U.A. LOCAL NO. 447

PIPE TRADES HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION

Revised July 1, 2013
For Retired Employees and Dependents

IMPORTANT PHONE NUMBERS

Trust Fund Administrative Office	(916) 457-0821
(Outside Sacramento area)	(877) 811-4474
Kaiser Permanente	(800) 464-4000
Delta Dental	(888) 335-8227
UHC (Formerly PacifiCare) Secure Horizons	(888) 457-8506
Blue Shield of California	(800) 541-6652
Catamaran Prescription Benefits Manager	(800) 800-1188

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 retirees and dependents may choose the Pipe Trades Self-Funded PPO Medical Plan or a Health Maintenance Organization (HMO) plan (Kaiser Permanente or UHC's Secure Horizons). The specific benefits you and your eligible dependents receive depend on whether you are enrolled in Medicare and what medical program you choose. You may also choose to self-pay for one of the two Delta Dental plans offered. You may change your medical coverage option and your dental 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 Self-Funded PPO Medical Plan, the prescription drug program and the employee assistance program. Benefits offered by Kaiser and UHC's Secure Horizons are described in detail in separate brochures prepared by Kaiser and UHC's Secure Horizons. The separate brochures, incorporated by reference in this booklet, are available from the Administrative office and will be provided to you free of charge upon request. In addition, you may self-pay for dental coverage through Delta Premier or DeltaCare USA Plan. Separate brochures detailing these plans are also available from the Administrative office free of charge upon request.

The Trustees have established retiree benefits for the U.A. Local No. 447 Health and Welfare Plan on the basis that the employer contributions on the active employees will, if continued, help maintain these benefits for retirees. At the present time, eligible retirees pay only a portion of the cost for retiree benefits. The cost of retiree benefits is subsidized from employer contributions earned by active employees. The benefits provided by this Plan can be paid only to the extent that the Trust has available adequate resources for those payments. The Trustees have discretion to reduce these benefits. The Trustees have discretion to reduce or eliminate the subsidy for benefit coverage to retirees. The Trustees have discretion to reserve the right to use Trust reserves for benefit coverage for active employees or retirees. The retiree coverage is not a vested benefit and while reserves of the Plan are being accumulated to help underwrite this benefit, those reserves may be utilized for other benefits at the discretion of the Trustees.

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, or should the Trustees in their discretion utilize Trust assets for benefits other than subsidizing retiree benefits.

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 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 RETIRED EMPLOYEES AND DEPENDENTS

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DEDUCTIBLE INFORMATION		
Deductible	**In-Network**	**Out-of-Network**
Maximum of two deductibles per family per year	$200 per person[1,2]	$200 per person[1]
Coinsurance Maximum per person[3]	$10,000	Does not Apply[4]
Annual Maximum	See page 20 for information regarding Annual Limits	

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 $10,000 maximum. See page 21.

4 Only In-Network benefits count toward the $10,000 coinsurance maximum. Charges incurred Out-of-Network will never be paid at 100%.

SCHEDULE OF BENEFITS

FOR RETIREES WHO HAVE SELECTED THE PIPE TRADES PPO PLUS
PIPE TRADES SELF-FUNDED PPO MEDICAL PLAN
(CONTINUED)

SCHEDULE OF MEDICAL BENEFITS		
Physician Care & Outpatient Services	**In-Network**	**Out-of-Network[1]**
Physician Visits	90% of contract rate, after deductible.	70% of usual, customary & reasonable, after deductible.
	Pre-Certification not required	
Diagnostics, X-Ray, Lab	90% of contract rate, after deductible.	70% of usual, customary & reasonable, after deductible.
Chiropractor	90% of contract rate, after deductible.	70% of usual, customary & reasonable, 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 & reasonable, after deductible.
	Pre-Certification not required.	
Durable Medical Equipment (DME)	90% of contract rate, after deductible.	70% of usual, customary & reasonable, after deductible.
	Not covered unless Pre-Certified[2]	
Outpatient Specialty Medications/Injectables over $500[3] (see page 22)	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[3]	

1 Only In-Network benefits count toward the $10,000 coinsurance maximum. Charges incurred Out-of-Network will never be paid at 100%.

2 Pre-Certification not required for retirees and dependents with Medicare.

3 Drugs costing $500 or less are covered through the outpatient prescription benefit. See page 32.

SCHEDULE OF BENEFITS

FOR RETIREES WHO HAVE SELECTED THE PIPE TRADES PPO PLUS
PIPE TRADES SELF-FUNDED PPO MEDICAL PLAN
(CONTINUED)

SCHEDULE OF MEDICAL BENEFITS		
Physician Care & Outpatient Services	**In-Network**	**Out-of-Network[1]**
Audiologist	90% of contract rate after deductible.	70% of usual, customary & reasonable, after deductible.
Hearing Aids	90% of contract amount, after deductible.	70% of usual, customary & reasonable, after deductible.
	\$4,000 (\$2,000 per ear) maximum payment. Annual hearing aid maintenance check is required.[2] Adults (18 & over): one aid per year 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 Maintenance Check[2]	90% of contract amount, after deductible, up to \$30.	70% of usual, customary and reasonable, after deductible, up to \$30.

[1] Only In-Network benefits count toward the \$10,000 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 RETIREES WHO HAVE SELECTED THE PIPE TRADES PPO PLUS
PIPE TRADES SELF-FUNDED PPO MEDICAL PLAN
(CONTINUED)

SCHEDULE OF MEDICAL BENEFITS		
Hospital Inpatient & Outpatient [1]	**In-Network**	**Out-of-Network[2]**
Pre-Certification Requirement:[3] 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 & reasonable, after deductible.
Intensive Care	90% of contract rate, after deductible.	70% of usual, customary & reasonable, after deductible.
Organ/Tissue Transplants[4]	90% of Distinction Facility [4] contract rate, after deductible, if pre-certified.	50% of usual, customary & reasonable, after deductible.
Emergency Room	90% of contract rate, after deductible.	70% of usual, customary & reasonable, after deductible.
Urgent Care Center	90% of contract rate, after deductible.	70% of usual, customary & reasonable, after deductible.
Home Health	90% of contract rate, after deductible.	70% of usual, customary & reasonable, after deductible.
	No coverage for Non-preferred home health care unless Pre-Certified[3] 100 Visit Maximum Per Year.	
Hospice Inpatient or Outpatient	90% of contract rate, after deductible.	70% of usual, customary & reasonable, after deductible.
	No coverage unless Pre-Certified[3] $15,000 Lifetime Maximum.	

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 $10,000 coinsurance maximum. Charges incurred Out-of-Network will never be paid at 100%.

3 Pre-Certification not required for retirees and dependents with Medicare.

4 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 and customary (Non-Network Hospital).

SCHEDULE OF BENEFITS

FOR RETIREES WHO HAVE SELECTED THE PIPE TRADES PPO PLUS
PIPE TRADES SELF-FUNDED PPO 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 & reasonable 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 & reasonable after deductible.
Immunizations	90% of contract rate.	70% of usual, customary & reasonable after deductible.
Routine Annual Gynecological Visits and Mammography	90% of contract rate.	70% of usual, customary & reasonable, after deductible.

[1] Only In-Network benefits count toward the $10,000 coinsurance maximum. Charges incurred Out-of-Network will never be paid at 100%.

SCHEDULE OF BENEFITS

MENTAL/NERVOUS BENEFITS FOR RETIREES WHO HAVE SELECTED THE PIPE TRADES PPO PLUS PIPE TRADES SELF-FUNDED PPO MEDICAL PLAN (CONTINUED)

COUNSELING BENEFITS FOR ALL PARTICIPANTS		
	In-Network	**Out-of-Network[1]**
Mental/Nervous/Psychiatric Conditions		
Inpatient 30 day yearly maximum	90% of contract rate, after deductible.	70% of usual, customary & reasonable, after deductible.
	Not covered unless Pre-Certified.	
Outpatient	90% of contract rate, after deductible.	70% of usual, customary & reasonable, after deductible.
	20 visit yearly maximum[2].	
Counseling Benefit		
Family counseling, grief counseling, outpatient counseling, etc.	90% of contract rate, after deductible.	70% of usual, customary & reasonable, after deductible.
	20 Visit Yearly Maximum[2].	

[1] Only In-Network benefits count toward the $10,000 coinsurance maximum. Charges incurred Out-of-Network will never be paid at 100%.

[2] Annual 20 visit limit applies to mental/nervous/psychiatric and counseling benefits combined.

SCHEDULE OF BENEFITS

The information below describes the Self-Funded Outpatient Prescription Drug Benefits for Participants covered by the Pipe Trades PPO Plus Pipe Trades Self-Funded PPO Medical Plan. Retirees and Dependents who are covered by Kaiser or Kaiser Senior Advantage must obtain their prescriptions through Kaiser. Retirees and Dependents who are covered by UHC's Secure Horizons must obtain their prescriptions through that Plan.

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 Plus medical plan, not this outpatient prescription drug benefit, and must be Pre-Certified by the Plan and obtained through the mail service pharmacy. No coverage if Pre-Certification not obtained. See page 22. 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). Coverage is 50% of cost.

Special rates apply to Medicare's Part D drug program. See page 35.

Prescription drug benefits count towards the annual maximum described on page 20.

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

SCHEDULE OF BENEFITS

SELF-FUNDED EMPLOYEE ASSISTANCE PROGRAM BENEFITS FOR PPO PARTICIPANTS

SCHEDULE OF EMPLOYEE ASSISTANCE PROGRAM BENEFITS		
Employee Assistance Program (EAP) [1] Treatment of Alcohol or Substance Abuse (In/Outpatient)		
	In-Network	Out-of Network
Deductible	$200 In-Network	$200 Out-of-Network
Course of treatment that may include Screening, Referral, Detoxification, Residential Recovery facility, and follow-up visits (maximum 5 per lifetime)	90% of contract rate, after deductible	70% of usual, customary and reasonable, after Out-of-Network Deductible
Lifetime Treatment Maximum	2 treatment courses (not to exceed 6 months each)	
Over-the-Counter Nicotine Replacement Therapy To assist participants in quitting smoking	50% up to a lifetime maximum benefit of $150.	

[1] Only In-Network benefits count toward the $10,000 coinsurance maximum. Charges incurred Out-of-Network will never be paid at 100%.

SCHEDULE OF BENEFITS

FOR RETIREES WHO HAVE SELECTED THE DELTA PREMIER OR DELTACARE USA PLAN[1]

SUMMARY OF DENTAL BENEFITS	
DELTA PREMIER	
Dental Benefits Under the Delta Premier Plan, you may go to any licensed dentist; however, dentists participating with Delta Premier may offer you more competitive prices than dentists who are not participating Delta Premier providers.	
Annual Deductible	**Annual Maximum**
$50 per person 3 per family	$1,000 per person
DELTACARE USA	
Dental Benefits Only services performed by your selected DeltaCare USA panel dentist are covered under this Plan.	
Annual Deductible	**Annual Maximum**
None Co-pays vary by procedure	None

[1] Delta Premier and DeltaCare USA are voluntary self-pay plans. Contact the Administrative office for detailed information and the current monthly premiums.

ELIGIBILITY RULES

RETIREES

Persons Eligible for Coverage
All retirees who are receiving a pension from the U.A. Local 447 Pension Plan and:

(a) Who worked in covered employment at least 300 hours per year in seven of the ten consecutive Plan years preceding retirement. Any hours lost from covered employment because of Total Disability during this period are considered qualifying hours in the same manner as hours worked; AND

(b) Who were covered under this Health and Welfare Plan immediately prior to retirement; AND

(c) Who have made any necessary self-payments, in accordance with the rules set forth by the Trustees; AND

(d) Who have waived COBRA coverage as an active and completed an application electing retiree coverage under this Health and Welfare Plan.

Different eligibility rules apply if you were not covered by a collective bargaining agreement (CBA) while you were an active participant in the Plan. Please call the Administrative office for a copy of the non-CBA retiree eligibility rules.

When Your Coverage Begins
When you retire, you must waive COBRA coverage and use your hour bank reserve before converting to the retiree plan. Any remaining banked hours (less than 135) will be forfeited. When you retire and are eligible for retiree health benefits, your retiree coverage will begin at the beginning 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 Fund Office prior to the date your active coverage terminates to ensure continuous health coverage.

Retirees Who Return to Work
If you are covered under the Retiree Health and Welfare Plan and you return to work, special rules apply:

1. If you are under age 63 and go to work in the plumbing industry in California for a non-signatory employer on any basis, your retiree health and welfare benefits will cease until you reach age 63 and receive a pension from the U.A. Local 447 Pension Plan.

2. If you are over age 63 and work for a non-signatory employer in the plumbing industry in California, your retiree health and welfare benefits will be suspended and will not resume until twelve months after the last month in which you worked for a non-signatory employer.

3. If you go to work for a signatory employer (or as an inspector for a city or county or the State of California), your retiree health and welfare benefits will remain unchanged, unless you work sufficient hours to re-qualify as an active participant (375 hours over a six month period), at which point you will become covered under the Active Plan.

4. Retiree monthly copays still apply if you are covered under this Retiree Health & Welfare Plan and you perform work which results in employer contributions paid to this Plan or another Plan with which there is a reciprocity agreement.

Termination of Coverage – Retirees
Your retiree coverage will end:

1. On the last day of the last month for which you made the applicable self-payment, if you fail to make subsequent payments;

2. The first day of the month in which you re-qualify for and become covered under the active plan;

3. The first day of the month following the month in which you perform work in the plumbing industry in California, for a non-signatory employer (see “Retirees Who Return to Work” on page 10); or

4. On the date this Plan ends.

If your retiree coverage terminates because you choose to terminate it or because you fail to make the applicable self-payments timely, your coverage will not be reinstated at a later date.

DEPENDENTS

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

1. The child will be 26 or younger at the end of the calendar year; and

2. Until July 1, 2014, the child is not eligible to enroll in his/her employer-sponsored health plan or health plan of a spouse.

A child who meets the above age requirements and does not share your principal place of abode will still be considered an eligible dependent if the child falls into one of the two following categories:

1. You are (a) divorced/legally separated from or have lived apart from the child's other parent during the last six months of the calendar year, (b) one or both parents provide more than half the child's support, (c) the child is in the custody of one or both parents for more than half the year, and (d) you are entitled to claim the child as a dependent for United States income tax purposes.

2. You provide more than half the child's support and the child cannot be claimed as a qualifying child by another taxpayer for United States income tax purposes.

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. If an eligible dependent is not residing with the Plan participant, the Plan must be notified in writing, so that EOBs and Plan information can be sent to the dependent's correct address.

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 retiree and for any minor child placed in the physical custody of an eligible retiree 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 calendar year 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 spouse will continue as long as she/he makes the required monthly self-payments timely.

SPECIAL ENROLLMENT RIGHTS

If you decline (or previously declined) enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to elect retiree coverage for 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

COBRA Continuation Rights
In accordance with federal law, 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. Death of retiree covered under Plan	Spouse and dependent children if covered under Plan	36 months after date of qualifying event
2. Divorce of covered retiree	Spouse and dependent children if covered under Plan	36 months after date of qualifying event
3. Dependent child's loss of that status under Plan	Affected dependent child if covered under Plan	36 months after date of qualifying event

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

The COBRA premium is 102% of the cost for participants who are covered under this Plan. 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.

The maximum continuation period is 36 months, even if more than one event occurs giving rise to COBRA continuation rights. The 36 month period of COBRA eligibility is reduced by the number of months of subsidized coverage provided in the event of the retiree's death.

COBRA continuation coverage will end before the 36 month continuation coverage period expires if: (1) your dependents fail to pay the required premium on time; (2) 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 your dependent, and such exclusion or limitation is enforceable under the Health Insurance Portability and Accountability Act); (3) your dependents become entitled, after the date of election, to Medicare; or (4) your former contributing employer ceases to maintain any health plan for active employees.

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 your spouse or dependent children to COBRA coverage, the Administrative office will provide detailed information concerning the coverage available and its cost. Your dependents must send the election form to the Administrative office within 60 days of loss of coverage or the date of receipt of the notice from the Administrative office, whichever is later. If your dependents do not send the election form within this 60 days they will lose all rights under COBRA, which may affect their 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 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 former employer ceases contributions to the Fund and your dependents are covered under COBRA when the cessation of contribution or withdrawal occurs, your dependents will be able to continue COBRA to the end of the continuation period, i.e., 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 and UHC's Secure Horizons 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 or UHC's Secure Horizons, if you were covered by one of those plans when your group coverage ended. 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 or UHC's Secure Horizons as soon as possible. Your right to conversion is discussed in the Kaiser and UHC's Secure Horizons brochures 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 dependents 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 your dependents 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 or your dependents 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.FR § 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.

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

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.

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 retirees and dependents may choose medical coverage provided through the Pipe Trades Self-Funded PPO Medical Plan, Kaiser Permanente or UHC's Secure Horizons.

Once you make your plan selection, you can change plans only during the annual open enrollment period. Exception: if you enroll in Kaiser or UHC's Secure Horizons 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 Self-Funded PPO Medical Plan is described in the following pages. The Kaiser and UHC's Secure Horizons plan are briefly described below and the benefits are described in the brochures (Evidence of Coverage) prepared by Kaiser and UHC's Secure Horizons, which are available free of charge from the Administrative office.

KAISER AND UHC'S SECURE HORIZONS: GENERAL DESCRIPTION

Kaiser and UHC's Secure Horizons are both HMOs. In order to enroll in one of the HMO's, you must live within 30 miles of one of the HMO's medical groups or facilities. UHC is available only to Medicare enrollees.

Most covered services will be provided at no charge or will require a copayment. An HMO 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 HMO 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 the HMO you've selected. The brochure will be provided at no cost to you by the HMO or the Administrative office.

When you enroll in an HMO, you must receive services at facilities associated with the HMO. A list of Kaiser or UHC's Secure Horizons facilities will be provided to you without charge by the Administrative office or the HMO. 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 the HMO will determine how much it will pay). The benefits provided by the HMO are subject to the terms and conditions of an agreement with the Plan.

SPECIAL RULES CONCERNING MEDICARE

The rules and benefits differ depending on whether or not you are eligible for Medicare. To obtain full benefits, you and your eligible dependents must enroll in Medicare Part A and Part B and begin paying the applicable Medicare premiums as soon as you become eligible. (Different rules apply to Medicare Part D coverage for prescriptions. See page 35.)

If you or your insured dependents have Medicare, Medicare will always pay before this Plan, unless you or your insured dependents are entitled to Medicare solely on the basis of end-stage renal disease (ESRD). If this is the case, Medicare will pay after this plan for the first 30 months after Medicare Part A eligibility or entitlement.

If you are enrolled in Kaiser Permanente Senior Advantage or UHC's Secure Horizons, Medicare benefits must be assigned to the HMO you have selected in order to be eligible.

Use of providers where Medicare cannot be billed (Pipe Trades PPO Plus Self-Funded Medical Program)
If you have Medicare but use the services of a provider where Medicare cannot be billed (for example, a Veterans Administration [VA] Hospital), Pre-Certification is required for you to receive maximum benefits. If you fail to obtain Pre-Certification, benefits may be reduced up to 50% of usual, customary and reasonable charges. To request Pre-Certification, call the Plan at (866) 771-8877.

BLUE SHIELD PPO

The Plan utilizes Blue Shield of California for PPO, utilization review and case management services.

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

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 in this SPD.

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

When you access Covered Services outside of California you may obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Plan"). In some instances, you may obtain care from non-participating healthcare providers. The 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 PLUS 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 Limits
For the Plan Years beginning July 1, 2012 and July 1, 2013 the annual limit for any eligible person for all Essential Benefits will be $2,000,000. For Plan Years beginning on or after July 1, 2014, there will be no annual maximums 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 Plus Pipe Trades Self-Funded PPO Medical Plan, with some exceptions (see below), will be paid at 100% of covered charges after you have incurred $10,000 in covered expenses in a calendar year, when you use Network providers.

The following do not count towards the $10,000 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 Plus Pipe Trades Self-Funded PPO Medical Plan (e.g., the Plan's EAP);

3. Charges for failure to use an 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
Specialty medications/injectables costing more than $500 for a supply of 31 days or less require Pre-Certification, **regardless of Medicare eligibility.**

The following services require Pre-Certification only for retirees and dependents not eligible for Medicare:

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

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.

For Retirees and Dependents who do not have Medicare, 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 <u>Not</u> Requiring Pre-Certification by the Plan

1. Outpatient physician office visits;

2. Routine laboratory tests and obstetrical ultrasounds;

3. Diagnostic imaging such as, CT scans, MRIs and PET scans;

4. Outpatient visits to specialists other than those listed above as requiring Pre-Certification if you don't have Medicare;

5. Outpatient prescription drugs (other than specialty medication/injectables and drugs costing more than $500 per prescription for a supply of 31 days or less);

6. Chiropractic care;

7. Emergency services as defined by the Plan;

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

9. 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 by the medical Plan, not the prescription drug plan. Even though the Plan's specialty drug contract is with a separate provider, the 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.

<u>Without Pre-Certification from the Plan</u>, 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) 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 Health 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
Unless you have Medicare, if you need to have a covered* 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 $10,000 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.

** Remember: unless you have Medicare, all organ transplants require Pre-Certification from the Plan. Experimental procedures (see Definitions section) are not covered, and additional exclusions apply (see Exclusions section).*

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;

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. The maximum benefit is $3,000 per year;

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;

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

13. Artificial limbs or eyes;

14. 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;

15. 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;

16. 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;

17. Drugs and medicines while hospital confined;

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

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

20. Pregnancy benefits for:

    (a) Charges in connection with normal pregnancy and delivery for female Retirees and spouses, but not for dependent daughters, 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;

    Prenatal care management services are available and can be obtained by calling one of the Plan's nurse case managers at (866) 771-8877. The Administrative office may also contact you directly regarding these services.

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

22. Voluntary termination of pregnancy, for retirees and dependent spouses;

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

24. 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;

25. 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.

26. Well-baby exams, well-child exams and childhood immunizations, from birth to the second birthday and one exam per year from age two through 19, including appropriate laboratory services and routine immunizations;

27. PAP smears and pelvic exams;

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

29. Home health care is covered as shown in the Schedule of Benefits. For non-Medicare retirees and dependents, 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.

30. Charges for hospice care are covered under the Plan as shown in the Schedule of Benefits. For non-Medicare retirees and dependents hospice services are covered only when Pre-Certified by the Plan. Charges for hospice care are covered up to $15,000 for the following services:

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.

31. 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 usual, customary and reasonable, 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, customary and reasonable, 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, with the following limitations:

1. Outpatient services limited to 20 visits per year, mental/nervous and counseling visits combined.

2. Inpatient benefits for non-Medicare retirees and dependents will not be covered unless Pre-Certification is obtained through the Plan (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.

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 (for participants not eligible for Medicare), 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

2. Prescription drugs which cost more than $500 for a supply of 31 days or less, unless Pre-Certified by the Plan, regardless of Medicare eligibility.

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 (voluntary dental benefit options are described on page 38);

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;

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 27;

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. Treatment for mental health conditions in excess of 20 outpatient visits per year or 30 inpatient days per year;

36. Myofunctional therapy;

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

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

39. 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 (see also “Use of Providers where Medicare cannot be Billed” on page 18);

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

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

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

43. 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);

44. 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;

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

46. 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.

PRESCRIPTION DRUG BENEFIT

Self-Funded for Participants covered through the Pipe Trades Self Funded PPO Medical Plan. Retirees and Dependents covered by Kaiser, Kaiser's Senior Advantage, or UHC's Secure Horizons must obtain their prescriptions through Kaiser or UHC.

The services described below are provided through a Pharmacy Benefit Management firm (PBM) for retail and mail prescriptions. Prescription drug benefits count towards the annual maximum described on page 20.

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 or if you use a non-Network pharmacy, you will pay 100% of retail price, and the Plan will reimburse you 50% of the retail price 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. In other words, 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.

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 drugs that cost more than $500 per prescription for a supply of 31 days or less require Pre-Certification from the Plan. Specialty/Injectable drugs which cost more than $500 for a supply of 31 days or less are covered under the Pipe Trades Self-Funded PPO Medical Plan when Pre-Certified by the Plan. See pages 21 and 22.

2. Human Growth Hormone.

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 over the internet.

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

3. Prenatal and well-baby vitamins;

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

5. Contraceptives; and

6. 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 pages 21 and 22.

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 pages 21 and 22);

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. Smoking deterrents (these are covered under Preventive Care benefit);

17. Non-drowsy antihistamines; and

18. Human growth hormone unless Pre-Certified by the Plan

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

Medicare Part D and Prescription Benefits
Whether you are covered through the Plan's self-funded pharmacy program, Secure Horizons or Kaiser Senior Advantage, your prescription drug coverage is at least as good as the standard Medicare Part D prescription drug coverage benefit. For this reason, retirees and dependents are urged not to enroll in an individual Part D plan.

You cannot be enrolled in more than one Medicare Part D plan at a time. The effect of being enrolled in more than one Medicare Part D plan at a time depends on whether you are covered under the Pipe Trades PPO Plus Self-Funded Plan, Kaiser Senior Advantage or Secure Horizons. If you are covered under the Pipe Trades PPO Plus Self-Funded Plan and you attempt to sign up with another Medicare Part D provider, you will be required to pay that provider's Part D premium and the Plan will not reimburse you. In exchange for this additional premium, you would likely gain little or no additional benefits because, as mentioned above, Plan's own prescription drug program is at least as good as the standard Medicare Part D benefit. If you belong to Kaiser Senior Advantage or Secure Horizons and enroll with another Part D provider, your medical and prescription coverage may be terminated by your HMO.

Medicare says a plan's prescription drug benefits are "creditable" when they are at least as good as the Medicare Part D drug benefits. The Plan is required to send you an annual notice telling you whether your drug coverage is creditable. You may also request a copy of the notice by calling or writing the Administrative office.

In case you ever drop or lose your Plan coverage, or in the unlikely event that the Plan's coverage becomes non-creditable, having this notice will allow you to immediately enroll in a Medicare Part D plan without paying a late enrollment penalty. Specifically, if you try to enroll after you are eligible, you will be charged a permanent Medicare Part D premium surcharge of 1% for every month since your initial Medicare eligibility for which you cannot show that you had creditable coverage (if such non-creditable period exceeds 63 days). Also note that you may have to wait for the next regular annual Medicare Part D enrollment period, which will be November 15th through December 31st, for coverage in the following calendar year.

More information regarding Medicare Part D benefits is provided in the handbook "Medicare & You" that is mailed to you annually. At any time you can also visit http://www.medicare.gov/ or call 1-800-633-4227. TTY users should call 1-877-486-2048. Every state has a Health Insurance Assistance Program to help Medicare beneficiaries and their families with their health insurance choices and with problems that might arise. In California it is called either the "Health Insurance Counseling and Advocacy Program" (HICAP) or "Department of Aging." You can call them at 1-916-419-7500 or learn more by visiting http://www.aging.ca.gov/ and click the button for "Medicare Rx". Contact information for similar programs in other states will be listed in your "Medicare & You" handbook.

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 Plus Plan participants. This benefit offers free, confidential help to eligible retirees 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 Plus 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 benefits are separate from the Pipe Trades Self-Funded PPO Medical Plan or HMO medical benefits. 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
Most EAP services are provided via referral to free community resources. In addition, the EAP pays for the following services:

(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 by the EAP's medical team;

(c) Following screening and referral, full cost of approved medically necessary inpatient or outpatient detoxification program provided the patient complies with program rules;

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

Course of Treatment
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 (maximum of 5 per lifetime).

For tobacco users wishing to quit, nicotine replacement therapy is covered at 50% of charges up to a lifetime maximum benefit of $150.

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
The EAP does not pay for:

1. Any services which are not for the treatment of drug or alcohol problems;

2. Any services for the treatment of drug or alcohol problems except as pre-approved;

3. Drug or alcohol treatment required by court order, unless the treatment is determined to be medically necessary;

4. Transitional housing, rent, transportation, meals or other living expenses;

5. Medical treatment except pre-approved detoxification (medical benefits may be payable under other provisions of the Pipe Trades Self-Funded PPO Medical Plan);

6. Psychiatric treatment or counseling (psychiatric treatment and/or counseling benefits may be payable under other provisions of the Pipe Trades Self-Funded PPO Medical Plan);

7. Preventive care;

8. Routine or random drug testing;

9. Claims not submitted within 12 months after services were received, except in the absence of legal capacity; and

10. More than two courses of treatment in a lifetime.

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.

VOLUNTARY DENTAL PLAN OPTIONS

The Fund makes two Delta Dental plans available to retirees and dependents, on a voluntary basis. This means you decide whether or not to enroll in a plan, and if you do enroll in a plan you are required to pay the monthly premium. The premium and benefits change from time to time, so you should call the Fund Office for the current information.

DELTA PREMIER

Under this program you can use any dentist, but using dentists participating in Delta Premier will generally save you money out-of-pocket. The Delta Premier plan pays a fixed amount towards certain procedures and you are responsible for the remainder of the billed amounts.

Call the Fund Office for information on participating dentists and benefit amounts.

DELTACARE USA

Under this program most dental procedures are covered, after you make a copayment which varies by procedure. However, services are covered only when you use a general dentist in the DeltaCare USA network. If you need a specialist, your general dentist must refer you.

Call the Fund Office for a list of participating dentists and copays.

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;

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
If you or your insured dependent has Medicare, Medicare will always pay before this Plan, unless you or your insured dependents is entitled to Medicare solely on the basis of end-stage renal disease (ESRD). If this is the case, Medicare will pay after this plan for the first 30 months after Medicare Part A eligibility or entitlement.

In determining benefits payable under Medicare, all the benefits to which you or your insured dependent is entitled under Medicare shall be included without regard to whether or not the individual has registered for Part A or enrolled in Part B of Medicare.

If you have Medicare but use the services of a provider where Medicare cannot be billed (for example, a Veterans Administration [VA] Hospital), Pre-Certification is required for you to receive maximum benefits. If you fail to obtain Pre-Certification, benefits may be reduced up to 50% of usual, customary and reasonable charges. To request Pre-Certification, call the Plan at (866) 771-8877. For emergency services, “Pre-Certification” means the Plan was contacted on the first working day after admission.

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.

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 ___ 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 which 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
1901 Olympic Blvd., Suite 200
Walnut Creek, California 94596

Claire Donnenwirth
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 and EAP benefits provided under this Plan are self-funded by the Fund from employer contributions on behalf of their active employees and through monthly retiree self-payments. The Fund pays premiums for the HMO plans through Kaiser Permanente and UHC's Secure Horizons 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

UHC's Secure Horizons' address is:

UHC's Secure Horizons
P.O. Box 6006
M/S CA 120-0515
Cypress, California 90630-5028
(800) 624-8822

This booklet is a summary of benefits. The Plan's contracts with HMOs, 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 on page 39, 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:

Benefits mean those services and supplies which are covered under the terms of the Plan.

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 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.

Custodial Care is care primarily for the purpose of meeting personal needs which could be provided by persons without professional skills or training. This includes, but is not limited to help in walking, 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.

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").

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 which, 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 which are capable of carrying out disciplined clinical efforts and scientific studies;

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

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

HMO means Health Maintenance Organization, a prepaid medical plan in which you receive coverage only when using certain designated providers. This Fund offers Kaiser and UHC's Secure Horizons.

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 which 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.

Illness means all sicknesses existing concurrently which 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 for the purpose of the Plan.

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.

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

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 Plan.

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

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.

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.

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.

Usual and Customary 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.

This 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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