Southern California Pipe Trades Health & Welfare Fund

LOCAL 78

February 22, 2022

1

Today's Presentation

- Benefit Summary
- Blue Shield of CA ID Cards
- Annual Coordination of Benefits Form
- Injury and Third Party Liability Form
- Health Reimbursement Arrangement (HRA)
- Covid-19 Testing
- No Surprises Act
- For More Information
- Questions?

2

Benefit Summary

Get the most from your Health Plan

- **Calendar Year Deductible**
  - $250 medical per individual; $750 family maximum
  - $50 prescription per individual
  - $50 dental per individual; $150 family maximum (PPO only)
  - $50 hearing aid per device
- **Calendar Year Out-of-Pocket Maximum for 2022**
  - In-network $8,700 individual; $17,400 family maximum
  - Out-of-network $17,400 individual; $34,800 family maximum
- **Prescription Drugs**
  - **Prescription drugs costing more than $1,000 for a 30 day supply may be covered under the Plan's specialty medication benefit. Contact the Fund Office for more information (Effective July 1, 2021)**
- **Health Reimbursement Arrangement (HRA)**
  - Full-time employee receives ~$2,100 HRA allowance per year*

*Assumes 2,000 hours at the Journeyman job-class per year. Based on current Plan provisions.

3

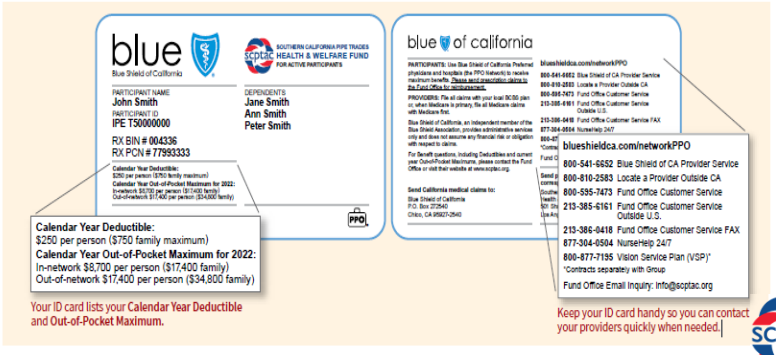
Blue Shield of California ID Cards

New Blue Shield ID cards now list:

- **Calendar year Medical deductible**
- **Calendar year Medical Out-of-Pocket Maximums**

Your Blue Shield Identification Card

Always present your Blue Shield of California ID card before receiving services. Verify that your provider or facility is in the preferred network. The easiest way to find out where to get in-network care is to log into your account at **www.blueshieldca.com**.



*To be mailed out late February 2022

4

Coordination of Benefits Form

Required once per year or as requested by the Fund Office for all Participants and Eligible Dependents
Note: This form replaced the prior annual Claim Form

SOUTHERN CALIFORNIA PIPE TRADES
HEALTH & WELFARE FUND
PENSIONERS & SURVIVING SPOUSES HEALTH FUND
501 Shatto Place, Suite 500, Los Angeles, CA 90020 | (800) 595-7473 (213) 385-6161 | Fax (213) 385-0418 | Email info@scptac.org | www.scptac.org

ANNUAL COORDINATION OF BENEFITS FORM

This form is required once per calendar year or upon change in other insurance. Benefits under these Plans will be coordinated with the other coverage you have under any other plan. If the plan determined to be your primary insurance is a prepaid HMO or PPO plan, and if you do not use that plan's contracted providers for services and supplies that are covered under that plan, the benefits payable under these Plans are reduced to 20%.

PART 1 Participant Information

NAME			
DATE OF BIRTH	mm/dd/yyyy / /	SOCIAL SECURITY NUMBER	Only last four SSN digits required - -
ADDRESS	Street	City	State ZIP
PHONE	( ) -	EMAIL	

Note: If your address on this form is different from your address on file with the Fund Office, your address will be changed for all five Southern California Pipe Trades Funds to the address on this form.

PART 2 Patient Information (if different from above)

NAME		RELATIONSHIP TO PARTICIPANT	
DATE OF BIRTH	mm/dd/yyyy / /	SOCIAL SECURITY NUMBER	Only last four SSN digits required - -
ADDRESS	Street	City	State ZIP

PART 3 Other Coverage or Benefits

Is the patient eligible for other coverage or benefits: (CHECK ONE) ☐ YES ☐ NO

If yes, what is the type of coverage: ☐ MEDICAL ☐ VISION ☐ OTHER:

POLICY HOLDER:	INSURANCE:
PLAN ID:	PHONE: ( ) -

PART 4 Authorization

I/We hereby certify that the foregoing statements, and any accompanying statements, are true, correct and complete to the best of my/our knowledge. I/We authorize any medical/health plan or issuer of an insurance policy under which I am eligible to receive medical/health benefits, to furnish the Southern California Pipe Trades health funds ("SCPT Funds"), upon their request, with information regarding benefits to which I/we may be entitled or have received. I/We further authorize any union or employer that has information about this other coverage to provide this information to the SCPT Funds.

PATIENT'S SIGNATURE *Not required if under 18 years of age* X	DATE / /
PARTICIPANT SIGNATURE X	DATE / /

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Injury and Third Party Liability Form

This form must be completed by the participant upon request by the Fund Office for injury and third party liability details.

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INJURY AND THIRD PARTY LIABILITY FORM

This form is required for each new Injury. These plans do not cover any Illness, Injury, or other condition 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 and against whom a Participant or Eligible Dependent has a claim. However, the plans will conditionally pay for benefits for such Illness or Injury while the claim is being adjudicated, providing the Patient executes an agreement to reimburse the funds, and will cover such benefits to the extent recovery against the third party is unsuccessful.

PART 1 Participant Information

NAME			
DATE OF BIRTH	mm/dd/yyyy / /	SOCIAL SECURITY NUMBER	Only last four SSN digits required - -
ADDRESS	Street	City	State ZIP
PHONE	( ) -	EMAIL	

Note: If your address on this form is different from your address on file at the Fund Office, your address will be changed for all five Southern California Pipe Trades Funds to the address on this form.

PART 2 Patient Information (if different from above)

NAME		RELATIONSHIP TO PARTICIPANT	
DATE OF BIRTH	mm/dd/yyyy / /	SOCIAL SECURITY NUMBER	Only last four SSN digits required - -
ADDRESS	Street	City	State ZIP

PART 3 Injury or Accident Information

DESCRIPTION
HOW
WHERE
WHEN (DATE & TIME)
WORK RELATED: (CHECK ONE) ☐ YES ☐ NO THIRD PARTY INVOLVED: (CHECK ONE) ☐ YES ☐ NO

PART 4 Third Party Information (If Applicable)

NAME	PHONE ( ) -
ADDRESS Street City State ZIP	
AUTO INSURANCE	POLICY NUMBER

Injury and Third Party Liability Form Page 1 of 2

PART 5 Attorney Information and Agreement (If Applicable)

NAME	PHONE
ADDRESS Street City State ZIP	

The undersigned, being attorney of record for the above Participant or other Claimant, does hereby agree to withhold such sums from any settlement, judgement, or verdict as may be necessary to reimburse the Fund for benefits paid as result of injuries, illnesses or conditions caused by third parties.

ATTORNEY SIGNATURE X	PRINT NAME DATE / /

PART 6 Authorization (If Applicable)

I hereby grant a lien to the Southern California Pipe Trades Health & Welfare Fund and the Pensioner's and Surviving Spouses Health Fund (hereinafter referred to as "Fund") of such sums as the Fund has paid out for benefits as a result of my injuries for which I am claiming payment from a third party or insurer. I hereby agree to pay, and/or authorize my attorney who is representing me to pay, such sums from any settlement, judgement, or verdict as may be necessary to adequately reimburse said Fund. This lien on my case or cases or any other recovery to said Fund shall be against any and all proceeds of any settlement, judgement, or verdict which may be paid to my attorney or myself as the result of injuries or damages caused by third parties for which the Fund has paid benefits.

PART 7 Attestation

I hereby certify that the foregoing information I have provided is true, correct and complete to the best of my knowledge. To the extent applicable, I hereby grant the Fund a lien as set forth in Part 6 of this form.

CLAIMANT SIGNATURE *Parent or Legal Guardian, if Minor Child, or Personal Representative** : X	DATE / /
PARTICIPANT SIGNATURE X	DATE / /

* If you are acting as the Personal Representative of the individual whose information is to be disclosed, you must provide proof of your authority to act for that individual.

Injury and Third Party Liability Form

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Effective January 2022

Health Reimbursement Arrangement

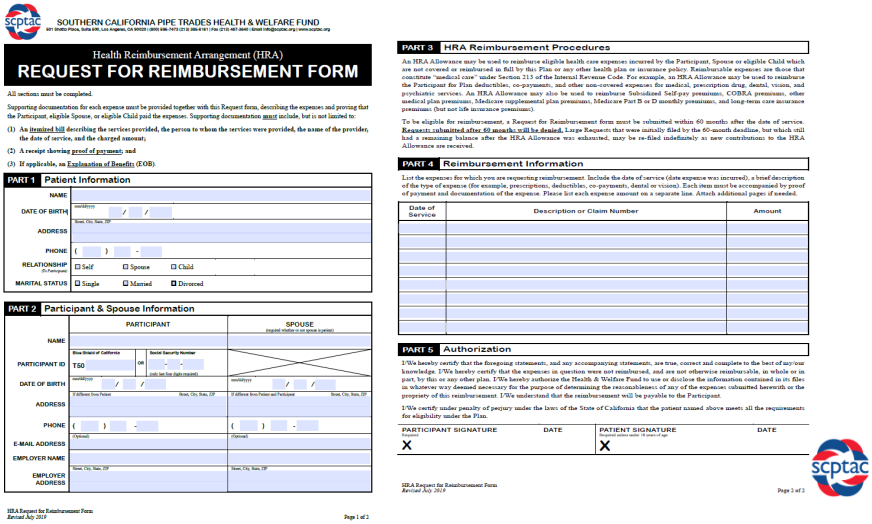
Your HRA Allowance can be used to cover eligible health expenses

- **Contributions**
  - Under most CBAs, $1.05 per hour worked goes into your HRA allowance
  - Contributions continue to accrue, only subject to forfeiture after 24 months without contributions or claims and no contact with the Fund Office
  - Not a vested benefit, offered at Trustees' discretion
- **Eligible Expenses**
  - Examples of eligible out-of-pocket expenses
    - COBRA premiums
    - Dental expenses
    - Vision expenses
    - Deductibles
    - Prescriptions
    - Out-of-Network
  - For more information regarding eligible expenses, review IRS Publication 502.

7

Health Reimbursement Arrangement – Sample Form

Required with every HRA paper claim submission. Download form at www.scptac.org.



SOUTHERN CALIFORNIA PIPE TRADES HEALTH & WELFARE FUND

Health Reimbursement Arrangement (HRA)

REQUEST FOR REIMBURSEMENT FORM

All sections must be completed.

Supporting documentation for each expense must be provided together with this Request form, describing the expenses and proving that the Participant, eligible Spouse, or eligible Child paid the expenses. Supporting documentation must include, but is not limited to:

(1) An itemized bill describing the services provided, the person to whom the services were provided, the name of the provider, the date of service, and the charged amount;

(2) A receipt showing proof of payment; and

(3) If applicable, an Explanation of Benefits (EOB).

PART 1 Patient Information

NAME

DATE OF BIRTH (mm/dd/yyyy)

ADDRESS (Street, City, State, ZIP)

PHONE

RELATIONSHIP (To Participant) ☐ Self ☐ Spouse ☐ Child

MARITAL STATUS ☐ Single ☑ Married ☐ Divorced

PART 2 Participant & Spouse Information

	PARTICIPANT	SPOUSE (required whether or not spouse is patient)
NAME		
PARTICIPANT ID	Show Shield of California: T50	Social Security Number: OR (only last five digits required)
DATE OF BIRTH	(mm/dd/yyyy)	(mm/dd/yyyy)
ADDRESS	If different from Patient: (Street, City, State, ZIP)	If different from Patient and Participant: (Street, City, State, ZIP)
PHONE	(Optional)	(Optional)
E-MAIL ADDRESS		
EMPLOYER NAME		
EMPLOYER ADDRESS	(Street, City, State, ZIP)	(Street, City, State, ZIP)

HRA Request for Reimbursement Form
Revised July 2019

Page 1 of 2

PART 3 HRA Reimbursement Procedures

An HRA Allowance may be used to reimburse eligible health care expenses incurred by the Participant, Spouse or eligible Child which are not covered or reimbursed in full by this Plan or any other health plan or insurance policy. Reimbursable expenses are those that constitute "medical care" under Section 213 of the Internal Revenue Code. For example, an HRA Allowance may be used to reimburse the Participant for Plan deductibles, co-payments, and other non-covered expenses for medical, prescription drug, dental, vision, and psychiatric services. An HRA Allowance may also be used to reimburse Subsidized Self-pay premiums, COBRA premiums, other medical plan premiums, Medicare supplemental plan premiums, Medicare Part B or D monthly premiums, and long-term care insurance premiums (but not life insurance premiums).

To be eligible for reimbursement, a Request for Reimbursement form must be submitted within 60 months after the date of service. Requests submitted after 60 months will be denied. Large Requests that were initially filed by the 60-month deadline, but which still had a remaining balance after the HRA Allowance was exhausted, may be re-filed indefinitely as new contributions to the HRA Allowance are received.

PART 4 Reimbursement Information

List the expenses for which you are requesting reimbursement. Include the date of service (date expense was incurred), a brief description of the type of expense (for example, prescriptions, deductibles, co-payments, dental or vision). Each item must be accompanied by proof of payment and documentation of the expense. Please list each expense amount on a separate line. Attach additional pages if needed.

Date of Service	Description or Claim Number	Amount

PART 5 Authorization

I/We hereby certify that the foregoing statements, and any accompanying statements, are true, correct and complete to the best of my/our knowledge. I/We hereby certify that the expenses in question were not reimbursed, and are not otherwise reimbursable, in whole or in part, by this or any other plan. I/We hereby authorize the Health & Welfare Fund to use or disclose the information contained in its files in whatever way deemed necessary for the purpose of determining the reasonableness of any of the expenses submitted herewith or the propriety of this reimbursement. I/We understand that the reimbursement will be payable to the Participant.

I/We certify under penalty of perjury under the laws of the State of California that the patient named above meets all the requirements for eligibility under the Plan.

PARTICIPANT SIGNATURE (Required)	DATE	PATIENT SIGNATURE (Required unless under 18 years of age)	DATE
X		X	

HRA Request for Reimbursement Form
Revised July 2019

Page 2 of 2

8

Health Reimbursement Arrangement – Useful Tips

- Claims may be submitted for up to 60 months from the date of service
- Claims must include proof of payment and either:
  A. An explanation of benefits (EOB) or
  B. An itemized bill
- Proof of payment may include receipt, cancelled check or statement. Save all receipts, even when using your HRA Debit Card for payment
- To maximize your HRA allowance, the Fund Office attempts to apply all other plan benefits (medical, dental, vision, etc.) before spending your allowance

9

Health Reimbursement Arrangement

HRA Visa Debit Card- *Coming late Spring 2022*

- Use your SCPTAC Prepaid Visa to access your Health Reimbursement Arrangement Allowance
  - Provided by WEX Health
  - Swipe your card to pay for qualified health care expenses* without having to pay up front.
    - Examples of eligible expenses include deductibles, co-insurance, prescriptions, vision services and dental services (Note: if you pay for prescriptions with your HRA debit card, remember to submit your prescription receipts to the Fund Office.)
  - Enter your card number on mail order prescription invoices, for online pharmacies, and on medical and dental statements to pay amounts due.
  - A list of pharmacies and stores where you can use your card will be available from the website listed on the back of your card and on the Fund Office website.
  - Each participant will be issued 2 cards; must activate and sign cards prior to use.
- WEX benefits Mobile App can be used to
  - File an HRA Claim
  - Check available HRA Allowance
  - Request additional cards
  - Replace lost/stolen cards

*For a list of eligible expenses, see IRS Publication 502

10

Covid-19 Testing (during the Coronavirus Public Health Emergency)

Applies to both the Active and Pensioners Health Plan

- Covid-19 PCR diagnostic tests (including rapid tests) are covered under your medical benefits.
  - No limit to the number of tests per eligible individual
  - Submit receipts to the Fund Office along with a Coordination of Benefits Form for any tests that you pay for out-of-pocket.
- Over-the-Counter Covid-19 tests
  - Effective January 15, 2022, the Plan will cover up to 8 at-home tests per eligible individual in a 30-day period under your medical benefits.
  - Submit your receipts as proof of payment, along with a Coordination of Benefits Form that indicates who the tests were for
  - Reimbursement requests for tests exceeding 8 per eligible individual in a 30-day period can be submitted for reimbursement under HRA

11

Note: Antibody tests are not covered by the Plan

No Surprises Act

- The 'No Surprises Act' protects Active members from surprise medical billing for services received on or after January 1, 2022.
- Applies to:
  1. Out of network charges for services such as anesthesia, radiology, or doctor charges provided in an in-network facility (hospital/surgery centers)
  2. Emergency services, including out-of-network
  3. Air Ambulance transportation
- Payment is negotiated with the provider of service so you don't receive a bill you weren't expecting. You will be responsible for the usual out of pocket amount due under in-network.
- Does not apply if you sign a waiver accepting financial liability for services provided.
- Does not apply to Pensioner's and Surviving Spouses Health Plan, or when the Fund is your secondary insurance (it should apply under your primary).

12

For more information on the No Surprises Act, visit www.dol.gov

For More Information

SOUTHERN CALIFORNIA PIPE TRADES ADMINISTRATIVE CORPORATION

Fund Office
501 Shatto Place, Suite 500
Los Angeles, CA 90020

Toll-Free Number (800) 595 - 7473

Email info@scptac.org
Website www.scptac.org

BLUE SHIELD OF CALIFORNIA

Website www.blueshieldca.com/networkPPO

DELTA DENTAL

PPO Number (800) 765 - 6003
HMO Number (800) 422 - 4234

Website www1.deltadentalins.com

VISION SERVICE PLAN (VSP)

Phone Number (800) 877 - 7195

Website www.vsp.com

13

Questions?