such items would have been covered had the patient been hospitalized.

    Home health care benefits are payable for up to 100 home health care visits per year. Each visit by a home health care team shall be considered as one visit. A visit of four hours or less by a home health aide shall be considered one visit. No benefits are payable for home health care services or supplies that are:

    (a) Not included in the physician's written treatment plan;

    (b) Provided by a person who lives with the patient or is a member of the patient's family or spouse's family;

    (c) Provided during any period in which the patient is not under the continuing care of a physician;

    (d) Custodial care; and

    (e) Transportation, except ambulance services as specifically provided.

29. Charges for hospice care are covered under the Plan as shown in the Schedule of Benefits. Hospice services are covered only when Pre-Certified by the Plan and Re-Certified if they extend beyond six months. Charges for hospice care are covered for the services listed below:

    Inpatient hospice care including:

    (a) room and board at a rate not to exceed the hospital's daily semiprivate room rate,

    (b) physician and skilled nursing services,

(c) respiratory therapy and life support system,

(d) pain relief therapy,

(e) drugs and medicines, and

(f) psychological counseling and spiritual support services;

Outpatient care, including:

(a) intermittent nursing care by nurses,

(b) visits by full-time hospice employees,

(c) physical and respiratory therapy,

(d) oxygen and equipment,

(e) rental of wheelchairs,

(f) rental of hospital beds and other medical equipment,

(g) medicines and drugs,

(h) homemaker services; and

(i) professional counseling sessions with the patient's family during the period of hospice care and during the three month period following the patient's death.

30. Nutrition or diet counseling shall be covered for the following conditions:

(a) Diabetes,

(b) Cardiovascular disease,

(c) Pediatric metabolic disorders and cystic fibrosis, or

(d) Certain metabolic disorders such as malabsorptive disease, ulcerative colitis, or Crohn's disease;

HEARING AID BENEFIT

The Plan pays for audiology on the same basis as any other specialist physician visits. For hearing aids the Plan pays 90% of the contract amount, after deductible. For hearing aids prescribed by a non-preferred provider the Plan pays 70% of the Usual and Customary charge, after the deductible.

For adults, the Plan will cover a maximum of one hearing device per ear every three years, if necessary as determined by the Plan. For children, the frequency is one device per ear annually, if necessary as determined by the Plan.

An annual hearing aid maintenance check is required. Maintenance checks are covered at 70% of the contract amount or Usual and Customary charge, up to $30 per year. If you fail to obtain this annual maintenance check, the Plan may not pay for replacement of hearing aids.

The Plan does not cover replacement of hearing aid batteries and parts.

MENTAL AND NERVOUS DISORDERS

Under the Plan, treatment of mental health or psychiatric conditions is covered as shown in the Schedule of Benefits.

Inpatient benefits will not be covered unless Pre-Certification is obtained through the Plan by calling (800) 378-1109. In an emergency, the Plan must be notified on the first working day after services are provided. The Plan has developed a team of mental health professionals to help you get the assistance you need in a timely manner.

Confidential referrals are available at no cost, to help you and your eligible dependents obtain the appropriate care – contact Blue Shield of California at (800) 378-1109 for assistance.

What is a Mental or Nervous Disorder?

Mental or nervous disorder means conditions, illnesses, diseases and disorders listed in the most recent edition of International Classification of Diseases (ICD) as psychoses, neurotic disorders, and personality disorders; also other non-psychotic disorders listed in the ICD, to be determined by the Plan. A mental/nervous disorder includes any mental/ nervous disorder manifested by physical symptoms, any physical disorder manifested by mental/nervous symptoms, and any condition involving a combination of physical and mental/nervous causes and/or physical and mental/nervous symptoms.

EXCLUSIONS

No benefits are payable under the Plan for:

1. Services provided that require Pre-Certification, if Pre-Certification is not obtained, for the following:

    (a) All inpatient Non-emergency hospital stays

    (b) Non-preferred home health care

    (c) Non-preferred home infusion/injectable therapy

    (d) Hospice care

    (e) Skilled nursing facility

    (f) Speech therapy

    (g) Clinical trials for cancer benefits

    (h) Select injectable drugs administered in the physician office setting

    (i) Durable medical equipment, including but not limited to motorized wheelchairs, insulin infusion pumps, and Continuous Positive Air Pressure (CPAP) machines.

    (j) Reconstructive surgery

    (k) Arthroscopic surgery of the temporomandibular joint (TMJ)

    (l) Dialysis services

    (m) Hemophilia home infusion

    (n) Bariatric surgery and associated services

    (o) Transplant benefits

The services that require Pre-Certification change from time to time, and network providers are made aware of these changes. Call the Plan at (800) 343-1691 if you are concerned about whether a planned service or procedure requires pre-certification.

2. Prescription drugs for specialty medications/injectable drugs which cost more than $500 for a supply of 31 days or less, unless Pre-Certified by the Plan.

3. Services, supplies, and treatment not prescribed by a physician or surgeon legally qualified to practice in the state in which services are provided;

4. Services, supplies or treatment not Medically Necessary for treatment of injury or illness (except as otherwise specifically provided);

5. Charges in excess of Usual and Customary Charges as defined by the Plan;

6. Charges incurred as the result of complications from procedures or treatments which are not covered by the Plan;

7. Charges that you or your dependents are not legally required to pay, or would not be required to pay in the absence of this Plan;

8. Claims not submitted within 12 months after expenses were incurred, except in the absence of legal capacity;

9. Charges for the completion of claim forms;

10. Charges for missed or broken appointments;

11. Interest on unpaid balances;

12. Dental care or treatment, or dental x-rays, except for tumors or cysts or medical services incurred as the result of an accidental injury to natural teeth, or as otherwise specifically provided (dental benefits are described starting on page 40);

13. Charges for diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues unless approved in advance by the Plan;

14. Procedures that are considered by the Plan to be experimental procedures or that are not in accordance with generally accepted medical standards in the United States;

15. Organ acquisition charges relating to any transplant procedure, unless the organ recipient is covered under this Plan and such expenses are not covered under the donor's insurance;

16. Services rendered outside the United States, unless such services are billed using CPT codes in U.S. dollars and would have been covered if provided in the United States;

17. Eye refractions, except as may be required as the result of an accidental bodily injury (vision benefits are provided as described starting on page 46);

18. Orthoptics and vision training;

19. Professional or other services from a person who lives with the patient or is related to the patient or patient's spouse;

20. Custodial care;

21. Personal comfort, beautification, or convenience items or services;

22. Cosmetic surgery, unless required for:

    (a) Accidental injuries,

    (b) Reconstructive surgery because of congenital disease or anomaly of an eligible dependent child that has resulted in a functional defect, or

    (c) Reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part, including, in the event of mastectomy:

        (i) reconstruction of the breast on which the mastectomy has been performed,

        (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

        (iii) prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

23. Any treatment of obesity, or services and supplies primarily for weight loss or control, unless necessitated as the direct result of a specifically identified and diagnosed condition of disease origin;

24. Gastric bypass or gastric stapling procedures unless Pre-Certified by the Plan;

25. Nutrition or diet counseling by any person other than a registered dietician or physician, except as provided as covered on page 30;

26. In-vitro fertilization, artificial insemination, infertility treatment, or any charges associated with the direct inducement of pregnancy (however, necessary services and supplies to diagnose infertility are covered);

27. Reversal of sterilization procedures;

28. Charges in connection with pregnancy or pregnancy-related conditions of a dependent child;

29. Routine hospital care for newborns, except while the mother is hospital confined;

30. Elective abortion for a dependent child;

31. Services associated with sex transformations and resulting complications;

32. Penile implants unless required as a result of injury or an organic disorder;

33. Professional services, except as specifically provided herein, rendered for study of behavioral characteristics, or vocational testing or counseling;

34. Treatment for learning disabilities, educational problems, therapy or surgery for sexual dysfunction or inadequacies, or psychiatric admissions that are primarily to control or change the patient's environment, except as specifically provided;

35. Myofunctional therapy;

36. Work-related injury or illness covered under Workers' Compensation, occupational disease, or similar laws;

37. Expenses incurred while in military service or resulting from declared or undeclared war or armed aggression;

38. Confinement in a hospital owned or operated by the federal government, except Usual and Customary charges otherwise payable and incurred at a Veterans Administration facility or by a covered person as an armed services retiree (or such person's dependent) for services or supplies unrelated to military service, which will be paid at the Out-of-Network benefit level and will not be coordinated with Medicare;

39. Travel expenses, whether or not recommended by a physician, except as specifically provided;

40. Chiropractic care in excess of $1,500 per year, including x-rays and massage therapy related to chiropractic treatment;

41. Massage therapy, unless performed by a licensed massage therapist as part of a written chiropractic treatment plan;

42. Immunizations, examinations or reports required for:

    (a) obtaining or continuing employment, or
    (b) insurance purposes, or
    (c) government licensing (including marriage license and pilot's license);

43. Orthotics in excess of $400 per pair, or not ordered by your medical doctor and made specifically for your personal use. Orthotics in excess of one pair every four years for adults or in excess of one pair for every two full shoe size increases for children up to age 19;

44. Any charges or medical claims for which a third party may be liable or legally responsible;

45. Health care services and expenses that arise out of a criminal act by the covered person or an intentionally self-inflicted injury that is not the result of a mental illness. Injuries resulting from an act of domestic violence or from a mental health condition are not excluded solely because the source of the injury was an act of domestic violence or a mental health condition.

46. Services for anyone involved in a surrogacy arrangement including medical expenses incurred by the Plan Participant if she is fulfilling the role of a surrogate mother, the medical expenses of the surrogate mother if the Participant is using another woman as the surrogate, any expenses paid to an agency to search for a surrogate mother, and any expenses related to the conception by artificial means related to a surrogacy arrangement. A surrogacy arrangement is one in which a woman (the surrogate) agrees to become pregnant and surrender the baby to another person or persons who intend to raise the child.

47. Treatment, including drug or alcohol treatment, required by court order.

48. Routine or random drug testing.

PRESCRIPTION DRUG BENEFIT

For Participants covered through the Pipe Trades PPO Self-Funded Medical Plan. Employees and Dependents covered by Kaiser must obtain their prescriptions through Kaiser Permanente.

The services described below are provided through a Pharmacy Benefit Management firm (PBM) for retail and mail prescriptions.

SCHEDULE OF OUTPATIENT PRESCRIPTION DRUG BENEFITS	
	YOUR PAYMENT[1] **At Retail PBM Pharmacy[2]**
Generic	20% of cost
Preferred Brand	30% of cost
Non – Preferred Brand	50% of cost
Maximum Supply	34 days

USING THE NETWORK PHARMACIES

To obtain a prescription at a PBM Network pharmacy, you must present your drug plan identification card and your doctor's prescription at the pharmacy. You will be asked to pay the appropriate copayment for your prescriptions.

If you do not show your card at a Network pharmacy or if you use a non-Network pharmacy, you will pay 100% of retail price. The Plan will reimburse you 50% of the retail price only if the prescriptions were obtained in conjunction with emergency services provided out-of-area (i.e., more than 30 miles from the nearest PBM pharmacy).

If you obtain a prescription at a Network pharmacy without presenting your drug ID card and pay 100% of the cost, you may return to the pharmacy within 14 days and present your ID card. In some cases and based upon the rules of each pharmacy, you may be able to obtain reimbursement up to the amount of your copay.

PREFERRED AND NON-PREFERRED DRUGS

The Plan has a three tiered pharmacy benefit program - you pay 20% of the cost for generic drugs, 30% of the cost for Preferred Brand drugs and 50% of the cost of Non-Preferred Brand drugs. You may receive more information on what drugs are Preferred and Non-Preferred from the Plan. From time to time, the PBM revises the Preferred Drug list removing some drugs and adding others. In this case, the Plan will make every attempt to notify you and your physician in advance and in writing of these changes. The notification will advise you and your physician of alternative medications on the Preferred Brand list.

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1 Your payment is due at time of purchase. No claim form required.

2 No benefit available at PBM pharmacies if you fail to show your PBM ID Card unless you have your PBM number with you.

PRE-CERTIFICATION

Some medications require Pre-Certification. If Pre-Certification is not obtained when required, the medication will not be covered.

The following medications require Pre-Certification:

1. All specialty medications/injectable drugs that cost more than $500 per prescription for a supply of 31 days or less require Pre-Certification from the Plan. Specialty medications/Injectable drugs which cost more than $500 for a supply of 31 days or less are covered under the Pipe Trades PPO Self-Funded Medical Plan when Pre-Certified by the Plan. See page 25.

2. Human Growth Hormone.

3. Retin - A

Most chain drug stores and some independent pharmacies are PBM Pharmacies. Call the Administrative Office if you need listings in your area.

For reimbursement from the Plan for out-of-area emergency prescriptions received from non-PBM pharmacies, submit a completed claim form and your original receipt to the Administrative Office. Please note that the Plan's PBM is nationwide, allowing you access to network pharmacies even if you are traveling. Your claim will be denied if it is not submitted within 120 days after your prescription is filled.

At the Network pharmacies, the quantity of covered medication dispensed will be limited to a maximum of a 34 day supply.

USING THE MAIL SERVICE PHARMACY FOR MAINTENANCE MEDICATIONS

Maintenance medications are drugs that you take for longer than 90 days. Maintenance prescriptions can be obtained through the Plan's mail service pharmacy.

Using the mail service pharmacy is simple. When your doctor prescribes a maintenance drug, ask that the prescription be written for a 90 day supply, with the number of refills indicated. By law, the mail service pharmacy can only fill your prescription up to the quantity indicated by your doctor.

Next, complete an order form and patient profile form. The patient profile will only need to be completed with your first order, but you should update it if your profile information changes. The order form, patient profile questionnaire and pre-addressed envelopes are available from the Administrative Office.

You may call the customer service number on the order form to determine what copayment applies to your prescription.

Mail the original prescription (not a photocopy), completed patient profile (if this is your first order) and order form, along with the appropriate copayment to the Fund's mail service pharmacy, as directed on the order form you obtain from the Administrative Office. The order forms also include information on how to request refills by phone and online.

The copayment can be paid by check, money order, MasterCard, VISA, American Express or Discover credit cards. Be sure to print your Social Security number on the back of each prescription.

Your mail order prescription will be filled with a generic drug when one is available unless your doctor indicates on the prescription that a generic should not be dispensed.

Medications will be delivered postage paid by first class U.S. mail or United Parcel Service directly to your home. Please allow 14 days for delivery from the day you send your order. Remember to order refills 14 days before you expect to need them.

COVERED DRUGS

The following are covered expenses under the Plan:

1. All drugs that require a written prescription from a licensed physician for the treatment of an illness or injury that is covered by the Plan, except as excluded or limited below;

2. Prenatal and well-baby vitamins;

3. Diabetic supplies, including syringes, insulin, and test strips (the applicable generic or preferred brand copay will apply);

4. Contraceptives;

5. Retin-A, if Pre-Certified by the Plan;

6. Human growth hormone, if Pre-Certified by the Plan;

7. Injectable drugs costing $500 or less when Pre-Certified in advance by the Fund's PBM. Specialty medications/ injectable drugs costing more than $500 for a supply of 31 days or less are covered through the medical plan when Pre-Certified by the Plan, see page 25; and

8. Smoking cessation drugs, including over-the-counter nicotine replacement, limited to two 12-week cycles per twelve month period. The copay for over-the-counter smoking cessation drugs is the same as for generics.

EXCLUDED DRUGS

The following are not covered under the Plan:

1. Specialty medications/injectable drugs costing more than $500 per prescription for a supply of 31 days or less (these are covered under the medical plan, see page 25);

2. Drugs not requiring a written prescription from a licensed physician, unless specifically shown as a covered drug above;

3. Therapeutic devices or appliances, support garments and other non-medical substances, unless specifically listed as a covered drug above;

4. Drugs intended for use in a physician's office or in a setting other than for home use;

5. Medication to be taken or administered to any individual, in whole or in part, while he or she is a patient in a hospital;

6. Prescriptions that an eligible person is entitled to receive without charge, such as prescriptions provided under a workers' compensation law, or any municipal, state, or federal program;

7. Charges for drug administration;

8. Fertility/infertility drugs;

9. Immunization agents, biological sera, blood, or blood plasma;

10. Prescriptions directing parenteral (I.V.) use, as these are covered under the medical plan when Pre-Certified;

11. Minoxidil and rogaine, unless determined by the Plan to be medically necessary;

12. Drugs labeled "Investigational Use" or "Experimental;"

13. Dietary supplements, anorexiants, diet pills and liquid diets;

14. Vitamins of any kind except vitamins included above;

15. Medication for cosmetic purposes;

16. Non-drowsy antihistamines;

17. Human growth hormone unless Pre-Certified by the Plan; and

18. Retin-A unless Pre-Certified by the Plan.

TREATMENT FOR ALCOHOL OR DRUG PROBLEMS

BLUE SHIELD OF CALIFORNIA EAP PROGRAM
(800) 378-1109

The Employee Assistance Program (EAP) is self-funded by the Plan and is available to Pipe Trades PPO Plan participants. This benefit offers free referrals to confidential help to eligible employees and their eligible family members with alcohol or drug problems (illegal or prescription).

It is the intent of the Trustees to provide Pipe Trades PPO Plan participants and their family members with benefits for the treatment of alcohol and/or drug problems. The sole purpose of the Employee Assistance Program is to provide medically specific and medically supervised treatment for chemical dependency.

The EAP program is intended to address drug and alcohol problems in a cost-effective manner by matching participants with existing community resources such as A.A. and other free counseling and support services and organizations and EAP approved drug and alcohol facilities.

Description of Benefits
Many EAP services are provided via referral to free community resources. In addition, the EAP pays for the following services in accordance with the Schedule of Benefits on page 6:

(a) Hotline (800) 378-1109 to seek assistance with drug and alcohol related problems and an EAP contact person to schedule initial screening and follow-up;

(b) Screening, referral and follow-up;

(c) Following screening and referral, coverage for approved. medically necessary inpatient or outpatient detoxification program provided the patient complies with program rules;

(d) Following screening and referral, treatment at an approved residential recovery facility, provided the patient complies with program rules and the treatment is medically necessary.

Course of Treatment
Participants who use the EAP are expected to follow the recommended treatment program. Those who fail to comply with program rules may be denied any further EAP benefits.

A course of treatment may not exceed a six month time period. A course of treatment can include:

1. Screening;
2. Referral;
3. Detoxification;
4. Residential recovery facility; and
5. Follow-up visits.

Follow-Up
After completion of one course of therapy, the EAP will provide follow-up care. After treatment, you will be contacted at least once a month for the next six months. Thereafter, you will be contacted on a quarterly basis.

Exclusions
Note that the Plan's exclusions (starting on page 31) also apply to treatment for alcohol or drug problems.

PIPE TRADES PPO SELF-FUNDED DENTAL PLAN

The dental benefit is self-funded by the Plan and is available for all active Plan participants. (Coverage for self-pay participants may be different. Please see the "Extended Coverage" section of this booklet.)

Your program provides the benefits shown in the following table when services are performed by a dentist and when necessary and customary according to standards of generally accepted dental practice as determined by the Plan. However, there are limitations and exclusions that apply to your dental benefits; they are discussed starting on page 43.

Payment will be made for the covered dental charges incurred in excess of the deductible and multiplied by the benefit amount shown in the Schedule of Benefits below. In no event will the benefit exceed the maximum per person per calendar year or, for orthodontia, the lifetime maximum as shown in the Schedule of Benefits.

Deductible
The deductible is the out-of-pocket expense shown in the Schedule of Benefits that you pay before you are entitled to dental benefits. The deductible applies only once in a calendar year, and it is waived for routine prophylaxis (cleanings).

SCHEDULE OF BENEFITS - FOR ALL PARTICIPANTS

Calendar Year Deductible:	$50[1] per person, 3 per family
Calendar Year Maximum:	$3,000 per person over age 18. There is no calendar year maximum for participants age 18 and younger
Orthodontia Lifetime Maximum:	$5,000 per child

SCHEDULE OF DENTAL BENEFITS		
Dental Service	**Contract Dentist**	**Non-Contract Dentist**
Preventive and Diagnostic Services Cleaning (two per calendar year[2])	90% of contract rate, no deductible	70% of usual & customary, no deductible
Fluoride Treatments, Exams, X-Rays, Bitewings (once every six months to age 18; once every twelve months ages 18 and over), Panoramic/Full Mouth X-Rays (once every three years)	90% of contract rate, after deductible	70% of usual & customary, after deductible
Basic Services Restorative: Amalgam, Synthetic Porcelain and Plastic Fillings for the Treatment of Cavities, Scaling and Root Planing, Repairs to Dentures, Partial Dentures and Bridgework, Simple Extractions and Extraction of Impacted Teeth, Oral Surgery	90% of contract rate, after deductible	70% of usual & customary, after deductible
Major Services Crowns, Full or Partial Dentures, Fixed Bridges	90% of contract rate, after deductible	70% of usual & customary after deductible
Orthodontia (Children under age 19 ONLY) Cephalometic, X-Ray, Study Models, Orthodontic Treatment (braces)	90% of contract rate, after deductible	70% of usual & customary, after deductible
Pre-Certification is required by the Plan prior to work costing $500 or more. Benefits will not be paid unless Pre-Certification is obtained.		

1 The $50 deductible will be waived for routine prophylaxis (teeth cleaning).
2 A third prophylaxis in a twelve month period may be covered if approved in advance by the Plan.

Contract Dentists
Under this plan you are free to use any dentist. However, the Trustees have negotiated lower charges with certain dentists, called "contract dentists." Because the Plan saves money when you use a contract provider dentist, your out-of-pocket costs are also less when you use contract dentists.

For your free copy of the listing of contracted dentists, call the Administrative Office or visit the Plan's website at www.pipetradesbenefits.org.

Obtaining services from a contracted dentist does not necessarily mean the services will be covered. Services that are not covered by the Plan are excluded regardless of where or by whom services are provided.

Pre-Certification Requirement
Treatments expected to cost more than $500 need Pre-Certification from the Plan. To obtain Pre-Certification, your dentist must send the proposed treatment plan to the Administrative Office for approval before treatment begins. Benefits will not be paid if you fail to obtain Pre-Certification for treatments of $500 or more. In some cases, the Plan will require a second opinion before a treatment is approved. In such cases, the Plan will refer you to a network dentist and pay the dentist's charges associated with the second opinion visit.

Covered Dental Charges
Covered dental charges are charges for the procedures described below when they are: prescribed, performed, or ordered by a dentist; Usual and Customary charges; incurred while you are covered by this Plan; and not excluded (see "Exclusions" on page 43).

1. **Preventive and Diagnostic Procedures**

   a. two oral examinations per calendar year;

   b. two prophylaxis (cleaning) per calendar year, deductible waived. A third prophylaxis treatment may be covered if determined by the Plan to be clinically appropriate;

   c. x-rays: bitewings once every six months to age 18, once every twelve months ages 18 and over; panoramic/full mouth x-rays once every three years,

   d. topical application of sodium fluoride or stannous fluoride for dependent(s) up to age 19;

   e. sealants to age 19 (once per tooth every 3 years, permanent molars only);

   f. tests and laboratory exams related to dental procedures;

   g. oral pathology;

   h. nutrition and oral hygiene counseling; and

   i. space maintainers to age 19.

2. **Basic Dental Procedures**

   a. amalgam and composite restorations (fillings);

   b. extractions and other oral surgery including pre and post-operative care;

   c. general anesthesia when administered by a dentist for a covered oral surgery procedure;

d. emergency palliative services;

e. periodontal treatment (treatment of gums and bones supporting teeth); and

f. endodontic treatment and related endodontic surgery including root canal therapy.

3. **Major Dental Procedures**

a. repair or recementing of crowns, inlays or bridges;

b. repair or relining of dentures (not more than one relining in 12 months);

c. installing removable partial denture or full dentures for the first time due to the extraction of one or more natural teeth extracted while covered by the Plan. (This includes adjustments made within 6 months following the installation);

d. replacement of an existing removable partial denture or full dentures, crown, or fixed partial denture by a new denture, crown, or fixed partial denture , or the addition of teeth to an existing denture or fixed partial denture to replace extracted natural teeth. These are covered only if:

i. the existing denture or fixed partial denture cannot be made serviceable and was installed at least 5 years before it is replaced,

ii. the existing denture is an immediate (temporary) denture and must be replaced by a permanent denture, and the replacement is made within 12 months from the date the immediate (temporary) denture was installed, or

iii. the replacement or addition of teeth is required to replace one or more natural teeth extracted while covered by the Plan and after the existing removable partial denture or fixed partial denture was installed.

Benefits for replacement will not be more than the amount that would be payable for the same type of denture, crown or fixed bridge that is being replaced.

e. inlays, onlays, gold fillings, crowns, and installation of fixed partial dentures for the first time. Fixed partial dentures are covered only if they are for replacement of one or more natural teeth extracted while covered by the Plan.

The Plan at its discretion may request clinical reports, charts and x-rays supporting the need for treatment.

If you are transferred from one dentist to another in the course of treatment, or if more than one dentist renders service on one dental procedure, the benefits will be determined as though one dentist had furnished all treatment.

Optional Services
If you select a more expensive plan of treatment than is customarily provided, the Plan will pay the applicable percentage of the lesser fee and you will be responsible for the remainder of the dentist's fee. For example: a gold crown where a silver filling could restore the tooth or a precision denture where a standard denture would suffice.

Orthodontia
Benefits will be payable for the necessary orthodontic treatment and services rendered by a dentist to your eligible dependent children under age 19, as shown in the Schedule of Benefits.

Covered orthodontic treatment charges will be deemed to be incurred as follows:

1. If the treatment plan allots a single charge to the entire treatment period or first phase of treatment, all of the charges will be deemed to have been incurred on the date of the initial banding. The first payment will be equal to 70% of total U&C charges for non-contracted providers or 90% of total contract charges for contracted providers up to the lifetime maximum of $5,000, after the annual deductible has been met.

2. If the treatment plan allots a single charge for further orthodontic services or second phase of treatment, all of the charges will be deemed to have been incurred on the date that the second phase of treatment begins. The second payment will be equal to 70% of total U&C charges for non-contracted providers or 90% of total contract charges for contracted providers up to the balance of the unused lifetime maximum of $5,000, after the annual deductible has been met.

Payments will be made upon submission of proof that treatments were rendered for the complete quarter.

EXCLUSIONS
No benefits will be payable for:

1. services or supplies for which an individual is not legally obligated to pay;

2. an illness or injury arising out of and in the course of the participant's employment;

3. an illness or injury due to occupational disease; for the purposes of this Plan, "occupational disease" shall mean a disease for which the participant is entitled to benefits under the applicable Worker's Compensation Law, Occupational Disease Law, or similar legislation;

4. the replacement of a lost or stolen prosthetic device;

5. charges that are made by someone who is not a dentist or for treatment not performed by a dentist. The cleaning and scaling of teeth may be performed by a licensed dental hygienist who works under the supervision of a dentist;

6. the first installation of denture or fixed/removable partial dentures if all teeth that will be replaced were extracted prior to the date the participant became covered. (Fixed partial dentures include crowns and inlays that form the abutments);

7. prosthetic devices and their fitting, for which treatment began prior to the date the participant became covered. (This includes fixed and removable partial dentures and crowns);

8. charges incurred as a result of an act of war, whether declared or not, or any related act; charges incurred as the result of participation in a riot or civil disorder;

9. extra sets of dentures or other appliances;

10. implants or the removal of implants. However, if implants are provided along with a covered prosthodontic appliance, the Plan will allow the cost of a standard partial or complete denture toward the cost of the implants and the prosthodontic appliances when the prosthetic appliance is completed. If the Plan makes such an allowance, the Plan will not pay for any replacement for five years following the completion of service;

11. educational or training programs (including oral hygiene or plaque control programs);

12. experimental procedures;

13. broken appointments;

14. completion of claim forms;

15. claims received more than twelve months after the services were received;

16. orthodontic treatment, except as provided for eligible dependent children under age 19;

17. charges that a participant is not legally obliged to pay; or treatment that he or she obtains, or is entitled to obtain, under any plan or program without charge, except Medicaid or Medi-Cal. This will include charges for treatment that is provided or paid by the federal government at a Veteran's Administration facility for:

    a. an injury or illness related to the participant's military service,

    b. you or your dependents, if you are retired from the armed services,

    c. provided or paid for by any governmental plan or law not restricted to its own civilian employees and their dependents, and

    d. for which benefits are payable under other provisions of: (1) this dental Plan, or (2) the Pipe Trades PPO Self-Funded Medical Plan.

18. full mouth reconstruction or rehabilitation, which is defined by the Plan as treatment involving 20 or more teeth;

19. treatment for the purpose of increasing vertical dimension;

20. any portion of a charge that is in excess of the reasonable and customary charge for the treatment;

21. charges for services that are cosmetic, not necessary, or are not recommended and approved by the Plan, or for care or treatment that is deemed inappropriate, or of a luxury nature;

22. extra oral grafts (grafting of tissue from outside the mouth to oral tissue);

23. services for restoring tooth structure lost from wear; for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion; or for stabilizing the teeth. Such services include but are not limited to equilibration and periodontal splinting;

24. prescribed drugs, premedication or analgesia (these may be covered under the Self-Funded Drug Plan or Kaiser);

25. prophylaxis, if the participant has received two prophylaxes covered under the Plan in the preceding 12 months, unless Pre-Certified by the Plan;

26. all hospital costs and any additional fees charged by the dentist for hospital treatment;

27. charges for anesthesia, other than general anesthesia administered by a dentist in connection with covered oral surgery services;

28. surgical procedures for correction of malalignment of teeth and/or jaws;

29. orthognathic surgery;

30. charges for diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues; or

31. services in excess of $500, unless Pre-Certification from the Plan is obtained.

Extended Benefits
If your coverage is terminated while you are receiving dental treatment (other than orthodontic procedures) that began while you were covered and for which services were performed by a dentist within the 31 days prior to the date of termination, benefits will be extended for that specific condition only, if further treatment for the condition is required. This is subject to the same terms that would have applied if the coverage had remained in force. Coverage will be extended only for necessary treatment received for the condition within the three months after the date the Plan terminates.

This provision will no longer apply as of the date the individual receiving extended coverage becomes covered under any other group policy for benefits that are like those provided by this Plan.

VISION BENEFIT

The self-funded vision benefits are administered by Medical Eye Services (MES) and are provided for all active Plan participants. (Coverage for self-pay participants may be different. Please see the "Extended Coverage" section of this booklet).

SCHEDULE OF BENEFITS			
		MES Participating Provider	**Non-Participating Provider**
Vision Exam	Every 12 months	No charge	$40 allowance
Lenses	Every 24 months OR at a 12-month intervals if the prescription change so indicates	No charge for standard lenses	Allowance varies based on lens type
Frames	Every 24 months	No charge for standard frame	$45 allowance
Contact Lenses	Every 24 months OR at 12-month intervals if the prescription change so indicates	Cosmetic or convenience: $150 allowance Medically necessary: Covered in full	Cosmetic or convenience: $100 allowance Medically necessary: $250 allowance

BENEFITS
Covered services and/or materials when you go to a Medical Eye Services participating provider include:

1. Vision examination every 12 months;

2. One pair of standard lenses every 12 months with prescription change*, otherwise, every 24 months (standard lenses fit any frame with an eye size less than 61mm);

3. One standard frame every 24 months (a standard frame is any frame that has a maximum retail cost of $90 or less); and

4. One pair of contact lenses every 12 months with prescription change*, otherwise, every 24 months.

* *A prescription change means any of the following:*

1. A change in the prescription of 0.50 diopter or more in one or both eyes;

2. A shift in axis of astigmatism of 15 degrees; or

3. A difference in vertical prism greater than 1 prism diopter.

If contact lenses are for cosmetic or convenience purposes, the Plan will pay up to $150 towards the contact lens evaluation, fitting costs and materials. Any balance is your responsibility.

If contact lenses are medically necessary, they are a fully covered benefit following cataract surgery; or when visual acuity cannot be corrected to 20/70 in the better eye except through the use of contacts; or when necessitated by anisometropia or certain conditions of keratoconus. Prior authorization from Medical Eye Services is required.

When you select a provider from the participating provider list, the vision benefits described above (examination, professional services, lenses, and frames) will be provided. Any additional care, service and/or materials not covered by this Plan may be arranged between you and the provider.

HOW TO USE THE PLAN

Obtain an MES claim form and listing of participating providers from the Administrative Office. Make sure you are eligible for vision benefits.

After you obtain your MES claim form, make an appointment with the eye care specialist of your choice. With Part 1 of the claim form completed, present it to the provider at the time of your visit.

Participating providers will submit the claim form to MES and will be paid directly. If you do not bring your claim form with you at the time of your visit, you may be required to pay in full for the services.

If services are received from a non-participating provider, reimbursement will be made to the employee, up to the Schedule of Allowances. You or the provider should submit an itemized bill and a copy of your prescription with the claim form to MES.

REIMBURSEMENT SCHEDULE FOR NON-PARTICIPATING PROVIDERS

Professional fees:

1. Vision examination, up to $40.00 allowance.

Materials (per pair):

1. Single vision lenses, up to $30.00;
2. Bifocal lenses up to $50.00;
3. Trifocal lenses, up to $65.00;
4. Lenticular or aphakic lenses, up to $125.00;;
5. Progressive lenses up to $125.00;
6. Frame, up to $45.00; and
7. Contact lenses:
    a. Cosmetic or convenience, up to $150.00,
    b. Medically necessary, up to $250.00.

LIMITATIONS

1. Contact lenses, except as specifically provided;
2. Contact lens fitting, except as specifically provided;
3. Eyewear when there is no prescription change, except when benefits are otherwise available;
4. Lenses or frames that are lost, stolen or broken will not be replaced, except when benefits are otherwise available;

5. Lenses such as no-line (blended type), progressive, beveled, faceted, coated or oversize exceeding the allowance for covered lenses;

6. Tints, other than pink or rose #1 or #2, except as specifically provided; and

7. Two pair of glasses in lieu of bifocals, unless prescribed.

EXCLUSIONS

1. Any eye examination required by an employer as a condition of employment;

2. Conditions covered by Workers' Compensation;

3. Contact lens insurance or care kits;

4. Covered services that begin prior to the participant's effective date or after benefits have been terminated;

5. Covered services for which the participant's is not legally obligated to pay;

6. Covered services required by any government agency or program, federal, state or subdivision thereof;

7. Covered services performed by a close relative or by an individual who ordinarily resides in the participant's home;

8. Medical or surgical treatment of the eyes;

9. Non-prescription (plano) eyewear;

10. Orthoptics, vision training or sub-normal vision aids;

11. Services that are experimental or investigational in nature; and

12. Services for treatment directly related to any totally disabling condition, illness or injury.

If you have any questions about the plan, please contact:

Medical Eye Services
P.O. Box 25209
Santa Ana, California 92799
(800) 877-6372

This is a brief outline of the plan and is not to be accepted or construed as a substitute for the provisions of the contract.

LASIK EYE SURGERY

This self-funded benefit is provided for all active Plan participants. However, the network of providers used to access this benefit varies by the medical plan under which the participant is covered.

Kaiser Permanente participants

1. Only services provided by Griffin & Reed Eye Care will be covered. Your first visit will be with a Griffin & Reed Eye Care physician.

2. During your initial exam with a Griffin & Reed physician you will be tested to determine if you are a candidate for a LASIK eye surgery. If you are a candidate for surgery, the testing fee will be included in the overall benefit, otherwise the Plan will pay the cost.

3. If you are a candidate for LASIK eye surgery, the surgery will be done by a Griffin & Reed surgeon at the Griffin & Reed facility at the Horizon Laser Center. In some cases continued medical treatment from a Griffin & Reed physician may be necessary.

4. For LASIK eye surgery prescribed by a Griffin & Reed physician, the Plan pays 90% of the contract amount, up to a maximum total payment of $3,400 ($1,700 per eye) in any seven year period.

5. Your cost will be $170.00 for each eye. $105.00 per eye must be paid to Griffin & Reed Eye Care, the remaining $65.00 per eye must be paid to Horizon Laser Center the day of the surgery.

6. As with other types of medical benefits, coverage is not available under this benefit for sight loss covered by workers compensation.

7. Griffin & Reed Eye Care and the Horizon Laser Center where surgery is performed are located at:

   651 Fulton Avenue
   Sacramento, California 95825
   (916) 483-2525

Pipe Trades PPO Self-Funded Medical Plan Participants

1. Only services provided by a BlueCross/BlueShield preferred provider will be covered.

2. During your initial exam with a preferred provider physician you will be tested to determine if you are a candidate for a LASIK eye surgery. If you are a candidate for surgery, the testing fee will be included in the overall benefit, otherwise the Plan will pay the cost.

3. If you are a candidate for LASIK eye surgery, the surgery will be done by a preferred provider. In some cases continued medical treatment from a preferred provider may be necessary.

4. For LASIK eye surgery prescribed by a preferred provider, the Plan pays 90% of the contract amount, up to a maximum total payment of $3,400 ($1,700 per eye).

5. As with other types of medical benefits, coverage is not available under this benefit for sight loss covered by workers' compensation.

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE

The life and accidental death and dismemberment insurance are fully insured by The Union Labor Life Insurance Company and provided by the Plan for all participants except self-pay participants. (Please see the "Extended Coverage" section of this booklet.)

SCHEDULE OF BENEFITS		
Life Insurance	Employee	$25,000
	Spouse and children	$2,500
Accidental Death & Dismemberment	Principal sum (covers employee only)	$5,000

LIFE INSURANCE

Employee Life Insurance
If you die of any cause while you are an active Plan participant, your beneficiary will receive a life insurance benefit of $25,000.

Dependent Life Insurance
If your spouse or child dies from any cause while covered under the Plan as your dependent, you will receive a life insurance benefit of $2,500.

Beneficiary
If your beneficiary does not outlive you or you have not selected a beneficiary, payment will be made in one sum to the first surviving beneficiary in the following sequence:

1. Lawful spouse;

2. Child or children including legally adopted children;

3. Parent or parents;

4. Brothers and sisters; or

5. Your estate.

If two or more persons are entitled to benefits, they will share equally. You may change your beneficiary at any time by filing the required card with the Administrative Office.

If you have named your spouse as beneficiary and you later divorce, or have the marriage annulled, the beneficiary designation is automatically revoked. A former spouse will no longer be your beneficiary unless you fill out a new beneficiary designation card naming your former spouse and file it with the Administrative Office.

Life Insurance Coverage
If you become totally disabled while covered by the Plan and before you reach age 60, your group life insurance will remain in effect at no cost to you. However, you will be required to submit proof of total disability periodically to Union Labor Life.

Your beneficiary will be entitled to the full benefit if your total disability continues until the date of your death, as long as acceptable written proof of your disability is submitted to Union Labor Life.

To qualify for this disability premium waiver, you must apply within one year of the date you lose eligibility for coverage.

Accelerated Benefits for Terminal Illness
If you are an active member who has been continuously insured for a maximum of two years and you become terminally ill, up to 50% (but not less than $5,000) of your life insurance benefit may be paid to you in advance of your death, accelerated subject to the terms and conditions of the Accelerated Benefits provision. Payment of the Accelerated Benefit shall be made in one lump sum to you or to whomever you designate. Once the Accelerated Benefit has been paid, your life insurance amount will be reduced by the amount of the Accelerated Benefit. The amount of life insurance available for conversion will be reduced by the amount of the Accelerated Benefit. Only one Accelerated Benefit is payable during your lifetime.

If you die after a request is made for the Accelerated Benefit, but before such benefit is paid, the Accelerated Benefit is not payable. In this case, the full life insurance benefit will be paid to your beneficiary as if no request for Accelerated Benefits has been made.

You or your legal representative must make the request for payment of the Accelerated Benefit to The Union Labor Life Insurance Company in writing. A diagnosis of terminal illness must be made by a licensed qualified physician (other than yourself or a member of your family). You must provide proof satisfactory to Union Labor Life of the diagnosis and terminal illness; such proof shall include clinical, radiological and laboratory evidence. This proof must be obtained at your own expense.

"Terminal illness" or "terminally ill" means that while insured under this Plan a determination is made that you have a life expectancy of six months or less as the result of a medical condition caused by injury, disease or illness.

Union Labor Life shall not be responsible for any tax or any other effects of any Accelerated Benefits payment. You must consult a personal tax advisor to determine any potential tax implications.

This Accelerated Benefit provision is not available for any reason other than terminal illness. Likewise, this benefit is not available:

1. If your life insurance benefit is less than $10,000;

2. When all or a portion of your life insurance benefits are to be paid as a part of a divorce settlement;

3. If your life insurance has been in force for less than two years, or if you are not an active employee;

4. If you are totally disabled on the effective date of this provision;

5. If you are required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise;

6. If you are required by a government agency to use this benefit provision to apply for, obtain or keep a government benefit or entitlement; or

7. If the injury, disease or illness that caused the medical condition is caused by intentional self-inflicted injury or attempted suicide.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Accidental Dismemberment Insurance

If you suffer one of the following losses because of and within 90 days of an accident, you will receive benefits as shown below:

Loss	Amount of Insurance
Both hands, both feet, both eyes, one hand and one foot, one eye and one hand or one foot	$5,000
One hand, one foot, or one eye	$2,500

With regard to hands and feet, loss shall mean severance at or above the wrist or ankle joint; with regard to eyes, total and irrecoverable loss of sight.

If you suffer more than one loss in a single accident, payment will be made only for the loss for which the largest amount is payable.

EXCLUSIONS

This benefit is not payable for accidental death or dismemberment that results from:

1. Bodily or mental infirmity; ptomaines; bacterial infections (except infections caused by pyogenic infection through a cut or wound); or disease or illness of any kind;

2. Self-inflicted injury or suicide;

3. Participation in a felony; or

4. Military service, war or insurrection.

The insurance benefits described in this section are not assignable during the lifetime of the insured person nor may the beneficiary assign any installments.

All insurance benefits are provided under a master insurance policy with The Union Labor Life Insurance Company. In the event of a dispute, the terms of the group policy will prevail over the terms of this Plan description.

Facility of Payment

If you or your dependents are not legally capable of giving valid receipt for a benefit payment, Union Labor Life has the right (if there is no legal guardian) to pay the party it believes is entitled to such payment by reason of having incurred funeral or other expenses incident to the last illness or death of the claimant, but not to exceed the amount allowed by state law. Once such payment is made, Union Labor Life has no further obligation with respect to the amount so paid.

Claims and Appeals Procedures

The claims and appeals procedures for the Life and AD&D insurance are available from Union Labor Life. If you would like a free copy of the claims and appeals, call Union Labor Life directly.

Examinations
Union Labor Life will have the right and opportunity through its medical representatives to examine any living insured during the pendency of a claim and so often as it may reasonably require.

Union Labor Life will also have the right to request an autopsy in case of death, where it is not forbidden by law.

Legal Actions
No legal action can be brought until at least 60 days after written proof of loss to Union Labor Life. No legal action can be brought more than three years after the date written proof of loss is required.

This limitation, and the time permitted to filing this notice of claim and proof of loss, is extended to comply with the minimum requirements of the state in which the claimant resides at the time his insurance under this plan is in effect.

CLAIMS AND APPEALS PROCEDURES

HOW TO FILE CLAIMS

Claims matters are handled by:

Administrative Office
P.O. Box 191030
Sacramento, California 95819-1030
Telephone: (916) 457-0155
(outside the Sacramento area): (877) 811-4474

All claims for benefits must be filed on forms provided by the Plan, which are available from the Administrative Office, except as required by law. A claim shall be considered to have been filed as soon as it is received at the Administrative Office or such other location as may be indicated on the claim form, provided it is substantially complete, with all necessary documentation required by the form. If the form is not substantially complete, or if required documentation has not been furnished, you will be notified as soon as possible of what is necessary to complete the claim, but not later than 5 days (24 hours in the case of a failure to file a claim involving emergency care).

The Plan may require additional evidence to establish whether or not any claim should be paid. The Plan may, for example, require supplementary documentation or the results of a physical examination or laboratory test in order to adjudicate a medical claim. If the patient fails to cooperate with such requests, the claim may be denied.

You should file your claims within 90 days after the expenses are incurred. Claims will still be considered for payment when it is not possible to provide notification within 90 days, but you should always file your claims as soon as possible.

Claims will not be paid if they are submitted more than 12 months after the expense was incurred, except in the absence of legal capacity.

The Plan requires a completed W-9 form from providers before the Plan can pay claims directly to the provider. If the provider fails to comply with the Plan's request for a completed W-9, claim payments will be made to the participant and the participant will be advised of his/her responsibility to pay the provider.

CLAIMS DENIALS

If your claim for benefits is wholly or partially denied, you will receive a written notice of denial that will contain the following information:

1. The specific reason for the denial with specific reference to pertinent Plan provisions on which the denial is based;

2. A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material is necessary; and

3. Appropriate information as to the steps to be taken if you wish to submit the claim for review.

4. The specific rule, guideline, protocol, or other similar criterion, if any, relied upon in making the determination; and

5. An explanation of the scientific or clinical judgment for the determination if the adverse benefit determination was based on medical necessity or other similar exclusion or limitation.

Emergency Care Claims
In the case of an Emergency Care claim, the Administrative Office shall notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the seriousness of your medical condition, but not later than 72 hours after receipt of the claim by the Plan, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Administrative Office shall notify you within 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. You shall be given a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Administrative Office shall notify you of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of: (1) the Plan's receipt of the specified information; or (2) the end of the period given to you to provide the specified additional information.

Pre-Service Claims
The benefit determination, whether adverse or not, shall be given within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the claim is filed, and unless special circumstances beyond the control of the Plan require an extension of time for processing the claim. If such extension is required, you will be sent written notice before the expiration of the initial 15 day period, stating the special circumstances requiring the extension and the date by which a decision on the claim can be expected. If such extension is necessary due to a failure by you to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you shall be given at least 45 days from the receipt of the notice within which to provide the specified information.

Post-Service Claims
The notice of denial shall be given within 30 days after the claim is filed, and unless special circumstances beyond the control of the Plan require an extension of time for processing the claim. If such extension is required, you will be sent written notice before the expiration of the initial 30 day period, stating the special circumstances requiring the extension and the date by which a decision on the claim can be expected. If such extension is necessary due to a failure by you to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you shall be given at least 45 days from the receipt of the notice within which to provide the specified information.

Concurrent Care Decision
If you are receiving an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such treatment shall be deemed an adverse benefit determination. Notice of such determination shall be sent at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

Any request by you to extend the course of treatment beyond the period of time or number of treatments involving an Emergency Care claim shall be decided as soon as possible, taking into account the seriousness of your medical condition, and the Administrative Office shall notify you of the benefit determination, whether adverse or not, within 24 hours prior to the expiration of the prescribed period of time or number of treatments. The appeal procedure is stated below.

CLAIMS APPEAL PROCEDURE

Within 180 days after receipt of a written notification of denial, you or your authorized representative may request a review of the claim by filing a written application with the Joint Board of Trustees. A late application may be considered by the Board, if it concludes the delay in filing was reasonable.

In the case of a claim involving Emergency Care, a request for an expedited appeal for an adverse benefit determination may be submitted orally or in writing by you or your duly authorized representative, and all necessary information, including the Plan's benefit determination shall be transmitted to you by telephone, facsimile, or other available similarly expeditious method.

You or your duly authorized representative shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. Relevant information includes identification of any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit decision. You will also be provided any statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination. The Trustees will not afford any deference to the initial benefit determination. If the adverse benefit determination is based in whole or in part on a medical judgment, the Board of Trustees shall consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. Such consultants shall be different from any individual consulted in connection with the initial determination or the subordinate of any such person.

Emergency Care Claims

You shall be notified of the Plan's benefit determination on review as soon as possible, taking into account the seriousness of your medical condition, but not later than 72 hours after receipt of your request.

Pre-Service Claims

You shall be notified of the Plan's benefit determination on review within a reasonable time, but not later than 30 days after receipt by the Plan of your request for review of an adverse benefit determination.

Post-Service Claims

Upon receipt of a petition for review, the Trustees or a committee appointed by the Trustees and authorized to act on such petitions, shall proceed to review the administrative file, including the petition for review and its contents. All comments, documents, records and other information submitted by you relating to the claim will be taken into account without regard to whether such information was submitted or considered in the initial benefit determination. A decision by the Trustees shall be made at the next succeeding regular Trustees' meeting following the request for review, except that a request for review received within thirty (30) days preceding the date of such meeting. In such case, a benefit determination may be made no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination will be made no later than the third meeting following the receipt of the petition for review. Notification of the extension shall be sent to you prior to the commencement of the extension describing the special circumstances and the date by which the benefit determination will be made. You shall be notified of the decision of the Trustees in writing within five (5) days after the benefit determination is made.

Any notice of adverse benefit determination will include:

1. the specific reason or reasons for the adverse determination;

2. reference to the specific Plan provisions on which the benefit determination 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 Claimant's claim;

4. a statement describing any voluntary appeal procedures; and

5. a statement of your right to bring an action under ERISA Section 502(a).

In the event that you desire additional time to present evidence in support of your petition for review, you may request such additional time in writing. The Trustees shall grant your written request for additional time necessary to perfect a petition for review, provided the written request is received before the Trustees issue their decision. Requests for additional time and requests to submit additional information received after the Trustees' decision has been rendered shall be denied, unless the Trustees, in their sole discretion, determine that the information is material to the petition and could have been provided earlier. You shall be notified of the decision of the Board of Trustees in writing. The notice of denial shall include, in addition to the information set forth above:

1. the specific rule, guideline, protocol, or other similar criterion, if any, relied upon in making the determination; and

2. an explanation of the scientific or clinical judgment for the termination if the denial was based on medical necessity or other similar exclusion or limit.

If the benefits are provided by an insurance company, insurance service, health maintenance organization, or other similar organization, that organization may be entitled to conduct the review and make the decision. Disputes concerning benefits provided by an HMO generally must be resolved using the appeal procedure established by that organization. See the applicable HMO brochure for details of the organizations' claims and appeals procedures. As part of the review procedure, you or your authorized representative may review pertinent documents and submit issues and comments in writing.

The Trustees have full discretionary authority to interpret all Trust Agreement documents and to make all factual determinations concerning any claim or right asserted under or against the Plan or Trust Fund.

The denial of an application or claim after the right to review has been waived or the decision of the Trustees on petition for review has been issued shall be final and binding upon all parties, including you. No lawsuit may be filed without first exhausting the above appeals procedures. In any such lawsuit, the determinations of the Trustees are subject to judicial review only for abuse of discretion. No legal action may be commenced or maintained against the Plan more than two (2) years after a claim has been denied.

GENERAL PROVISIONS

COORDINATION OF BENEFITS

In General
All medical and prescription drug benefits are subject to coordination. If you or your dependents are entitled to benefits under any other plan that will pay part or all of the expense incurred for treatment of sickness or injury, the benefits payable under this Plan and any other plans will be coordinated so that the aggregate amount paid will not exceed 100% of the expense incurred. In no event will the amount of benefits paid under this Plan exceed the amount that would have been paid if there were no other plan involved.

Benefits under this Plan will be coordinated with any group plan providing benefits or services for hospital or medical treatment that is: (a) group insurance coverage, (b) blanket insurance coverage that does not contain a nonduplication of benefits or excess policy provision, (c) group Blue Cross, Blue Shield, group practice and other prepayment coverage provided on a group basis, (d) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or any other arrangement of benefits provided on a group basis; (e) any group coverage under governmental programs, and any group coverage required or provided by any statute, and (f) no-fault auto insurance.

Which Plan Pays First?
If both plans have a coordination of benefits provision, the plan that insures you as an active employee pays first. If you receive benefits as an active employee under one plan and as a retiree under another, the plan you have as an active employee pays first. If you are insured as an employee under two plans, the plan that has insured you longer is primary. If one plan does not have a coordination of benefits provision, that plan is always primary. A participant or qualified beneficiary is subject to this Plan's rules even if the Plan is a secondary carrier. If a dependent child is covered under two plans, the plan of the parent whose birthday (month and day) is earlier in the year will pay its benefits first. If the parents of a dependent child are divorced or legally separated, the plan of the parent with custody of the child pays its benefits first. If the parent with custody remarries, the order of payment is as follows:

1. Natural parent with whom the child resides;

2. Stepparent with whom the child resides;

3. Natural parent not having custody of the child.

This order of payment can change if a court order specifically and unambiguously requires one of the parents to be financially responsible for the child's medical expenses.

Special Rules Concerning Medicare
This Plan will pay benefits before Medicare in the following circumstances:

1. All claims for an active employee who is age 65 or older and who has not elected Medicare as primary carrier;

2. All claims for an active employee's dependent spouse who is age 65 or older and who has not elected Medicare as primary carrier;

3. The first 30 months of treatment for end-stage renal disease received by any insured person who is less than age 65; and

4. All claims for an active employee or any dependent of any active employee who is totally and permanently disabled.

When these circumstances do not apply, this Plan will pay benefits only after Medicare has paid its benefits. This Plan will provide no medical coverage to an active employee age 65 or older or the spouse of an active employee age 65 or older who elects Medicare as primary carrier, as Medicare rules do not allow that option.

RIGHT TO RECEIVE AND RELEASE INFORMATION

This Plan may, without the consent of or notice to any insured, release or obtain from any insurance company, organization, or person, any information it deems necessary to determine eligibility, and to process benefit claims. Whenever payments that should have been made by this Plan have been made by any other plan, this Plan will have the right to repay the plan the amount it determines will satisfy the intent of the coordination of benefits provision. Whenever this Plan pays out more than necessary, it has the right to recover the excess payment from any person to whom such payments were made, or any insurance company or other organization.

RIGHT OF RECOVERY

This Plan does not cover any injury for which a third party may be liable or legally responsible, by reason of negligence, an intentional act or breach of any legal obligation on the part of that third party.

If any service is provided or medical claims paid in connection to any injury caused by a third party, and you or your eligible dependents receive reimbursement from or on behalf of a third party or from uninsured motorist coverage, the Plan is entitled to recover the full amount of benefits paid under the Plan for such services, up to the gross amount recovered by you or your eligible dependents. Upon settlement of the claim against the third party, insurance company or uninsured motorist coverage, you will pay or cause to be paid to the Plan all amounts to which it is entitled, in accordance with this paragraph. If you or your eligible dependents receive a settlement or judgment from a third party in an amount which is less than you anticipated, this in no way affects the Plan's right to recover the full amount for claims paid on you or your eligible dependents behalf.

The Plan has a right to first reimbursement of any recovery from a third party or any uninsured motorist coverage, even if you or your eligible dependents are not otherwise made whole and without regard to how your recovery is categorized. An automatic lien will arise in favor of the Plan on all funds recovered from a third party insurer. This lien shall remain in effect until the Plan is reimbursed. The participant and/or eligible dependent are prohibited from commingling the recovered funds with other assets or alienating or spending the recovered funds until the Plan has been reimbursed for the benefits paid on his or her behalf. The assets recovered are owed to the Plan and you and/or your eligible dependents shall be obligated to pay them over to the Plan. The Plan shall be entitled to enforce this requirement by way of equitable restitution or constructive trust, or any other remedy permitted by law.

You or your eligible dependents must complete and sign an Agreement to Reimburse in such a form or forms as the Plan may require BEFORE any benefits are paid. If you or your eligible dependents refuse to sign an Agreement to Reimburse, or any other such agreement the Plan may require, you and/or your eligible dependents shall not be eligible for benefits under the Plan for medical claims related to this injury.

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

Sample

Agreement to Reimburse
This agreement shall relate to plan provisions regarding acts of the third parties.

It appears there may be some degree of third party liability in connection with claims submitted to this office on _____, by plan member, _____, on behalf of _____.

The U.A. Local 447 Health and Welfare Plan (the "Plan") does not wish to delay payment to its eligible member as it would in the absence of third party liability. The undersigned understands that the Plan requires reimbursement for medical claims paid on your behalf for injuries caused by a third party, and for which you receive a settlement from such injuries caused by a third party, as stated on page 59 of the Summary Plan Description which terms are incorporated by reference herein.

As a condition and in consideration for the Plan to pay these claims, _____ agrees to furnish all requested information to this office with respect to involved third parties who may or may not have liability, and the undersigned further agrees to reimburse the Plan for any expenses incurred in connection with this claim provided that there has been some type of monetary settlement in favor of the member and against such third party and further does agree to sign a lien in this regard. Reimbursement to the Plan shall be limited to such financial settlement.

Executed At _____On_____
(City & State) (Date)

_____ _____
(Plan Member's Signature) (Print Member's Name)

_____ _____
(Injured Party's Signature) (Print Injured Party's Name

Address: _____
(Street Address, City, State And Zip Code)

Member's Relationship To Injured Party:_____

SUMMARY PLAN INFORMATION

The U.A. Local 447 Health and Welfare Plan is a welfare benefit plan that provides medical, dental, prescription drug, vision, life and AD&D benefits to employees. The Plan also provides medical and prescription drug benefits to retirees. The Board of Trustees intends that the terms of the Plan shall be legally enforceable.

Duration of the Plan
It is intended that the Plan will continue indefinitely, but the Board of Trustees reserves the right to change and/or discontinue the Plan at any time. In addition, this Plan may terminate by agreement of the participating employers and unions or by operation of the law. If the Plan is terminated, its remaining assets after payment of all expenses will be used to continue to provide benefits for as long as the Plan assets permit, or else the assets will be transferred to a successor plan providing health care benefits. In no event will termination of the Plan result in a reversion of any assets to the contributing employers.

Plan Administrator and Sponsor
The Plan is sponsored and administered by a joint Board of Trustees composed of 14 Trustees, of whom seven are appointed by management and seven are appointed by labor. The address of the joint Board of Trustees is:

Employer Trustees

Larry Cook
c/o Airco Mechanical
5720 Alder Avenue
Sacramento, California 95825

Rod Barbour
Lawson Mechanical Contractors, Inc.
6090 Watt Avenue
Sacramento, California 95829

Scott Strawbridge
Mechanical Contractors Association
P.O. Box 159
Benecia, California 94510

Claire Dunnenwirth
APMC
50 Fullerton Court, Suite 100
Sacramento, California 95825

John O'Connor
c/o Luppen and Hawley
P.O. Box 2008
Sacramento, California 95820

Rick Chowdry
Intech Mechanical Co., Inc.
650 Commerce Drive, Suite B
Roseville, California 93678

Larry Booth
Frank M. Booth Co.
P.O. Box 5
Marysville, California 95901

Employee Trustees

Harry M. Rotz
5841 Newman Court
Sacramento, California 95819

William S. Haley
5841 Newman Court
Sacramento, California 95819

Lewis Long
5841 Newman Court
Sacramento, California 95819

Ronald Morgan
5841 Newman Court
Sacramento, California 95819

Philip Smyth
5841 Newman Court
Sacramento, California 95819

Robert M. Taylor Jr.
5841 Newman Court
Sacramento, California 95819

Aaron Stockwell
5841 Newman Court
Sacramento, California 95819

The Identification Number assigned by the Internal Revenue Service is 94-1268305 and the Plan Number is 501.

The collective bargaining agreements between U.A. Local 447 and the various employers and employer associations require each participating employer to contribute to the Plan at a specified rate per hour for hours worked in covered employment by each of their employees. Employers also may sign participation agreements providing coverage for non-bargaining unit employees and retirees. The Pipe Trades Self-Funded PPO Medical Plan, prescription drug, EAP, hearing, vision and dental benefits provided under this Plan are self-funded by the Fund from employer contributions made on behalf of their active employees. The Fund pays premiums for the Life/AD&D insurance provided through The Union Life Insurance Company and the HMO plan through Kaiser Permanente that are fully insured by those entities respectively.

Kaiser Permanente's address is:

Kaiser Foundation Health Plan, Inc.
Northern California Region
1950 Franklin Street
Oakland, California 94612
(800) 464-4000

The Union Labor Life Insurance Company's address is:

The Union Labor Life Insurance Co.
180 Montgomery Street, Suite 1100
San Francisco, California 94104
(866) 795-0680

This booklet is a summary of benefits. The Plan's contracts with insurance providers, other health service providers providing benefits under the Plan, the Administrative Office, plan consultant, counsel, auditor and investment manager, the Trust Agreement, collective bargaining agreements providing for contributions to the Plan, and all filings required by the state and federal governments are hereby incorporated by reference and are available for inspection by Plan participants and union or employer representatives at the Administrative Office upon reasonable notice.

A complete list of employers maintaining this Plan is available for examination at the Administrative Office or your local union office. A copy may be obtained upon written request to the Administrative Office. A charge may be made by the Administrative Office to provide you with this information.

Legal process may be served on:

Plan Administrator
5841 Newman Court
Sacramento, California 95819

Legal process also may be served on any member of the joint Board of Trustees.

Plan Year: July 1 to June 30

No health care provider is an agent or representative of the Plan or of the Board of Trustees. The Plan does not control or direct the provision of health care services/and or supplies to Plan participants and beneficiaries 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.

The foregoing statement applies to any and all health care providers, including both preferred and non-preferred providers under the terms of Plan. The statement also applies to all entities (and their agents, employees and representatives) that contract with the Plan to offer preferred provider Networks, or health-related services or supplies to participants and beneficiaries.

Nothing in this Plan affects the ability of a provider to disclose alternative treatment options to a participant or beneficiary.

STATEMENT OF ERISA RIGHTS

You, as a participant, have a right to full information about your Plan, how it operates and the benefits to which you and/or your eligible dependents are entitled under the terms of the Plan.

As a U.A. Local No. 447 Pipe Trades Health and Welfare Trust Fund participant, the Employee Retirement Income Security Act of 1974 (ERISA) provides that you are entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may 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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part and you have followed and exhausted the claims and appeals procedure starting on page 54, you may file suit in 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 and you have brought the matter to the Board of Trustees for their review, and you are dissatisfied with their decision, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and legal fees. If you lose, the court may require you to pay these costs and legal fees; for example, if the court finds your claim is frivolous.

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.

DEFINITIONS

As used in this Plan, the following terms shall have the meanings specified below:

Allowable Amount (see "Covered Charges")

Benefits means those services and supplies that are covered under the terms of the Plan.

BlueCard Program is the program through which you can obtain covered services outside of California, from a health care provider participating as a Host Plan, where available.

Blue Shield is a health cost management company employed under contract with the Board of Trustees.

Business Associate means a person or entity that provides certain functions; activities or services to the U.A. Local No. 447 Health and Welfare Plan involving the use and/or disclosure of Protected Health Information.

Chiropractic treatment means services for correction by normal or mechanical means of structure unbalance or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column.

Coinsurance is the percentage amount you pay toward the cost of your care (your out-of-pocket expense) in addition to your deductible and copays.

Copays or Copayments are the fixed dollar amounts you pay towards certain services.

Covered Charges are negotiated charges by preferred providers or Usual and Customary charges by other providers, incurred by an eligible person for the medically necessary treatment of conditions covered under the Plan, when provided in accordance with Plan rules. The Plan pays a percentage of covered charges.

Covered Dental Charges mean the reasonable and customary charges or the negotiated fees, for services rendered or supplies furnished or recommended by a dentist or doctor.

Covered Services means medical care, drugs or supplies which qualify for payment under the provisions of the Plan.

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

Deductible is the amount you pay before the Plan pays benefits. Charges not considered "covered charges" cannot be used to satisfy the deductible.

Dental Hygienist means an individual who:

1. is licensed to practice dental hygiene by the government authority which has the jurisdiction over the practice of dental hygiene; and

2. works under the supervision of a dentist.

Dentist refers to a person authorized by law and duly licensed to practice dentistry.

Designated Facility is a facility designated by Blue Shield as one which is preferred for organ transplants. Failure to use a Designated Facility for covered transplant services will result in a significant benefit reduction even if the facility is part of the Blue Shield PPO.

Doctor (see "Physician").

Durable Medical Equipment means equipment that is designated for repeated use, is mainly and customarily used for medical purposes, and is not generally of use to a person in absence of a disease or injury. Durable Medical Equipment includes, but is not limited to, equipment such as hospital beds, wheelchairs, traction apparatus, intermittent positive pressure breathing machines, braces and crutches.

Emergency means a sudden, serious and unexpected onset of acute illness or accidental injury for which the patient secures immediate care within 24 hours of the onset of symptoms and that, in the absence of immediate emergency medical treatment, could be reasonably expected to result in:

1. severe jeopardy to the patient's health;

2. serious impairment to bodily functions; or

3. serious dysfunction of any bodily organ or part.

Essential Benefits means ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental Procedures means:

1. any medical procedure, equipment, treatment or course of treatment, or drug or medicine that is under investigation or is limited to research;

2. techniques that are restricted to use at those centers that are capable of carrying out disciplined clinical efforts and scientific studies;

3. procedures that are not proven in an objective way to have therapeutic value or benefit; and

4. any procedure or treatment whose effectiveness is medically questionable.

Explanation of Benefits means a document sent to you from the Administrative Office which sets out the Benefits paid or payable for the Covered Services received by the you, and which sets out your financial responsibility for services provided.

HMO means Health Maintenance Organization, a prepaid medical plan in which you receive coverage only when using certain designated providers. This Fund offers Kaiser Permanente.

Home Health Care is medically necessary care provided in the patient's home by a licensed organization primarily engaged in skilled nursing and other therapeutic services under the full-time supervision of a physician or registered nurse. Home health care must be recommended by a physician and Pre-Certified by the Plan.

Hospice means a facility that provides a Hospice Care Program and operates in accordance with the laws of the jurisdiction where it is located. It operates as a unit or program that only admits terminally ill patients. It is separate from any other facility but may be affiliated with a hospital, nursing home or home health care agency.

Hospice Care Program means a coordinated program of inpatient and home care that treats the terminally ill patient and the family as a unit. 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 means an institution operated pursuant to law that is primarily engaged in providing, for compensation from its patients, medical, diagnostic and surgical facilities for the care, treatment and rehabilitation of disabled, injured and sick persons on an inpatient basis, which provides such facilities under the supervision of a staff of physicians and with 24-hour-a-day nursing service by registered graduate nurses. In no event, however, shall such term include any institution or part thereof that is used principally as a rest facility, nursing facility, convalescent facility or facility for the aged or the care and treatment of drug addicts or alcoholics, except as mandated by state law or any institution that makes a charge that the patient is not legally required to pay.

Host Plan means providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that geographical area outside of California.

Hours of Employment are straight time hours worked for a participating employer.

Illness means all sicknesses existing concurrently that are due to the same cause or are pathologically related shall be considered one illness. Successive sicknesses due to the same cause or pathologically related causes are considered one illness. Pregnancy is considered an illness.

Incurred date refers to the date the care or service is rendered. However, the "insert" date of an appliance shall be considered the date such charge was incurred.

Injury means all injuries sustained by a covered person in one accident.

Inpatient means you have been admitted to a Hospital as a registered bed patient and are receiving services under the direction of a physician.

Medically Necessary means appropriate for the condition being treated, in accordance with standards of good medical practice, and not for the convenience of the patient or provider of services. To be considered medically necessary, the service must be one that, if exceeded, would adversely affect the patient's condition. The mere fact that a doctor 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.

Medical necessity is determined by the Administrative Office.

Network or In-Network Provider means a Preferred Provider (see below).

Non-Preferred Provider means any provider who has not contracted with the Plan to accept the Plan's payment, plus any applicable Deductible, Copayment or amounts in excess of specified Benefit maximums, as payment-in-full for covered Services. Certain services of this Plan are not covered or benefits are reduced if the service is provided by a Non-Participating/Non-Preferred Provider (also referred to as an out-of-network provider).

Nurse means a graduate registered nurse.

Occupational Illness means an illness or injury for which the individual is entitled to benefits under the applicable Worker's Compensation Law, occupational disease law, or similar legislation.

Out-of-Area means you live 30 miles or more from the nearest Blue Shield provider.

Outpatient means services provided in a setting where you are not admitted as inpatient.

Participant or Plan Participant means a person covered by the Plan.

Participating Hospital means a Hospital that is under contract with the PPO (Preferred Provider Organization), also referred to as an In-Network Hospital, to furnish Services and to accept the Plan's payment, plus applicable Deductibles and Copayments, as payment-in-full for Covered Services.

Participating Physician means a Physician who is under contract with the PPO (Preferred Provider Organization), also referred to as an In-Network Physician, to furnish Services and to accept the Plan's payment, plus applicable Deductibles and Copayments, as payment-in-full for Covered Services.

Participating Provider means a Physician, a Hospital, an Ambulatory Surgery Center, an Alternate Care Services Provider, a Certified Registered Nurse Anesthetist, or a Home Health Care and Home Infusion agency that has contracted with the Plan to furnish Services and to accept the Plan's payment, plus applicable Deductibles and Copayments, as payment in full for Covered Services.

PBM see Pharmacy Benefit Manager.

Pharmacy Benefit Manager (PBM) means a firm used by the Plan to provide a network of retail and/or mail service pharmacies where prescriptions can be filled by the Plan participants at a cost that is less than "retail."

Physician or Doctor means a licensed doctor of medicine authorized to perform a particular medical or surgical service within the lawful scope of his/her practice, and shall also include any other health care provider or allied health practitioner duly licensed in the state where services are provided.

Plan means the U.A. Local 447 Health and Welfare Plan and the program of benefits it provides, as amended from time to time.

PPO means Preferred Provider Organization, the Network of Preferred Providers used by the Plan.

Pre-Certification is a requirement that specified services must be approved in advance by the Plan. Failure to comply with the Plan's Pre-Certification rules will result in benefit reductions or denial of payment.

Preferred Provider means a doctor, hospital, urgent care center, laboratory or x-ray facility providing services at reduced rates in accordance with direct or indirect agreement between Blue Shield and the Board of Trustees, or in accordance with an agreement directly with the Board of Trustees. A directory of preferred providers may be obtained from the Administrative Office.

Protected Health Information means individually identifiable health information that is transmitted or maintained by electronic media or is transmitted or maintained in any other form.

Self-Payment is the amount you pay monthly to maintain coverage.

Specialty Drug is a medication or injection which costs $500 or more, per prescription for a supply of 31 days or less.

Surrogacy Arrangement means an arrangement in which a woman (the surrogate) agrees to become pregnant and surrender the baby to another person or persons who intend to raise the child.

Terminally Ill Patient means a patient who does not have a reasonable prospect for a cure and who has a life expectancy of six months or less.

Totally Disabled and Total Disability, for the purpose of health coverage, means:

1. If you are an employee, that you are prevented from engaging in your regular customary occupation or employment by injury or illness. A period of disability begins with the cessation of active employment and ends when you are able to return to active employment.

2. If you are a dependent, that you, due solely to injury or illness, are prevented from engaging in substantially all of the normal activities of a person of like age and sex who is in good health. Disability means all periods of disability arising from the same cause or causes, including any and all complications; however, if the dependent recovers for a period of six months and also resumes normal activities, expenses incurred for the same disability will be paid as for a new disability.

Usual and Customary (U&C) Charges means the maximum amount that will be considered for payment, taking into account:

1. the usual fee charged by institutions, physicians, or dentists for the service or supply;

2. the range of usual fees charged by institutions with similar facilities and by physicians or dentists of like training and experience for the same service in a given area; or

3. unusual circumstances or complications requiring more time, skill or experience for the service or procedure.

Work-Related Illness or Injury means an illness or injury for which the individual is entitled to benefits under the applicable Workers' Compensation Law, occupational disease law, or similar legislation.

The index is provided to help you find the primary section(s) where a term is discussed.
It is for quick reference only and is not intended to be all-inclusive.

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