**AMENDMENT #2**
**to the**
**ARIZONA PIPE TRADES HEALTH AND WELFARE TRUST FUND**
**Summary Plan Description (SPD)/Plan Rules and Regulations**
**for Active Employees and Non-Medicare Retirees**
**Amended, restated and effective June 1, 2018**

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**Effective January 1, 2019, the Summary Plan Description/Plan Rules and Regulations are amended as noted below:**

**In the Summary of Benefits chapter, the Schedule of Benefits for Life and Accidental Death and Dismemberment (AD&D) is amended to add the text in italics and delete the text in strike-through:**

| **Schedule of Benefits for Life and Accidental Death and Dismemberment (AD&D)**<br>This is a brief overview. For more complete information on these benefits refer to the certificate of insurance available from the Life Insurance Company whose name is listed on the Quick Reference Chart in the front of this document. | |
|---|---|
| **Life Insurance (Death Benefit)** | Effective on the later of June 1, 2001 or the day the Eligible Employee becomes eligible under the Plan,<br>• **Employee's Death:** ~~$20,000~~ *$50,000* (paid to your designated Beneficiary)<br>• **Spouse's Death:** $1,000<br>• **Child's Death:**<br>  • Age less than 14 days: none<br>  • Age 14 days but less than 6 months: $100<br>  • Age 6 months but less than 26 years: $500 |
| **Accidental Death and Dismemberment (AD&D) (Active Employees Only)** | • ~~$20,000~~ *$50,000* for losses of life~~, both hands, both feet, or both eyes~~<br>• *$20,000 for loss of both hands, both feet, or both eyes*<br>• $10,000 for loss of one hand, one foot or sight of one eye<br>• $5,000 for loss of thumb and index finger of same hand |

**In the Summary of Benefits chapter, the Schedule of Weekly Disability Benefits is amended to add the text in italics and delete the text in strike-through:**

| **Schedule of Weekly Disability Benefits**<br>This is a brief overview. For more complete information on these benefits refer to Article III. | |
|---|---|
| **Weekly Benefit** | ~~$350~~ *$500* per week |
| **Duration of Disability Benefit** | Up to 26 weeks |

**In the Summary of Benefits chapter, the Schedule of Dental PPO Plan Benefits is amended to add the text in italics and delete the text in strike-through:**

| | | |
|---|---|---|
| **Deductible for *the* Dental Plan** | $25 per person per Calendar Year<br>$50 per family per Calendar Year<br>The Dental Deductible will be waived ~~for dental check-ups, cleanings and fluoride treatments.~~ *Preventive dental services described in Article VI of this document.* | |
| **Annual Dental Benefit Maximum** | ~~$2,000~~ *$2,500* per person per Calendar Year. | |
| | **Dental PPO *and Premier* Network Providers** | **Out-of-Network Providers** |
| **Coinsurance for Dental Services** | *No charge, no deductible for preventive dental services*<br>*All other covered dental services:*<br>80% of the network discounted amount is paid by the Plan<br>and<br>20% of the network discounted amount is paid by the Participant | 80% of the Allowed charge is paid by the Plan<br>and<br>20% of the Allowed charge is paid by the Participant, plus you could be billed for the difference between the provider's billed charges and the Plan's Allowed Charge amount (referred to as balance billing) |
| | **Reminder:**<br>**Using Dental PPO Network providers will save YOU and our Fund money.** | |
| **Orthodontia** | No coverage | |

**In the Summary of Benefits chapter, page 16, under the section on Self-Payment Provisions and COBRA Information, Option 1 and Option 2 wording is revised to add the text in italics:**

**OPTION 1: NON-COBRA REDUCED SELF-PAYMENT**

An Active Employee electing to continue eligibility for himself or herself and his/her eligible Dependents on a self-payment basis **can continue Medical Plan benefits *and Weekly Disability benefits* only**. Any Participant who has been continuously eligible for health and welfare benefits for 36 months out of the last 42 consecutive months may continue coverage under this option **for up to 12 months** at a reduced self-payment rate.

Reduced self-payment rates are not available to Participants whose coverage has been terminated as a result of engaging in prohibited employment as outlined in the paragraphs numbered 1 and 2 of the "Termination of Benefits" section noted above.

After 12 months on Option One, the individual can elect to continue Medical Plan ***and Weekly Disability*** benefits for up to 6 more months and can now choose to add Dental PPO Plan and/or Vision benefits. There is no coverage available under Option One after a total of 18 months of Medical Plan coverage unless the individual is disabled.

**OPTION 2: COBRA SELF-PAYMENT**

In 1986, Congress passed the Consolidated Omnibus Budget Reconciliation Act, commonly called COBRA. This law generally requires that most employers with group health plans offer Employees and their covered Dependents the opportunity to **temporarily** continue their health care coverage (medical, dental and vision) at group rates when coverage under the Plan would otherwise end. An Active Employee electing to continue eligibility for himself or herself and the Employee's eligible Dependents on a COBRA self-payment basis can choose to continue Medical Plan, Dental PPO Plan, ***Weekly Disability,*** and Vision benefits.

**In Article II, Section 2, (e) (1), C. "Coverage Available - Self-payment premium," is amended to add the text in italics as noted below:**

C. **Coverage Available - Self-Payment Premium.**

An Active Employee electing to continue eligibility for himself/herself and/or his/her eligible Dependents on a self-payment basis can choose between the Options expressed below, depending upon his/her eligibility for those Options:

1. **NON-COBRA Reduced Self-Payment OPTION 1:**

   Under this Option, an Active Employee electing to continue eligibility for himself or herself and his/her eligible Dependents on a self-payment basis may **continue Medical Plan *and Weekly Disability* benefits only**. Any Participant who has been continuously eligible in the Plan for 36 months out of the last 42 consecutive months may continue coverage under Option 1 for **up to 12 months** at a reduced self-pay rate, beyond the date coverage would otherwise terminate because the number of hours in his/her Hour Bank drops below the number of hours required for the current month's coverage.

   Reduced self-payment rates are not available to Participants whose coverage has been terminated as a result of engaging in prohibited employment as outlined in the paragraphs numbered 1 and 2 of the "Termination of Benefits" section noted above.

   After 12 months on Option One, the individual can elect to continue Medical Plan ***and Weekly Disability*** benefits for up to 6 more months and can now choose to add Dental PPO Plan and/or Vision benefits. There is no coverage available under Option One after a total of 18 months of Medical Plan coverage unless the individual is disabled.

2. **COBRA Self-Payment OPTION 2:**

   Under this Option, an Active Employee electing to continue eligibility for himself or herself and his/her eligible Dependents on a COBRA self-payment basis can choose to **continue Medical Plan, Dental PPO Plan, *Weekly Disability,* and Vision benefits**. The Prepaid Dental Plan coverage can also be continued under COBRA self-payment provisions. The amount of the self-payment premiums for each Option will be established by the Board of Trustees, and is subject to change at their discretion.

   Note that for a COBRA Qualified Beneficiary who elected Medical Plan, Dental PPO Plan, ***Weekly Disability*** and Vision benefits and who is no longer eligible to participate in COBRA's Medical Plan coverage because of the Qualified Beneficiary's entitlement to Medicare, the Plan will permit the COBRA Qualified Beneficiary to continue to self-pay his/her COBRA premium to continue coverage under the Dental PPO Plan and Vision benefits for the remainder of the months of COBRA coverage.

   **Other Health Coverage Alternatives to COBRA:** Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the **Health Insurance Marketplace**. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

**In Article III: Death, Accidental Death and Dismemberment and Weekly Disability Benefits, Section 1: "Death Benefits", Subsection (a) is amended to add the text in italics and delete the text in strike-through:**

(a) **Your Death Benefit:** Effective on the later of June 1, 2001 or the day the Eligible Active Employee becomes insured, if an Eligible Active Employee of the Arizona Pipe Trades Plan dies while eligible or within 31 days following the termination of the Eligible Active Employee's eligibility, the Fund will, subject to the provisions hereafter stated, pay a Death benefit to the Eligible Active Employee's Beneficiary of: ~~$20,000~~ *$50,000*.

**In Article III: Death, Accidental Death and Dismemberment and Weekly Disability Benefits, Section 2: "Accidental Death and Dismemberment (AD&D) Benefits", Subsection (a) is amended to add the text in italics and delete the text in strike-through:**

(a) **Accidental Death Benefit:** If an Eligible Active Employee of the Arizona Pipe Trades Plan sustains bodily injuries solely through external, violent and accidental means, and dies as a result of such injuries within 90 days following the accident in which the injuries were sustained, the Fund will, subject to the provisions hereafter stated, pay an Accidental Death Benefit of ~~$20,000~~ *$50,000*.

**In Article III: Death, Accidental Death and Dismemberment and Weekly Disability Benefits, Section 5: "Accidental and Sickness Benefit (Non-Occupational Weekly Disability Benefits Only", Subsection (b) is amended to add the text in italics and delete the text in strike-through:**

(b) **Benefits:** If an Eligible Active Employee becomes Totally Disabled as a result of sickness or accidental bodily injury, while covered hereunder, the Fund will, subject to the provisions hereinafter set forth, pay to the Eligible Active Employee up to ~~$350~~ *$500* per week. **Payment of Benefits:** Payments begin with the first day of disability due to an accident and the eighth day of disability due to sickness (however, for a sickness for which the Eligible Active Employee is absent from work for more than 7 days, payment will be made from the first day of the absence). Payment will continue for the period of disability up to a maximum of 26 weeks for each disability.

**In the Quick Reference Chart, the Dental row is amended to add the text in italics:**

| | |
|---|---|
| **Dental PPO Plan**<br>• Dental PPO *and Premier* Network provider directory<br>• Dental PPO *Plus Premier* Plan Claims (Claim Appeals managed by the Administrative Office) | **Delta Dental Plan of Arizona**<br>P. O. Box 43000 Phoenix, AZ 85080-3000 (general correspondence)<br>Phone: (602) 938-3131 *(option 1)* or (800) 352-6132 *(option 1)*<br>www.deltadentalaz.com<br>• *To find a dentist visit: deltadentalaz.com/provider search*<br>• *Download the Delta Dental Mobile App (free for Android and iOS.*<br>• *Sign up for Member connection at deltadentalaz.com/member to view benefits, eligibility, claims status, check average dental costs in your area or update your delivery preference for dental benefit statements (EOBs) and go paperless.* |

**In Article VI: Dental PPO Benefits, Section 3: "Dental PPO Benefits", Subsection (b) is amended to add the text in italics and delete the text in strike-through:**

(b) **Annual Dental Benefit Maximum**: The maximum aggregate amount payable for dental services rendered to each Eligible Individual in any one Calendar Year shall be ~~$2,000~~ *$2,500*.

**In Article V: Health Reimbursement Arrangement (HRA), Section 1: "Establishment of HRA(s)", Subsection (b)(7) is amended to add the text in italics and delete the text in strike-through:**

(7) **Medical Care Expenses"** means

a) medical care expenses including, but ~~are~~ not limited to, COBRA premiums~~,~~ and non-COBRA reduced self-payments; and

b) medical care expenses for COBRA Participants and for surviving spouses and surviving dependent children; and.

c) medical care expenses ~~subject to the deductible up to an annual maximum of $1,500 per family~~ *that meet the definition of "medical care" under Internal Revenue Code §213, except those expenses that are excluded in the Exclusions Section of this Article*; and

d) medical care expenses incurred by an Active Employee or his/her Dependents for an emergency situation as defined under Section 3 (a) in this Article, and which are medical care expenses eligible for reimbursement pursuant to Code §105 and 213(d) (including, for example, amounts for certain bills for Hospital care, doctors, dental care, vision care and prescription drugs and includes medical expenses paid toward a Medical Plan deductible), but does not include expenses that are described in the Exclusions Section of this Article.

**In Article V: Health Reimbursement Arrangement (HRA), Section 2: "Benefits Offered and Method of Funding", Subsection (a) is amended to add the text in italics and delete the text in strike-through:**

**Section 2. Benefits Offered and Method of Funding.**

(a) **Benefits Offered**. When an Active Employee or COBRA Participant becomes an HRA Participant, an HRA Account will be established for such HRA Participant to receive contributions actually made with respect to his/her employment for the purpose of providing benefits in the form of reimbursements for:

(1) COBRA premiums and non-COBRA reduced self-payment Participants, as described in Section 3, and

(2) for COBRA Participants and non-COBRA reduced self-payment Participants medical care expenses under IRC Section 213, except those expenses excluded under Section 8 of this Article.

(3) medical care expenses ~~subject to the deductible up to an annual maximum of $1,500 per family~~, *that meet the definition of "medical care" under Internal Revenue Code §213, except those expenses excluded under Section 8 of this Article*; and

(4) for Active Employees and their Dependents: certain emergency situation Medical Care Expenses (defined below), in accordance with medical care expenses under IRC Section 213, except those expenses excluded under Section 8 of this Article, and,

***NOTE:*** *Participants must meet an aggregate threshold of $250 in Medical Care Expenses before the Plan will pay/reimburse any expense under this HRA Plan, as described in Section 4 of this Article.*

Benefits will be provided up to the unused amount in the HRA Participant's HRA Account, as set forth and adjusted under sub-section 4e below, provided a claim for such benefits is submitted in the appropriate manner, as determined by the Board of Trustees.

In no event shall benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses. The HRA Participant's HRA Account shall not accrue interest.

**In Article V: Health Reimbursement Arrangement (HRA), Section 2: "Benefits Offered and Method of Funding", Subsection (a) is amended to add the text in italics and delete the text in strike-through:**

**Section 3. HRA Benefits.**

(a) **Benefits.** The Plan will reimburse the following HRA benefit expenses:

(1) COBRA premiums and non-COBRA reduced self-payments; and

(2) for COBRA Participants and non-COBRA reduced self-payment Participants, medical care expenses under IRC Section 213, except those expenses excluded under Section 8 of this Article.

(3) medical care expenses ~~subject to the deductible up to an annual maximum of $1,500 per family~~, *that meet the definition of "medical care" under Internal Revenue Code §213, except those expenses excluded under Section 8 of this Article*; and

(4) for Active Employees and their Dependents: certain emergency situation Medical Care Expenses (defined below), in accordance with medical care expenses under IRC Section 213, except those expenses excluded under Section 8 of this Article.

***NOTE:*** *Participants must meet an aggregate threshold of $250 in Medical Care Expenses before the Plan will pay/reimburse any expense under this HRA Plan, as described in Section 4 of this Article.*

Benefits will be provided up to the unused amount in the HRA Participant's HRA Account, provided a claim for such benefits is submitted in the appropriate manner, as determined by the Board of Trustees.

**In Article V: Health Reimbursement Arrangement (HRA), Section 4: "Reimbursement Procedure", Subsection (b)(4) is amended to add the text in italics and delete the text in strike-through:**

(b) **Claims Substantiation**. An HRA Participant who seeks benefits may apply for reimbursement by submitting an application, called an HRA Reimbursement Request, in writing to the Administrative Office in such form as the Board of Trustees may prescribe, but **no later than two years from the date of service** on the claim, setting forth:

(1) the person or persons on whose behalf Medical Care Expenses have been incurred;

(2) the nature and date of the Medical Care Expenses so incurred;

(3) the amount of the requested reimbursement; and

(4) a statement that such Medical Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source and that Health FSA coverage, if any, for such Medical Care Expenses has been exhausted. The application shall be accompanied by bills, invoices, or other statements from an independent third-party showing that the Medical Care Expenses have been incurred, payment is due and the amounts of such Medical Care Expenses, together with any additional documentation that the Administrative Office may request. No claim for reimbursement may be made unless and until the aggregate claims for reimbursement is at least ~~$25~~ ***$250***.

(5) The Board of Trustees may waive the time deadline of two years from the date of service on the claim for good cause.

**In Article VI: Dental PPO Benefits, Section 1: "Overview" is amended to add the text in italics and delete the text in strike-through:**

While you do not have to use A Dental PPO Network provider, using Dental PPO Network providers will save you and the Fund money. This is because you will pay your Participant Coinsurance based on the discounted amount rather than on the non-discounted amount. *Also, Preventive dental benefits (as described under Section 4 of this Article) are provided at no cost when you use Dental PPO and Premier Network providers.*

~~Also,~~ Out-of-Network providers do not offer discounted fees to you or the Fund and they can also bill you for any balance that is due in addition to the amount that was payable by the Fund (called "Balance Billing"). Network

providers are prohibited (by their contract with the Dental PPO Network) from billing you for differences between their normal fees and the amount that is considered an Allowed Charge by this Plan.

**In Article VI: Dental PPO Benefits, Section 2: "Dental PPO Plan Benefits", Subsection (c) is amended to add the text in italics and delete the text in strike-through:**

(c) **Dental Deductible:** The term "Dental Deductible", with respect to Covered Dental Expenses incurred by each Eligible Individual **is $25 per person and $50 per family (of two or more persons) each Calendar Year.**

The Dental Deductible applies separately to each Eligible Individual once during each Calendar Year. However, if the Dental Deductible has been satisfied by two or more Eligible Individuals of the same Eligible Employee's family during any Calendar Year, Covered Dental Expense incurred by any other Eligible Individual whose coverage arises from the same Eligible Employee will not be subject to the Dental Deductible during the remainder of the Calendar Year.

The Dental Deductible will be waived for all *Preventive* dental ~~check-ups, cleanings and fluoride treatments~~ *services* ~~allowed~~ described under ~~the Preventive provisions~~ *Section 4* of this Article.

**In Article VI: Dental PPO Benefits, Section 3: "Dental PPO Plan Benefits", is amended to add the text in italics and delete the text in strike-through:**

**Section 3: Dental PPO Plan Benefits**

(a) **Coinsurance:** If an Eligible Individual incurs necessary (*non-preventive*) Covered Dental Expenses which exceeds the Dental Deductible, the Fund will, subject to the terms and conditions hereafter stated, pay an amount equal to 80% of all such expenses which are in excess of the Dental Deductible.

- If a *PPO or Premier* network dental provider is used the Plan pays 80% of the **Network provider's discounted fee** (*discounted fee is determined by the Dental Plan claims administrator as the lesser of billed charges or the PPO dentist's allowable fee or the Premier dentist's Maximum Reimbursement Amount*) and the Eligible Individual pays 20% ~~of the network provider's discounted fee~~.
- If a Non-Network dental provider is used the Plan pays 80% of the Plan's Allowed Charge (~~as defined in the Definitions Article~~ *defined as the lesser of billed charges or the fee listed on the Dental Network's non-participating dentist table of allowance*) and the Eligible Individual pays 20% of the Plan's Allowed Charge, plus the Eligible Individual could be billed for the difference between the provider's billed charges and the *Dental* Plan's Allowed Charge amount (referred to as balance billing).

(b) **Annual Dental Benefit Maximum**: The maximum aggregate amount payable for dental services rendered to each Eligible Individual in any one Calendar Year shall be ~~$2,000~~ *$2,500*.

*(c) **Preventive Dental Benefits**: If a PPO or Premier network dental provider is used the Plan pays **100% of the Network provider's discounted fee** (defined in (a) above) with no deductible. Out-of-network providers paid at 80% coinsurance (with no deductible). Preventive dental benefits are described under Section 4 of this Article.*

**In Article VI: Dental PPO Benefits, Section 4: "Schedule of Dental PPO Plan Services", Subsection (a) is amended to add the text in italics and delete the text in strike-through:**

**Section 4: Schedule of Dental PPO Plan Services**

Subject to the Limitations and Exclusions hereinafter contained in Section 5 of this Article, the following is the Schedule of Dental Services covered hereunder when rendered by a Dentist and when necessary and an Allowed Charge, as determined by the ~~standards of generally accepted dental practice~~ *Dental Plan Claims Administrator.*

*Predetermination (from the Dental Plan Claims Administrator) is recommended for dental services over $250.*

(a) ~~**Basic**~~ ***Preventive*** **Dental Benefits** (~~payable~~ after ~~the Dental~~ Deductible ~~is~~ met, ~~except where noted below~~):

(1) **Diagnostic** - Procedures to assist the Dentist in evaluating the existing conditions to determine the required dental treatment.

(2) **Preventive** - ~~Routine prophylaxis (cleaning) with exam two times per year (not subject to the Dental Deductible)~~. Includes the following services:

- ***Routine prophylaxis (cleaning)*** *two times per year. Difficult cleanings may be exchanged for a routine cleaning with no limits.*
- ***Routine dental exams, evaluations, or*** *consultations two times per year*
- *Two (2) topical applications of* ***fluoride*** *for adults and children per year*
- ***Space maintainers*** *for adults and children, as needed. Not covered for Ortho.*

*Preventive services obtained from PPO and Premier Network providers are paid at 100% coinsurance and are not subject to the Dental Deductible. Out-of-network providers paid at 80% coinsurance.*

~~(3) Topical application of **fluoride** solution (not subject to the Dental Deductible)~~

*(b)* ***Basic Services*** *(after deductible met)*

(1) **Sealants** are payable for children up to age 19 *(all teeth no limits).*

(2) *X-rays (full mouth/panorex, or vertical bitewing or periapical x-rays as needed no limits), Fillings (silver amalgam and synthetic tooth color fillings all teeth no limits), Stainless Steel Crowns (as needed, no limits), Emergency (Palliative) treatment for relief of pain as needed no limits, Emergency exams (ADA codes 0140, 0160, 0170 as needed no limits), Endodontics (root canal treatment as needed no limits), Periodontics (treatment of gum disease surgical or non-surgical as needed no limits), Periodontal maintenance (as needed no limits), Oral surgery (simple and surgical extractions).*

~~(4) **Oral Surgery** - Procedures for extractions and other oral surgery including preoperative and postoperative care.~~

~~(5) **General Anesthesia** - When administered for a covered oral surgery procedure performed by a Dentist.~~

~~(6) **Restorative** - Provides amalgam, synthetic porcelain and plastic restorations for treatment of carious lesions. Gold restorations, crowns and jackets will be provided when teeth cannot be restored with the above materials or when used in teeth that serve as bridge abutments.~~

~~(7) **Endodontic** - Procedures for pulpal therapy and root canal filling (treatment of non-vital teeth).~~

~~(8) **Periodontic** - Procedures for treatment of the tissues supporting the teeth.~~

*Basic services obtained from PPO and Premier Network providers are paid at 80% coinsurance after deductible met. Out-of-network providers paid at 80% coinsurance after deductible met.*

*(c)* ***Major Services*** *(after deductible met)*

(1) Prosthodontic*s* ~~Benefits~~ *bridges, partial dentures, complete dentures -5 year waiting period for replacement last performed no limits), Bridge and denture repair (repair of such appliances to their original condition including relining of dentures), Implants and implant related procedures (as needed no limits and is applied to the patient's annual maximum benefit), Interim partial stayplates (flipper – all teeth no limits), Occlusal guards, night guards or bite guards (covered once), and Restorative crowns, inlays, onlays, gold restorations, veneers (as an alternative benefit of crown provided, 5-year waiting period for replacement last performed, as needed no limit).*

~~(1) Procedures for construction of bridges, partial and complete dentures.~~

*Major services obtained from PPO and Premier Network providers are paid at 80% coinsurance after deductible met. Out-of-network providers paid at 80% coinsurance after deductible met.*

(d) **Certain outpatient prescription drugs used for a Dental Purpose (e.g. antibiotic, pain medication) are payable** under the Medical Plan's outpatient prescription drug benefit.

**This Amendment #2 to the Arizona Pipe Trades Health & Welfare Trust Summary Plan Description/Plan Rules and Regulations <u>for Active Employees and Non-Medicare Retirees</u> was duly adopted by the Board of Trustees at a meeting held on January 24, 2019.**

**Chairman** **Secretary**

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