BAY AREA ROOFERS
HEALTH AND WELFARE TRUST FUND

SUMMARY PLAN DESCRIPTION

(Medical, Prescription Drug,
Vision, Disability and Life Insurance)

Restated as of August 1, 2016

KEEP THIS BOOKLET FOR FUTURE REFERENCE

BAY AREA ROOFERS
HEALTH AND WELFARE TRUST FUND

TO: Participants in the Bay Area Roofers Health and Welfare Plan

We are pleased to provide you with this updated booklet which sets forth in detail provisions relating to eligibility and benefits provided to you and your Eligible Dependents as of August 1, 2016. This booklet outlines the Bay Area Roofers Health and Welfare Plan and reflects plan changes up to August 1, 2016. The pages that follow give you an explanation of the coverages which are available to you. The Joint Board of Trustees may amend the Plan from time to time or discontinue all or any portion of the Plan.

This is your Health and Welfare Plan. To secure maximum benefits, study the provisions and instructions in this booklet carefully.

If you have any questions regarding this program, please contact United Administrative Services at 6800 Santa Teresa Blvd Ste 100, San Jose, California 95119; telephone (408) 288-4400.

Sincerely yours,

BOARD OF TRUSTEES

HIGHLIGHTS OF THIS BOOKLET

This booklet contains the Summary Plan Description ("SPD") of your Health and Welfare Plan as of August 1, 2016. You may go to the Bay Area Roofers benefits website (www.roofersbenefits.com) for additional information. On the website you may access monthly hours reported and contributions remitted by employers, healthcare information including eligibility, hour bank status, claims, history, and dependents on file. Click on the "Personal Information" button. First-time users **must** contact United Administrative Services at (408) 288-4457 to request your personal login ID and password.

This booklet is only a summary. In the event of any dispute, the official language of the group insurance policy, or other master agreements, will be in control.

Please note that all of the rules of the Plan are subject to modification by the Board of Trustees. Any amendments to the Plan adopted by the Board of Trustees after the publication of this booklet supersede summaries in this booklet.

DON'T BE CAUGHT UNAWARE:

Basic Information about the Health and Welfare Plan

1. Your claims must be **medically necessary** and properly prescribed to be covered by the Health and Welfare Plan.

2. You or your provider may call the Plan Administrator, United Administrative Services, at (408) 288-4400, to confirm your eligibility status or for information about the benefits payable under the Plan. A list of other addresses and phone numbers of Plan providers appears on page 86 of the SPD.

3. It is your responsibility to inform the Plan Administrator of a change in address, and to complete an enrollment form within 30 days of any of the following events occurring:

   - Change of name
   - Change of address
   - Change in marital status
   - Change in beneficiary
   - Change or addition of Eligible Dependents
   - Member or dependent becoming eligible for Medicare

IMPORTANT NOTICES

BENEFITS ARE NOT VESTED!

Plan rules and benefits may change from time to time. Your benefits under the Plan are not vested. The Board of Trustees may reduce or eliminate or change any benefits provided under the Plan (or any insurance policy, HMO or other entity) at any time. Participants may also be required to make new or additional contributions for benefits provided by the Plan.

LIMITATION UPON RELIANCE ON BOOKLET AND STATEMENTS

This booklet provides a brief, general summary of the Plan. It is not intended to cover all of the details of the Plan.

You are not entitled to rely upon oral statements of Employees of the Trust Fund Office, a Trustee, an Employer, any Union officer, or any other person or entity. As a courtesy to you, the Trust Fund Office may respond orally to questions; however, oral information and answers are not binding upon the Plan and cannot be relied upon in any dispute concerning your benefits.

If you wish an interpretation of the Plan you should address your request in writing to the Board of Trustees at the Trust Fund Office. To make their decision, the Trustees must be furnished with full and accurate information concerning your situation.

You should further understand that, from time to time, there may be an error in a statement that you receive or a payment that has been made which may be corrected upon an audit or review. **The Board of Trustees reserves the right to make corrections whenever any error is discovered.**

C A U T I O N - FUTURE PLAN AMENDMENTS

Future amendments to the Plan may have to be made from time to time to comply with new laws or amendments passed by Congress, rulings by federal agencies or courts, and other changes deemed necessary or prudent by the Board of Trustees. You will be notified if there are important amendments to the Plan. Before you decide to retire, you may want to contact the Trust Fund Office to determine if there have been Plan amendments or other developments that may affect your situation.

AUTHORIZED SOURCE OF INFORMATION

United Administrative Services ("UAS"), the administrative office of the Health and Welfare Trust Fund, is the only authorized source of information concerning the administration of the Trust and the Board of Trustees' interpretation of the Plan provisions affecting the rights and duties of any Employee, retiree, or other person. All other sources, including without limitation, any Individual Trustee or officers and representatives of the Local Union, individual Employer or Employer Association (whether a Trustee or not) are completely unauthorized, and statements and opinions from them are not to be relied upon. Employees, retirees and other persons desiring information about the administration of the Trust, or a ruling as to their particular rights and duties under the Plan of the Trust, must request the same in writing from the Plan Administrator.

Only the Board of Trustees has the authority to make final and binding interpretations of the Plan. Any person who believes he or she is adversely affected by an initial claim determination may appeal it to the Board of Trustees. An appeal must be submitted in writing to the Plan Administrator's Office within 180 days of the receipt of the notice of the adverse determination, or all objections to that determination are considered waived. Please refer to the Plan's Claims Appeal Procedures set forth in full herein on page. As a courtesy to you, the Plan representatives may respond informally to oral questions; however, oral information and answers are not binding upon the Board of Trustees or the Plan and cannot be relied on in any dispute concerning your benefits.

This Welfare Trust believes the plans offered by the Fund are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Live Well Benefits Center at 800-825-5647 (option 1). You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or http://www.dol.gov/ebsa/pdf/grandfatherregtable.pdf. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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ELIGIBILITY RULES

Contractual and Non-Contractual Active Employees

A. **General Rules.** This Plan is intended to benefit employees of employers that have collective bargaining agreements with Local 40, 81 and/or 95 of the United Union of Roofers, Waterproofers and Allied Workers AFL-CIO. Each of these Local Unions, and any other Local Union of the United Union of Roofers, Waterproofers and Allied Workers AFL-CIO which is allowed to cover employees represented by it under this Plan, is referred to herein as a "Participating Union." Those employees covered by collective bargaining agreements with the Participating Union are in general referred to as "contractual employees." Other employees of signatory employers who are not covered by a collective bargaining agreement requiring contributions to this or any other health plan are in general referred to as "non-contractual employees."

B. **General Eligibility Rules for Contractual Employees**

(1) **Initial Eligibility for Contractual Employees.** Subject to the rules set forth below, each contractual employee working in employment covered by a collective bargaining agreement with a Participating Union is eligible on the first day of the second calendar month following the month for which the individual has accrued 480 units. Units are only accrued for hours for which contributions are required and actually paid under a collective bargaining agreement with a Participating Union.

(2) **Units.** Contractual employees are credited with units or partial units toward coverage based on the contributions received for each hour for which contributions are required. The value of units and the number of units credited will be dependent on the hourly contribution rate in effect at the time and the actual cost of providing coverage under rules adopted from time to time by the Board of Trustees.

(3) **Reserve.** A special "reserve" is maintained for contractual employees by the Administrator’s Office. The number of units earned by an individual for which contributions are required under the current collective bargaining agreements and which are paid for by his or her employer is added to his or her "reserve" each month. One **hundred twenty (120) units** are deducted each month he or she is eligible under the Plan. The maximum "reserve," regardless of an employee’s reserve before that date, is limited **to 480 units** after the current month's charge off. The Board of Trustees may from time to time adjust the number of units in a participant's reserve to reflect changes in the cost of providing coverage.

(4) **Disabled Employees.** The reserve of a covered contractual employee who is unable to perform his or her regular roofing duties because of disability will be credited with 120 units for each month of disability, provided that an employee will not be credited with more than 720 units under this provision (a) for any one disability, or (b) during any consecutive 18 month period beginning with the month in which 120 units were first credited under this provision. Whether a contractual employee is disabled will be determined by the Board of Trustees or its designated agent for this purpose, based on such medical certifications it deems necessary in its discretion.

(5) **Termination.** If a contractual employee's reserve should fall below 120 units at the end of any month, his or her eligibility will automatically terminate at the end of that month, subject to the self-payment rules of subparagraph (6) below.

(6) **Self-Payments.** If a contractual employee's reserve falls below 120 units, self-payments are allowed for a period of three (3) months provided payments are made by the 30th of the month for the month in which the coverage applies (except for the first month of self-payment, for which payment is due within 10 days after notice of termination of coverage is mailed by the Administrator's Office to the last known address of the contractual employee). Self-payment must begin for the first month immediately after reserve or disability coverage has ended. Self-payment will not be allowed if there has been any lapse in coverage. No self-payments are permitted if the contractual employee's reserve is frozen for working in non-covered roofing service as provided in Paragraph D on pages 6 and 7. The self-payment rates may be set and changed by the Board of Trustees from time to time. The self-payment rates depend on whether an employee has more than or less than 80 units in his reserve as follows:

- (a) If the contractual employee has 80 or more units in his or her reserve, to continue coverage the employee needs to pay only the difference between number of hours in his or her reserve and 120, multiplied by an hourly rate established from time to time by the Board of Trustees.
- (b) If the contractual employee has less than 80 units in his or her reserve, to continue coverage the employee needs to pay the full monthly self-payment rate established from time to time by the Board of Trustees.

(7) **COBRA.** Contractual employees are eligible for COBRA after their reserves are exhausted. Self-payment months are to be integrated with COBRA months (i.e., self-payment months subtracted from maximum period of COBRA coverage). See page 59 for a more complete explanation of your COBRA rights.

(8) **Reinstatement.** A contractual employee's coverage will be reinstated on the first day of the second calendar month after his or her reserve has again reached 120 units, provided either of the following conditions has been met:

- (a) He or she has been eligible for coverage under this Plan for at least one month out of the previous twelve months; or
- (b) He or she has been eligible for coverage under a significant medical plan maintained by a Qualified Employer (as defined in paragraph F(1) on page 7) for at least one month out of the previous twelve months. The other significant medical plan must provide benefits similar to benefits under this Plan as determined in the Trustees discretion.

(9) **Forfeiture.** Units in a contractual employee's reserve will be forfeited either before or after the contractual employee becomes eligible for benefits in accordance with the following rules:

(a) **If a contractual employee who has become eligible for Plan benefits is not eligible under the Plan for a period of twelve (12) consecutive months based on either (i) units credited for which contributions were required and paid for under the Plan; or (ii) units credited for periods of disability due and given under the Plan, then all units accrued more than twelve (12) months prior to the current month will be forfeited and will not thereafter be credited in determining whether the contractual employee is eligible for Plan benefits. Months of eligibility under the Plan's self-payment or COBRA provisions do not count as months of eligibility for purposes of the previous sentence. If units remain in the bank after such forfeiture, the contractual employee will become eligible again by meeting the monthly unit requirement. If no units remain in the bank after such forfeiture, the contractual employee must again meet the initial eligibility requirements of the Plan.**

(b) If, before a contractual employee has first become eligible for Plan benefits, at the end of any month the contractual employee has not yet accrued 480 units, then all units accrued more than twelve (12) months prior to that month will be forfeited and will not thereafter be credited in determining whether the contractual employee is eligible for Plan benefits.

(c) **If, while eligible under the Plan, a contractual employee with a reserve works as a non-contractual employee for an employer contributing to this Plan, then if his reserve is not used to provide coverage upon becoming a non-contractual employee, it will be frozen. If the reserve is frozen, the provisions of paragraph (a) will not apply so long as the non-contractual employees is continuously employed by a contributing employer to the Plan who participates in this Plan on behalf of non-contractual employees. If the contributing employer provides medical coverage for the non-contractual employee but not under this Plan, the non-contractual employee's reserve will be frozen only for a period of 60 days unless the employee notifies the Plan in writing that he is working for a contributing employer on a full-time basis. If the employee does not so notify the Plan, then upon the expiration of the 60 day freeze period, the provisions of paragraph (a) will apply even if the employee continues to work for the participating employer. The Board of Trustees may from time to time adjust the number of units in a reserve account to reflect the new contribution rates necessary to accrue units. An employee's frozen reserve will be used only in determining his eligibility immediately following the termination of his continuous full-time employment with a contributing employer or employers, and once the employee is no longer employed on a full-time basis by any contributing employer, the rules of paragraph (a) will be applied. A non-contractual employee with a frozen reserve who is not participating in this Plan must notify the Plan in writing when his full-time employment with all participating employers ceases, and if he fails to do so within 60 days, then his entire reserve will be forfeited.**

C. General Eligibility Rules for Non-Contractual Employees

Qualified Non-Contractual Employees (as defined In Paragraph F(3) on page 8) of Participating Employers (as defined in Paragraph F(4) on page 8) may be eligible for Plan benefits if they meet the following conditions:

(1) **Written Agreement**. Their employer must have signed a written agreement in a form satisfactory to the Board of Trustees setting forth the terms and conditions of their participation and providing rules for the termination of their eligibility.

(2) **Delinquent Employers.** In no event shall such non-contractual employees be eligible for benefits if their employer is delinquent in its contributions required on behalf of contractual employees. Furthermore, in no event shall such non-contractual employees be eligible for benefits if a premium has not been paid on their behalf in advance as required under Paragraph F(8)(b) on page 10.

(3) **Special Eligibility Rules for Non-Contractual Employees.** The following special rules apply to non-contractual employees:

(a) Non-contractual employees will lose their eligibility on their first day of work in non-covered roofing service (as hereafter defined in Paragraph D(1) on page 6 and 7). Any non-contractual employee whose coverage was so terminated will not again be eligible for coverage until the first day of the second calendar month after he or she completes 120 hours of employment for a Participating Employer in any calendar month following the month in which his or her non-covered roofing service occurred.

(b) Non-contractual employees do not accumulate reserves.

(c) The liquidated damages and interest provisions applicable to delinquency payments; the submission of and the examination and review of relevant information and records provisions; and any other appropriate provisions of the Plan's Trust Agreement shall apply to the Employer's subscription agreement for non-contractual employees.

(d) Non-contractual employees must complete and return such enrollment or other forms as the Plan may from time to time require.

(4) **Extended Eligibility Rules for Non-Contractual Employees.**

(a) Non-contractual employees are not allowed to self-pay after severance of employment by other than retirement, except as may be allowed under COBRA.

(b) A non-contractual employee who is unable to work an average of 30 hours per week due to disability may have his coverage continued by his Participating Employer paying the contribution required during the period of his disability, up to a maximum of six months during any consecutive 18 month period beginning with the first month in which the disability contribution was first paid under this provision. Whether a non-contractual employee is disabled will be determined by the Board of Trustees, or its designated agent for this purpose, based on such medical certification as it deems necessary. After a Participating Employer ceases to provide disability coverage to a Non-contractual employee under this provision, if eligible the Non-contractual employee may elect COBRA or retiree plan coverage.

D. Cancellations for Contractual and Non-Contractual Employees Due to Work in Non-Covered Roofing Service

(1) Definition. "Non-covered roofing service" is any kind of work either as a roofer or waterproofer or in the roofing and/or waterproofing industry in the United States or any of its territories whether as an employed or self-employed person and whether compensated or not unless either the person doing the work or the legal entity for which the work is performed has a collective bargaining agreement with a Participating union of the United Union of Roofers, Waterproofers and Allied Workers, AFL-CIO requiring health and welfare contributions on behalf of employees covered by the agreement. The only exceptions are:

(a) Work as an employee of a governmental agency (but not as an independent contractor or one of the independent contractor's employees) which agency has committed itself to compensate roofers at no less than the sum of the wage and fringe benefit rates required under current bargaining agreements of the Participating union of the United Union of Roofers, Waterproofers and Allied Workers, AFL-CIO with geographical jurisdiction over the area where the work is performed;
(b) Work as an employee of the United Union of Roofers, Waterproofers and Allied Workers, AFL-CIO, or any Participating union thereof;
(c) Work as an employee of Associated Roofing Contractors of the Bay Area Counties, Inc.;
(d) Work for a Participating Employer as defined in Paragraph F(4) on page 8; and
(e) Work after February 1, 1994, with an unorganized employer for a specified limited period of time, not to exceed 6 months, but which may be extended for a like period(s), pursuant to written authorization of the Union with jurisdiction over the area where the work was performed. A copy of any such written authorization must be filed in a timely fashion with the Plan, and this exception will apply only so long as the employee abides by the terms of the written authorization on file and leaves such work when the Union notifies him in writing to do so, at which time the Union must also notify the Plan. If the written authorization terminates for any other reason, the Union will also notify the Plan in a timely manner.

(2) Cancellation of Coverage. Notwithstanding the Plan's general rules, an employee who works in non-covered roofing service will be subject to the following special rules:

(a) No expenses incurred as a result of the non-covered roofing service will be covered by this Plan.
(b) Non-contractual employees will lose their eligibility on their first day of employment in non-covered roofing service as provided under the general eligibility rules for non-contractual employees in Paragraph C(3) (a) on page 5.
(c) The contractual employee's reserve will be frozen as of his first day of employment in non-covered roofing service, and will remain frozen until the first day of the second calendar month after he or she returns to work in covered employment and earns at least 110 units in covered employment in a single month, provided that contributions are actually received by the Plan for such work. While an employee's reserve is frozen, no benefits are payable with respect to any

expenses incurred by the employee or his or her dependents during that period coverage is frozen.

(d) If the contractual employee is disabled, so long as his or her reserve is frozen he or she will not be credited with any additional units.

(e) So long as a contractual employee's reserve is frozen, no self-payments are permitted on his or her behalf.

(f) **Working in non-covered roofing service will lead to loss of eligibility and non-payment of benefits.** If a COBRA contractual Participant works in non-covered roofing service, the Participant and his or her dependents will be eligible for benefits under the same rules that apply to active contractual employees who work in non-covered roofing service.

(g) **Working in non-covered roofing service will lead to loss of eligibility and nonpayment of benefits.** If a COBRA non-contractual Participant works in non-covered roofing service, the Participant and his or her dependents will be eligible for benefits under the same rules that apply to active non-contractual employees who work for non-covered roofing service.

E. Receipt of Contributions Required

If contributions are not received on an individual's behalf for a month in which he or she was employed in a position requiring contributions to this Plan, he or she will not receive credit for the units or other eligibility he or she earned until the contributions are received.

F. Special Participation Rules for Non-Contractual Employees

The following are the qualifications which must be met in order for contributing employers to participate in the Plan for employees other than those represented by Participating Unions.

(1) **A "Qualified Employer"**:

(a) Is a contractor who is covered under a current collective bargaining agreement in force with one or more Participating Unions.

(b) Has an established shop as defined in the collective bargaining agreement with one or more Participating Unions located in the geographical jurisdiction of a Participating Union.

(c) Is an Employer who is not delinquent in its payments to any of the trust funds to which contributions are required under its collective bargaining agreement with the Union. When a delinquent Employer pays its delinquent contributions in full within the calendar month following the month in which they were due, it will be reinstated as a Qualified Employer.

(2) **"Non-Contractual Employees"** are employees of a Qualified Employer other than:

(a) Employees covered by the Qualified Employer's collective bargaining agreement with one or more Participating Unions; or

(b) Employees covered by any other collective bargaining agreement requiring contributions to this or any other health plan.

(3) **“Qualified Non-Contractual Employees”** are Non-Contractual Employees who:

(a) Work an average of 30 hours per week or more; and
(b) Do not work in a craft represented by unions in the building trades industry; and
(c) Are consistently reported as employees by the Participating Employers to the appropriate taxing authorities, and are not treated as independent contractors.

(4) **“Participating Employers”** are Employers who elect to participate in the Plan if they are of the type described in subparagraph (a) below, meet the percentage requirements in subparagraph (b) below, and, if applicable, also meet the additional requirements of subparagraph (c) below.

(a) Types of Entities That May Participate:

(i) Roofing or waterproofing contractors who are Qualified Employers as defined in Paragraph F(1) on page 7;
(ii) Participating Unions;
(iii) Associated Roofing Contractors of the Bay Area Counties, Inc., and
(iv) Such other entities related to the roofing or waterproofing industry as the Board of Trustees may approve from time to time.

(b) Percentage Requirements: All of the types of employers listed in subparagraph (a) must meet the following requirements:

(i) To become a Participating Employer, an Employer must elect to participate in the Plan with respect to at least 80% of its Qualified Non-Contractual Employees. In determining this percentage, Non-Contractual Employees who have group health care coverage through their spouse’s employment may be excluded in the discretion of the Employer.
(ii) To remain a Participating Employer, the Employer must at all times cover at least 80% of its Qualified Non-Contractual Employees if the Employer has 5 or more Non-Contractual Employees. If an Employer has 4 or fewer Non-Contractual Employees, not less than 50% must be covered, assuming they are not already covered by their spouse.
(iii) If an Employer drops coverage for a Qualified Non-Contractual Employee, that employee will not thereafter be allowed to reenroll in the Plan while employed by the same Employer as a Non-Contractual Employee.

(c) Additional Requirements for Contractors: In addition to all other requirements, Qualified Employers described in F(4) (a) (i) above must also meet the following requirements:

(i) Initial enrollment by a Participating Employer for coverage of its Qualified Non-Contractual Employees may take place at any time following the date the Qualified Employer both signs or otherwise becomes covered by a collective bargaining agreement with one or more Participating Unions and has met the requirements of subparagraphs (b), (c) and (d) of Paragraph F(1) on page 7, but in no event can initial enrollment under this subparagraph (i) be made after

120 days following the date the Qualified Employer signs or otherwise becomes covered by its collective bargaining agreement with the Union and has met the requirements of subparagraphs (b), (c) and (d) of Paragraph F(1). Initially enrolled employers have up to three months to attain the 300-hour criteria set forth in Paragraph F(1)(c) on page 7, and must maintain 300 hours continuously thereafter. The effective date of coverage shall be the first date of the month following the date required enrollment materials are received by the Administrator's Office. Required enrollment materials include, but are not limited to the following:

- enrollment forms,
- subscription agreement, and
- necessary premium.

(ii) A Qualified Employer who has not elected to participate within the period specified in Paragraph F(4)(c)(i) above, will be eligible to participate at any succeeding open enrollment date of the plan.

(5) **New Participating Employers:** All Qualified Non-Contractual Employees of new Participating Employers for whom contributions have been received shall become covered on the effective date of enrollment provided the required aforementioned enrollment materials are received by the Administrator's Office.

(6) **Newly Hired or Newly Eligible Qualified Non-Contractual Employees of Participating Employers:** Newly hired or newly eligible Qualified Non-Contractual Employees of a Participating Employer shall be covered as follows:

(a) A newly hired or newly eligible Non-Contractual Employee may become covered under the Plan on or after the date he or she first becomes a Qualified Non-Contractual Employee subject to the following rules:

(i) Enrollment of the employee must occur no later than the first of the month following the 90th calendar day after he or she first became a Qualified Non-Contractual Employee pursuant to consistently applied rules set forth in the Participating Employer's subscription agreement.
(ii) Coverage may start during a month but a full month's premium must be paid for that month.
(iii) The Plan must have received an enrollment form and premium payments before coverage commences.

(b) If a Qualified Non-Contractual Employee is not covered by the Plan but has had continuous health care coverage under a spouse's group health plan described in Paragraph F(4)(b)(i) on page 8 above during the period his or her Employer was a Participating Employer, then if that Qualified Non-Contractual Employee no longer is covered under his or her spouse's group health care plan, the Qualified Non-Contractual Employee may become covered under this Plan upon payment of the necessary premium by the Participating Employer, including the receipt of required enrollment forms by the Administrator's Office, immediately or on the

first day of the month immediately following the termination of his or her other group health care coverage.

(c) Any Qualified Non-Contractual Employee for whom coverage is requested under the Plan beyond the periods specified in subparagraph (a) and (b) of this Paragraph F (6) may be covered only as of the Plan's next open enrollment date.

(7) **Open Enrollment:** The Plan's Board of Trustees in its sole discretion, may, from time to time have open enrollment periods during which Qualified Employers may become Participating Employers.

(8) **Premiums:**

(a) The premium rates for Qualified Non-Contractual Employees shall be the rates set from time to time by the Plan's Board of Trustees.

(b) Premiums are to be remitted for qualified Non-Contractual Employees in the month prior to the month of coverage along with the Employer's report and payment for its contractual employees covered under the Participating Union's collective bargaining agreements. (Example: Premiums for qualified Non-Contractual Employees should be listed on the January hours report which is paid in February and gives coverage for March.)

(c) Non-payment of the required premium for any Participating Qualified Non-Contractual Employee required to be covered under the Plan rules in accordance with paragraph F(4) on page 8 will constitute cancellation of coverage for <u>all</u> such Participating Qualified Non-Contractual Employees of the Employer as of the first day of the month for which the unpaid premium would have provided coverage.

(d) In no event will coverage be provided by the Plan for any Non-Contractual Employee for whom a premium has not been paid in advance.

(9) **Termination:**

(a) Coverage for Qualified Non-Contractual Employees under the Plan will terminate upon any violation of any part of the Employer's subscription agreement with the Plan.

(b) Coverage for Qualified Non-Contractual Employees will terminate if the provisions of either subparagraphs (b), (c) or (d) of paragraph F(1) on page 7 are not met.

(c) Coverage for Qualified Non-Contractual Employees will terminate at the end of the last month for which premiums have been paid, if not terminated earlier under the Plan rules.

(d) If a Participating Employer ceases to maintain a collective bargaining agreement with one or more participating unions, coverage for non-contractual employees shall continue only for a period of 30 days after such expiration or during a period that meaningful bargaining is taking place, but in no event shall eligibility continue beyond the fourth month after the expiration of the collective bargaining agreement(s), unless a new collective bargaining agreement with a Participating Union has been consummated by that time.

(e) An Employer's subscription agreement and participation may be terminated by the Plan's Board of Trustees upon no less than 30 days notice to the Employer in writing.

(10) **Self-pay, Reserve and Other Rules:**

(a) Non-Contractual Employees will lose their eligibility on their first day of work in non-covered roofing service (as defined in Paragraph D(1) on page 6). Any non-contractual employee whose coverage was so terminated will not again be eligible for coverage until the first day of the second calendar month after he or she completes 120 hours of employment for a Participating Employer in any calendar month following the month in which his or her non-covered roofing service occurred.
(b) Non-Contractual Employees are not allowed to self-pay after severance of employment by other than retirement except as may be allowed under COBRA.
(c) Non-Contractual Employees do not accumulate reserves.
(d) Non-Contractual employees who are disabled may have up to six months of coverage if it is paid for by their Contributing Employer as provided in Paragraph C(4)(b).
(e) The liquidated damages and interest provisions applicable to delinquency payments; the submission of and the examination and review of relevant information and records provisions; and any other appropriate provisions of the Plan's Trust Agreement shall apply to the Employer's subscription agreement for Non-Contractual Employees.
(f) Non-Contractual Employees must complete and return such enrollment or other forms as the Plan may from time to time require.

G. Survivorship Coverage for Dependents of Actives:

(1) Eligibility: Upon the death of an eligible Contractual or Non-Contractual covered employee, the surviving spouse and/or any dependent children may elect to continue major medical (including prescription drug), vision and life insurance coverage in amounts shown for dependents, upon payment of the required premium without interruption. The surviving spouse may elect either this coverage (which terminates on remarriage) or COBRA (which does not terminate on remarriage), but not both.

(2) **Survivorship Coverage Will Terminate at the Earliest of:**

(a) with respect to surviving spouses, the coverage for the surviving spouse will terminate when the surviving spouse remarries someone who does not participate in the plan (this does not terminate coverage for dependents) or becomes insured under or eligible to elect coverage under another group plan, or
(b) with respect to dependent children, the coverage for the dependent children will terminate:

(i) when the dependent child reaches the disqualifying age, at which time COBRA will be available for the child, or

(ii) when the dependent child becomes insured under or eligible to elect coverage under another group plan, or

(iii) when the dependent child is legally adopted by someone who is not covered by this Plan.

(3) **Required Premium:** To continue survivorship coverage the Trust's required premium for dependent coverage must be paid. Multiple dependents of a deceased Participant are charged one composite premium for all of their coverage. During the first 12 consecutive months of coverage, the Trust will pay 50% of the required premium. Each dependent for whom coverage is sought under this provision, must elect to be registered as a dependent and have his or her share of the premium paid on his or her behalf. Any dependent on whose behalf either coverage under this provision is not elected, or the required premium is not paid, shall not be eligible for benefits under the Plan.

(4) **Notice:** To be eligible for survivorship coverage, the Administrator's Office must be notified within sixty (60) days of the Participant's death. Upon notification of any Participant's death, the Administrator will provide notice of these survivorship provisions to the Participant's dependents and allow a reasonable amount of time, to be determined by the Board of Trustees, in which to make the required premium payments. All such payments must be retroactive to the date dependents' coverage ceased due to the death of the Participant and survivorship coverage begins.

H. Family Care Leave: If your employer grants you a Leave of Absence in accordance with the federal Family and Medical Leave Act of 1993 or the California Family Rights Act of 1991, your coverage may be continued, upon payment of any required premium, for a period of time set forth in those Acts. Contact the Administrator's Office for further details if you go on such a leave of absence.

I. Special Enrollment Periods: Notwithstanding any other provisions of the Plan:

(1) **Enrollment after Loss of Coverage:** A Non-Contractual Employee and his or her dependents who are eligible under the Plan but are not enrolled may enroll if each of the following conditions is met:

(a) The Non-Contractual Employee or dependent was covered under a group health plan or had health insurance at the time this Plan's coverage was previously offered.

(b) The Non-Contractual Employee's or dependent's other coverage was either (i) under a COBRA continuation provision and the coverage under such provision was exhausted; or (ii) not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of divorce, death, or termination of employment) or employer contributions toward such coverage were terminated.

(c) The Non-Contractual Employee requests such enrollment not later than 30 days after the date of the exhaustion or termination of coverage as described in (b) above.

(d) The foregoing provisions do not apply to Contractual Employees and their dependents because they are automatically enrolled if they are eligible.

(2) **New Dependents:** Dependents of Contractual Employees and Qualified Non-Contractual Employees are eligible for benefits and a person who becomes such a dependent through marriage, birth, or adoption or placement for adoption may be enrolled as a dependent within a period of 30 days from the date of marriage, birth, adoption or placement for adoption, and coverage shall be effective:

(a) in the case of marriage, as of the date of marriage;
(b) in the case of a dependent's birth, as of the date of birth;
(c) in the case of adoption or placement for adoption, the date of such adoption or placement.

J. Uniform Services Employment and Re-employment Rights Act of 1994 (USERRA): If as an active employee you enter the uniformed military service of the United States (as defined in USERRA), you and your Dependents may continue participation in the Plan under the following rules:

(1) Less than 31 Days. If you enter uniformed military service for a period of less than 31 days, (a) your unit bank reserve will be credited with 8 hours per day of uniformed military service, up to a maximum of 40 hours per week, if you are a contractual employee, or (b) if you are a non-contractual employee, you employer must pay the required contribution for this period coverage.

(2) 31 Days or More. If you enter uniformed military service for a period of 31 days or more, you will have the following two options if you are a contractual employee:

(a) You may elect to freeze your unit bank by notifying the Administrator's Office no later than 15 days after you entered uniformed military service of your election. When you return from uniformed military service, your coverage will commence as of the first day of the month after you notify the Administrator's office of your return, provided you have sufficient units in your reserve bank to provide such coverage.

(b) If you do not elect to freeze your unit bank as provided in subparagraph (a), you and your Dependent's coverage will be continued until your unit bank is exhausted, at which time you and your Dependents may continue coverage for the lesser of an additional 24 months or the period of your uniformed military service by making the required self-payments under the Plan's COBRA rules. If you do not elect to freeze your unit bank and it is exhausted while you are in uniformed military service, you and your Dependent's coverage will recommence after you are reemployed in covered service on the first day of the month following the month in which your unit bank is credited with the number of units to provide one month of coverage.

If you are a non-contractual employee in military service for a period of 31 days or more, you may continue coverage for you and your Dependents for the lesser of 24 months or the period of your uniformed military service by making the required self-payments under the Plan's COBRA. Eligible non-contractual employees may

again participate in the Plan on the first day of the month following reemployment after uniformed military service.

K. Qualified Medical Child Support Orders Under The Omnibus Budget Reconciliation Act Of 1993 (OBRA '93): On and after August 10, 1993, individuals required to be treated as dependents under ERISA Section 609 will be treated as dependents by the Plan. Such individuals include alternate recipients under a Qualified Medical Child Support Order and any child who has not attained the age of 18 who is placed with a participant for the purpose of adoption. A Medical Child Support Order is any judgment, decree or order which provides for child support with respect to a child of a participant which is issued by a court of competent jurisdiction and which provides for child support with respect to a child of a participant under the Plan for health benefit coverage to such a child and is made pursuant to a state domestic relations law and related to benefits under the Plan or enforces a law relating to medical child support described in Section 1908 of the Social Security Act. A proposed Medical Child Support Order must be provided in advance to the Fund Manager in order that the Trustees may determine whether or not the order is a qualified Medical Child Support Order. An order will be deemed qualified if it includes all information required under ERISA Section 609 and meets all requirements of ERISA Section 609. Additional information related to this subdivision is available from the Fund Manager and will be supplied upon request.

ELIGIBILITY RULES
Contractual and Non-Contractual Retirees

A. Eligibility for Contractual Retirees.

(1) **Retirement.** This retiree medical plan is designed to provide benefits to individuals who retire from the roofing industry and remain retired and their Eligible Dependents. A "contractual retiree" is any person who is eligible for and actually is receiving pension benefits from the Pacific Coast Roofers Pension Plan for work covered by a collective bargaining agreement or as an employee of the Union. Retirees' spouses are also eligible as dependents, but no person is eligible both as a retiree and a spouse.

(2) **Initial Eligibility.** To initially be eligible under this Plan a person must meet the following conditions:

- (a) The person must be a contractual employee (as defined above) or a contractual employee's spouse or a dependent child of a contractual employee.
- (b) The contractual employee must have used up his or her eligibility in the active plan.
- (c) The contractual employee must have been an eligible participant as a contractual employee in the active plan at any time during the 6 months immediately prior to being eligible for this retiree plan.
- (d) The contractual employee must have received at least 5 Vesting credits under the Pacific Coast Roofers Pension Plan during the five year period immediately prior to disability and/or retirement.
- (e) The contractual employee must pay a premium to the Plan in an amount as determined from time to time by the Plan's trustees.

(3) **Continued Eligibility.** Once a contractual retiree is eligible, the contractual retiree and the retiree's spouse and dependent children will continue to be eligible for any month when the retiree remains eligible to receive a pension from the Pacific Coast Roofers Pension Plan for work covered by a collective bargaining agreement or as an Retiree of the Union and pays any premium required by the Plan Trustees, subject to the loss of eligibility rules specified below.

(4) **Temporary Loss of Eligibility.** If a contractual retiree resumes work under a collective bargaining agreement of a local union of the United Union of Roofers, Waterproofers and Allied Workers, his or her eligibility and that of his or her dependents under this Plan will cease during the period he or she is eligible under the health and welfare plan of that local union. The retiree's and his or her dependents' eligibility under this Plan will be reinstated when his or her eligibility under that other roofers’ plan is exhausted, subject to the permanent loss of eligibility rules specified in Article C (6) below.

(5) **Special Rule for Valley Roofers Retirees.** Those retirees of the Valley Roofers Trust Fund who started receiving benefits under this retiree plan in 1997 will continue to be covered for the benefits they were receiving under the Valley Roofers Plan unless and until changed by the Trustees of this Plan.

B. Eligibility for Non-Contractual Retirees.

(1) Retirement. This retiree medical plan is designed to provide benefits to individuals who retire from the roofing industry and remain retired and their Eligible Dependents. A Non-Contractual retiree is any person (a) who is not gainfully employed for 40 or more hours per month, and (b) meets the Plan's eligibility rules for Non-Contractual retiree coverage.

(2) General Rule. Age (minimum of 55) plus years of participation in the active plan (minimum of 5) to equal at least 65. At least 5 years of participation in the active plan must be immediately prior to retirement, and a maximum of twelve (12) months of COBRA self-payment will be counted as participation in the active plan.

(3) Continued Eligibility. Once a Non-Contractual retiree is eligible, the Non-Contractual retiree and the retiree's spouse and eligible dependent children will continue to be eligible for any month when the retiree is retired, as defined in subparagraph (1), and pays the premium required by the Plan Trustees, subject to the permanent loss of eligibility rules specified in Article C (6) below.

C. General Rules Applicable to Contractual and Non-Contractual Retirees.

(1) **Coverage to Begin after Exhaustion of Active Coverage.** Coverage under this retiree medical plan is designed to take effect only after a person's eligibility under the active plan has been exhausted.

(2) **Application.** The retiree must apply for retiree coverage within 31 days of loss of active plan coverage, including any reserve, disability, self-pay and COBRA to which the retiree is entitled. The retiree premium must be paid retroactive to the loss of active coverage.

(3) **Choice.** Upon initial enrollment in the retiree plan, retirees will be given a onetime choice of the following coverages:

- (a) Full retiree plan benefits (including comprehensive major medical, prescription drugs for individuals not eligible for Medicare, supplemental accident, vision, life insurance and accidental death and dismemberment benefits):
- (b) Retiree comprehensive major medical, prescription drug for individuals not eligible for Medicare, and supplemental accident benefits only.

(4) **Special Enrollment Period.** A retiree who is eligible but not enrolled under the retiree medical plan may enroll if each of the following conditions is met:

- (a) The retiree was covered under a group health plan or had health insurance coverage at the time coverage was previously offered;
- (b) The retiree stated in writing that the reason for originally declining enrollment was that he or she had coverage under another group benefit plan or health insurance coverage;
- (c) The retiree's coverage described in (a) either was under COBRA which was exhausted, or the coverage was not under COBRA and terminated as a result of loss of eligibility or employer contributions toward such coverage were terminated; and
- (d) The retiree requests enrollment under this Plan not later than 30 days after the exhaustion of COBRA coverage or other termination of coverage described in (c).

D. Survivorship Rules for Retirees.

(1) **Eligibility.** Subject to the permanent loss of eligibility rules in paragraph E below, an eligible spouse and/or any eligible dependent children of a retiree shall remain eligible after the retiree's death upon payment of any required premium without interruption.

(2) **Termination.** Subject to the permanent loss of eligibility rules in paragraph E below, the dependents of a deceased retiree shall remain eligible under the retiree plan until the earliest of:

(a) when the eligible dependent child reaches the disqualifying age, at which time COBRA will be available for the child, or

(b) when the dependent child is legally adopted by someone who is not covered by the Plan, or

(c) when the surviving spouse remarries, except that a covered dependent child will be allowed to continue coverage until the earliest date when one of the events described in (a) or (b) above occurs with respect to that dependent child, or one of the events described in paragraph E below occurs.

(3) **Required Premium.** To continue survivorship coverage under the Retiree Plan, the Trust's required premium for dependent coverage must be paid. Multiple dependents of a deceased retiree are charged one composite premium for all of their coverage. No subsidies are currently provided by the Trust for this coverage. Each dependent for whom coverage is sought under this provision must elect to be registered as a dependent and have his or her share of the premium paid on his or her behalf. Any dependent on whose behalf either coverage under this provision is not elected, or the required premium is not paid, shall not be eligible for benefits under the Retiree Plan.

(4) **Notice.** Upon learning of the death of a retiree, the Plan will provide notice of these survivorship provisions to the participant's dependents and allow· a reasonable amount of time as determined by the Trustees, in which to make the required premium payments. All such payments must be retroactive to the date the dependents' coverage ceased due to the death of the retiree and survivorship coverage begins.

E. Permanent Loss of Eligibility. A retiree, his or her spouse and eligible dependent children will lose their eligibility permanently in the following situations:

(1) If a retiree works at all in non-covered roofing service, the retiree, his or her spouse and dependent children will permanently lose all eligibility. "Non-covered roofing service" is any kind of work either as a roofer or waterproofer or in the roofing and/or waterproofing industry in the United States or any of its territories whether as an employed or self-employed person and whether compensated or not unless either the person doing the work or the legal entity for which the work is performed has a collective bargaining agreement with a local union of the United Union of Roofers, Waterproofers and Allied Workers, AFL-CIO requiring health and welfare contributions on behalf of Retirees covered by the agreement. The only exceptions are:

(a) Work as an employee of a governmental agency (but not as an independent contractor or one of the independent contractor's employees) which agency has committed itself to compensate roofers at no less than the sum of the wage and

fringe benefit rates required under current bargaining agreements of the local union of the United Union of Roofers, Waterproofers and Allied Workers, AFL-CIO with geographical jurisdiction over the area where the work is performed;

(b) Work as an employee of the United Union of Roofers. Waterproofers and Allied Workers, AFL-CIO or any local union thereof; and

(c) Work as an employee of Associated Roofing Contractors of the Bay Area Counties. Inc.

(2) If a retiree (or a retiree's spouse or children after the retiree's death) becomes insured under or eligible to elect coverage under another group health and welfare plan (other than Medicare or a local roofers union health and welfare plan) the retiree, his or her spouse and all dependent children will permanently lose all eligibility.

(3) If a retiree or a retiree's spouse or dependent child who is required to pay a premium to the Plan fails to do so, the retiree, his or her spouse and all dependent children will permanently lose all eligibility.

F. **Provisions Subject to Modification or Termination.** All coverage under this retiree medical plan is subject to modification or termination by the Trustees, including, but not limited to, the right to reduce or eliminate benefits, require additional contributions from retirees, modify the Plan's eligibility provisions and to terminate the Plan entirely.

G. **Medicare Part B Required.** Retiree and spouse must take Part B of Medicare when they become eligible to qualify for Medicare.

H. **Premium Required.** The retiree is required to pay a premium to the Trust, as determined by the Plan's Trustees, which may be changed from time to time. These payments must begin the first month for which he or she will not be covered under the active Plan. Payments are due on the last day of the month prior to the month of coverage, and no coverage will be provided until the required premium has been received. Coverage must be continuous. and coverage will not be provided for any retiree who is more than 90 days delinquent in payment of the required premium without special action of the Board of Trustees.

I. **Kaiser Coverage.** Kaiser coverage is available to all retirees.

J. **Continued Eligibility of Spouse and Dependents.** Subject to the permanent loss of eligibility rules in paragraph E. above, if a retiree is enrolled in Medicare Parts A and B and elects coverage under another plan or program, and if the retiree's spouse or other dependents are not yet eligible for Medicare, then such spouse and dependents can continue to be covered by this Plan upon payment of any required premium without interruption.

K. **Local Area.** The Local Area attributable to a retiree will be the geographical area he or she was last reported as an active Retiree.

ELIGIBLE DEPENDENTS

For the purpose of this Plan, Eligible Dependents are defined as:

1. Your lawful spouse, or if you have no lawful spouse, your Registered Domestic Partner. For this purpose, Registered Domestic Partner shall mean any person who has registered a domestic partnership with a governmental body pursuant to state or local law authorizing such registration.

2. Your natural born children and other children defined as follows:

   (a) Adopted Children. Adopted children beginning on the date of placement for the purpose of adoption;
   (b) Stepchildren. Stepchildren (including children of spouses and Registered Domestic Partners) who are domiciled with the Participant in a parent-child relationship and are chiefly dependent upon the Participant for support and maintenance.
   (c) Guardianship. Other children who are (i) domiciled with the Participant in a regular parent-child relationship, (ii) are chiefly dependent upon the Participant for support and maintenance, and (iii) either the Participant or the spouse is the dependent's legal guardian.

Coverage for Children
Children, as defined above, of an eligible Employee or eligible Retiree are covered as dependents until the child's 26th birthday. Coverage terminates as of the last day of the month in which the child attains age 26.

If your spouse is also an eligible person for coverage under this Plan as an employee, your spouse shall be eligible both as an Employee and as a dependent. When both husband and wife are insured as Employees, their children are eligible as dependents of both. During the time anyone is eligible as an Employee, he or she cannot also be eligible as a dependent child.

If a person has dual coverage under the Plan because he or she is eligible as the dependent of two insured employees, the total amount of benefits payable by reason of such dual coverage shall in no event exceed the amount of the expense actually incurred for which benefits are provided for such person under the Plan.

Disabled Children
Unmarried dependent children, age 26 or over, of an eligible Employee or eligible retiree, who are incapable of self support because of physical or mental incapacity that commenced prior to reaching age 26 will not be terminated because of age. A physician's certificate as to such incapacity must be submitted within 6 months following the 26th birthday**.**

The coverage for the child may be continued for as long as:

1. The incapacity and dependency continues; and
2. The coverage remains in force for you.

Newborn or Adoptive Children
A child born to you or your dependent spouse or domestic partner will become covered as a dependent. The effective date of coverage for the child will be the date of birth or the date of placement for adoption.

Effective Date of Dependent Coverage
A person who is an eligible dependent of an Employee shall become eligible for benefits when the Employee becomes eligible for benefits or upon becoming an eligible dependent, if later, except that an otherwise eligible dependent who is Medicare-eligible shall be eligible only if he or she enrolls in Medicare Parts A and B.

When Dependent Coverage Ends
Except as provided herein for survivorship coverage (page 11) or COBRA continuation (page 67), a dependent's coverage ends when he or she is no longer a dependent or you are no longer eligible for benefits. In addition, a dependent's coverage will end at midnight on the earliest of:

1. The last day of the month the dependent is no longer eligible;
2. The day any dependent premium is due and unpaid; or
3. The day your coverage ends.

Continuation Coverage
After you or your dependents' eligibility terminates, you may be eligible for continuation coverage for a limited period of time. Please refer to page 67 for a description of this coverage.

GENERAL EXCLUSIONS APPLICABLE TO ALL HEALTH BENEFITS

With respect to the Plan's Medical and Vision Benefits, the following general exclusions apply, together with the specific limitations applicable to each of these benefits.

No coverage is provided for losses caused or expenses incurred by or resulting from the following:

1. Services, supplies or equipment for which a charge is not customarily made in the absence of insurance. This does not apply to covered expenses incurred at a charitable research Hospital.

2. Injury or Sickness (a) arising out of or in the course of any employment for wages or profit, or (b) which is covered by any Workers' Compensation or Occupational Disease policy or (c) which under applicable state law should have been covered by a Workers' Compensation or Occupational Disease policy, whether or not such a policy was in force, or (d) arising out of or in the course of performing work in the roofing industry as a licensed or unlicensed contractor, whether or not such work is performed for pay. If there are reasonable grounds for suspecting that coverage is not afforded to a person because of this exception, the burden of proof shall be upon the claimant to demonstrate by a preponderance of the evidence that this exception does not apply.

3. Declared or undeclared war or act of war.

4. Expenses which are not approved by a Physician.

5. Cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part, reconstructive surgery because of a congenital disease or anomaly of you or your dependent and initial reconstruction of a breast after a mastectomy.

6. For any treatment which is not a Necessary Treatment as defined on page 82 including treatments which are experimental in nature or not medically necessary. A drug, device or medical treatment or procedure is Experimental:

    a. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
    b. If reliable evidence shows that the drug, device or medical treatment or procedures is the subject of ongoing Phase I, II or III clinical trials or under study to determine its: Maximum tolerate dose, toxicity, safety or efficacy, as compared with the standard means of treatment or diagnosis.

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7. Intentionally self-inflicted injury or sickness, unless due to a medical condition or domestic violence.

8. Treatments for military service-connected conditions for which care or reimbursement is available from a government agency or program, other than Medicaid.

9. Treatments covered under other prepaid health programs, except for co-payments required of all prepaid plan members.

10. Any expenses which are in excess of the Usual and Customary Charge as defined on page 82.

11. Expenses for injuries incurred during the commission or attempted commission of any criminal act as defined by the State or Federal Government, involving, but not limited to the following:

    a. Involving the use of alcohol or illegal drugs, excluding minor traffic violations; or
    b. Involving violence or the threat of violence to another person; or
    c. In which the covered person uses a firearm, explosive or other weapon likely to cause physical harm or death.

    Should an individual accused of an aforementioned act(s) subsequently have the criminal charge dismissed or is acquitted of the charge in its entirety the exclusion above shall no longer be applicable to injuries resulting from the specific act. No additional rights are stated or implied under the Policy for such circumstances.

ELECTION OF COVERAGES

Medical and Prescription Drug Benefits Elections

Contractual & Non-Contractual Active Employees

At initial enrollment and at such other times as the Board of Trustees may determine, employees must elect between the following medical and prescription drug coverages:

- Self-funded Medical and Prescription (PPO)
- Kaiser (Deductible Plan), including its prescription drug benefits

Early Retirees not on Medicare

At initial enrollment and at such other times as the Board of Trustees may determine, early retirees not on Medicare must elect between the following medical and prescription drug coverages:

- Self-funded Medical and Prescription (PPO)
- Kaiser (Deductible Plan), including its prescription drug benefits

Retirees on Medicare

At initial enrollment and at such other times as the Board of Trustees may determine, retirees on Medicare must elect between the following medical and prescription drug coverages:

- Self-funded Medical Only (PPO); no prescription benefits
- Kaiser (Senior Advantage), including its prescription drug benefits.

Other Benefits

There are no optional elections at enrollment for alcohol and drug abuse or supplemental accident benefits. In addition, there are no optional elections for dental, vision, life insurance or accidental death and dismemberment benefits.

MEDICAL BENEFITS

The options currently offered to active Employees and to Retirees who are not eligible for Medicare are the self-funded Preferred Provider Organization Plan (or "PPO Plan") operated through Blue Cross and a health maintenance organization plan ("HMO"): Kaiser Foundation Health Plan. The options currently offered to Retirees who are eligible for Medicare are the self-funded PPO Plan (medical only – no prescription benefits) and the Kaiser Senior Advantage Plan. **The Board of Trustees has reserved the right to change the medical benefits options at any time; participants will be notified if this occurs.**

The self-funded Plan currently uses Blue Cross of California ("Blue Cross") as the Preferred Provider Organization. The list of preferred providers can be found online at www.anthem.com. This list changes frequently, so when you seek covered care, you should determine in advance with your doctor and hospital whether they are still part of the Blue Cross network. You may also check with Blue Cross.

If you elect coverage from Kaiser (an HMO) you and your eligible family members will receive your medical, hospital, and surgical care from that HMO. (All eligible family members are covered in the same option that you choose for yourself, if they become timely enrolled.) Kaiser members will receive their prescription drug and vision benefits from Kaiser, while self-funded Plan members receive their prescription drug benefits through Caremark, and their vision care benefits through Vision Service Plan (VSP).

SELF-FUNDED PPO MEDICAL PLAN

The Self-Funded PPO Medical Plan is available to:

- **Contractual & Non-Contractual Active Employees**
- **Early Retirees not on Medicare**
- **Retirees on Medicare** ***(no prescription benefits)***

Under the medical plan, certain hospitals, doctors, and laboratories have agreed to accept negotiated rates for services provided to participants and dependents insured under this Plan. To receive the maximum available benefits, use a member of the Blue Cross of California Preferred Provider Organization network for your covered services. Please check their website at www.anthem.com for a current listing of contracted members.

Although certain exceptions apply, you are generally required to pay a $300 individual deductible before the plan begins paying benefits. Once you have met your deductible, you will be required to pay a percentage for covered services. The chart below outlines the Health & Welfare Fund's benefit schedule for covered expenses. Retiree participants who are eligible for Medicare Part B must enroll in Medicare Part B.

Deductible	$300 per person per calendar year, limited to $600 per family, per calendar year.
Out of Pocket	PPO - $3,000 per person per calendar year, limited to $6,000 per family per calendar year. Non PPO - $15,000 per person per calendar year
Maximum	There is no lifetime maximum.
Hospital Benefits (Inpatient or Outpatient)	PPO – 90% of the contract rate. $1,000 in-patient only hospital admission charge. Non PPO – 70% of Usual and Customary Charges.
PPO	90% of the negotiated rate for the first **$30,000 per person** of covered charges per calendar year; 100% thereafter. After **$30,000** of PPO covered expenses in excess of the Deductible, in a calendar year, reimbursement is made at 100% of the contract rate during the remainder of the calendar year.
Non-PPO	70% of Usual and Customary Charges for the first **$50,000 per person** of covered charges per calendar year; 100% thereafter. After **$50,000** of Non-Preferred Provider covered expenses in excess of the Deductible in a calendar year, reimbursement is made at 100% of the Usual and Customary Charges during the remainder of the calendar year.

Physician	Office Visit - $30.00 co-pay for a preferred provider physician instead of a deductible. Does not apply towards deductible. This $30.00 co-pay does not apply to Retirees on Medicare Non PPO – 30% co-insurance of Usual and Customary charges. No $30.00 co-pay.
Preventative Care Benefits for Children	The first $250 is covered, then once your deductible has been met, services are covered at 90% for PPO and 70% for Non-PPO. Services includes examination, laboratory and inoculations. Limited to 19 periodic physical examinations at approximately each of the following intervals: Birth, 2, 4, 6, 9, 12, 15, 18 and 24 months, 3, 4, 5, 6, 8, 10, 12, 14, 16 and 18 years.
Immunization	Flu Shots and H1N1 Vaccinations – Covered under preventive care annually. Shingles Vaccination – Covered under Usual and Customary, 90% PPO and 70% out of network.
Physical Exam/ Preventative Care Benefits for Adults	The first $200 is covered, then once your deductible has been met, services are covered at 90% for PPO and 70% for Non-PPO as follows: Every 5 years up to age 35; every 2 years for ages 36 through 50; every year for ages 51 or over.
Chiropractic Benefit	PPO - 90% of the negotiated rate. Non-PPO – 70% of Usual and Customary charges.
Supplemental Accident	100% of Usual and Customary Charges up to $500 per injury (no deductible applied); regular benefit schedule applies thereafter.
Physical and Other Therapies	PPO – 90% of the negotiated rate. Non-PPO – 70% of Usual and Customary charges.
Laboratory	Routine Lab – $10.00 co-pay for a preferred provider lab. This does not apply towards the deductible. This $10.00 co-pay does not apply to retirees on Medicare. Non-PPO – 70% of Usual and Customary Charges.

Prescription Drugs ***(not available to Retirees and their dependents who are eligible for Medicare)***	Caremark Prescription Card – $15.00 generic and $30.00 for brand name on the Preferred Brand list for a 30-day supply. All other Brands $50.00. There is a $100.00 calendar year deductible for all Brand named prescriptions. Major Medical – 80% of Usual and Customary charges after deductible. Caremark Mail Order Plan - The same as the Caremark Prescription Card Plan except for a 90-day supply of maintenance medications. CRX International is a discount prescription drug plan and they ONLY supply Brand Name medications. **Medicare Exclusion** – No coverage is provided for prescription drug coverage for retirees and their dependents who are eligible for Medicare.
Skilled Nursing Facility	90% of charges incurred at a PPO skilled Nursing Facility and 70% at a non-PPO Skilled Nursing Facility. Confinement therein must start within 14 days of a Hospital stay. It must also be for continued treatment of the condition causing the hospital stay or any subsequent condition or complication related to the condition that caused the hospital stay or that arose as a result of the hospital stay.
Mental Health/ Substance Abuse	Inpatient – $1,000 Hospital Admission Charge. For PPO providers 90% of contract rate. For Non-PPO providers 70% of Usual and Customary Charges. Outpatient – Benefits are paid at 90% of contract rate for PPO providers. For Non-PPO providers 70% of Usual and Customary Charges. **Substance Abuse Only:** Beat It! Plan – First time use is paid at 100% of inpatient or outpatient services approved by Beat It! After your first time use, your medical plan benefits will apply.

MAJOR MEDICAL BENEFITS

If you or your dependents incur covered expenses which are in excess of the deductible, if any, during any calendar year, the Plan will pay the medical benefits as stated in the Schedule of Benefits.

Covered Expenses

Any expense will be considered a covered expense if it satisfies the following conditions:

1. Is Necessary Treatment (as defined on page 82) of a Sickness or Injury (as defined on page 81);
2. To the extent that it does not exceed Usual and Customary Charges (as defined on page 82);
3. Is received while covered for this benefit; and
4. Is covered under the Plan.

The following is a listing of covered expenses:

1. Hospital room and board (including intensive and cardiac care units);
2. Hospital extras such as recovery room and operating room charges, medications, anesthesia, etc.;
3. Charges made by a Physician;
4. Charges made for diagnostic testing;
5. Charges made for radiation and chemotherapy treatment;
6. Charges made for private duty nursing;
7. Charges made for prescription drugs from any licensed pharmacy or through the Plan's mail order prescription service (see pages 33-35 for complete details);
8. Charges made for rental (or if cheaper, purchase) of wheelchairs, Hospital type beds, oxygen and equipment for its administration, and mechanical equipment for the treatment of respiratory paralysis;
9. Charges for physical therapy;
10. Charge made for artificial limbs, eyes, casts, splints, crutches and braces (not including dental braces);
11. Charges for ambulance service will be paid as any other medical benefit;
12. Charges for blood and blood plasma except when replaced;
13. Charges incurred at a Skilled Nursing Facility as defined on page 81. Confinement therein must start within 14 days of a Hospital stay. It must also be for continued treatment of the condition causing the Hospital stay or any subsequent condition or complication related to the condition that caused the Hospital stay or that arose as a result of the Hospital stay;
14. Charges made by a licensed home health care agency for home health care services, subject to a maximum of 100 visits in 12 consecutive months. Each visit by an employee of a licensed home health care agency will be considered one home health care visit. A visit of more than 4 hours in a day will be considered as 2 visits. Multiple visits a day by one or more persons shall be considered as one visit if they total less than 4 person hours.

    Coverage includes:

    (a) Part-time or intermittent nursing care by or under the supervision of a registered nurse;

(b) Part-time or intermittent home health aide services which consist primarily of caring for the individual;

(c) Physical therapy provided by a home health care agency; and

(d) Medical supplies, drugs and medications prescribed by a Physician and laboratory services provided by or on behalf of a licensed home health care agency, but only to the extent that such charges would have been payable had the insured been confined in a Hospital;

15. Charges for routine mammographic examinations as diagnostic screening procedures, as specified:
    (a) A baseline mammogram for covered females age 35 through 39;
    (b) For covered females age 40 through 49 a mammogram every 2 years unless recommended more frequently by her attending Physician; and
    (c) For covered females age 50 or over a mammogram annually;
16. Charges for:
    (a) The cost of fitting of external breast prostheses (but not more than two in any calendar year for each breast); and inpatient or outpatient chemotherapy; after a mastectomy for which benefits are paid under this Plan.
    (b) Reconstruction of the breast on which the mastectomy was performed.
    (c) Surgery and reconstruction of the other breast to produce a symmetrical appearance; or prostheses and physical complications of all states of mastectomy, including lymphedemas;

    Definition: Mastectomy means the removal of all or part of the breast for medically necessary reasons.
17. Charges for a routine pap smear exam, but not to exceed one exam each calendar year; and
18. Charges for in vitro fertilization limited to the following conditions:
    (a) Physical certification of infertility exclusively attributed to bilateral tubal obstruction.
    (b) Compatible hormonal profile including, and not limited to, at least one functioning ovary.
    (c) A sufficient level of sound health to permit full-term delivery without unforeseeable complications.

ALCOHOL AND DRUG ABUSE BENEFITS

The Plan has three basic programs for treatment of alcohol or drug abuse, the Beat It! Program, the Self-Funded program, and the Kaiser program. In general, you and the Plan will save money if you use the Beat It! Program. Whichever program you use, pre-admission authorization is required before you receive any inpatient services.

Beat It!. Beat It! benefits include comprehensive inpatient and outpatient programs in a pre-approved facility or with a pre-approved therapist. Benefits are paid without any deductible for any Participant or beneficiary (including Kaiser members) as follows:

- First time use: 100% of inpatient or outpatient services approved by Beat It!
- After the first time use, the Self-Funded medical plan benefits will apply.

Beat It! approved inpatient treatment environments are flexible and are determined by the individual needs of the patient. Treatment through Beat It! is available through contracting facilities and include acute care Hospitals and residential treatment facilities. (These facilities may differ from those available under the self-funded Plan.) All inpatient programs include 21 to 28 days of primary care and 6 months to 1 year of aftercare for patients and family members.

Outpatient counselors are carefully selected according to their specific area of expertise and are matched appropriately with patients. Outpatient treatment plans include up to 40 hours of individual and family therapy. After 40 hours of outpatient treatment, outpatient benefits for alcohol and substance abuse are available through the Self-Funded plan as set forth below.

Remember: in order for substance abuse benefits to be payable, you MUST contact Beat It! prior to treatment. The telephone number for Beat It! is (408) 232-9885 or (800) 828-3939.

If you or a family member is admitted to a Hospital on an emergency basis, you MUST contact Beat It! the first business day following admission.

Kaiser Chemical Dependency Services. Kaiser offers a full range of care for chemically dependent individuals and their families, including adult treatment, adolescent treatment, co-dependency treatment, treatment for adult children of alcoholics, detoxification and education. Kaiser participants must obtain their prescriptions from Kaiser.

Self-Funded Program. The Self-Funded program includes substantial inpatient benefits and limited outpatient benefits.

Inpatient benefits for alcohol and drug abuse which are pre-authorized by Blue Cross are paid the same as inpatient benefits for other conditions after satisfaction of the Plan's deductible as follows:

- $1,000 Hospital Admission Charge
- 90% of contract rate at preferred provider.
- 70% of Usual and Customary Charges at non-preferred provider.

Inpatient benefits are those incurred in a Hospital or treatment center as a resident patient.

Outpatient benefits are those incurred while not confined as a resident patient in a Hospital or treatment center.

Outpatient benefits for alcohol or drug abuse do not require pre-authorization and, after satisfaction of the Plan's deductible, are paid at 90% of contract rate for PPO providers and at 70% of Usual and Customary Charges for Non-PPO providers.

If you plan to enter an alcohol or drug abuse treatment program and you are NOT using the Beat It! Program, you MUST get pre-admission authorization through Blue Cross. If you or a family member is admitted to a Hospital on an emergency basis, you must contact United Administrative Services the first business day following admission.

Lifetime Maximum

The Beat It! plan has no lifetime maximum. Kaiser members and Self Funded members do not have a lifetime maximum.

Common Accident

If two or more insured members of one family are injured in the same accident, only one deductible will be applied in the current and next succeeding calendar year against expenses arising from that accident, in order to satisfy the deductible.

Extension of Benefits

In the event coverage terminates while you or your dependents are receiving benefits under the Plan and if:

1. You or your dependents are totally disabled on the date of termination;
2. The expenses result from the same Injury or Sickness which caused the total disability;
3. The expenses are incurred within 12 months after coverage terminated; and
4. You or your dependents remain totally disabled as the result of the same Injury or Sickness;

then benefits for that Injury or Sickness will be paid on the same basis as if your coverage was still in force.

Limitations

No coverage is provided for losses caused or expenses incurred by or resulting from the following:

1. Dental care and treatment except that necessitated by injury and rendered within 6 months of the injury, and expenses incurred in connection with replacement of teeth caused by such injury or fracture of the jaw (see page 42 for dental benefits);
2. Eye examination for the purpose of prescribing corrective lenses or for the fitting of glasses (see page 42 for Kaiser vision and page 43 for VSP vision benefits);
3. Eyeglasses, hearing aids, or contact lenses except contact lenses when necessitated because of surgical procedures (see page 42 for Kaiser vision and page 43 for VSP vision benefits);
4. Charges made by a health care provider if related to you or your dependent or ordinarily residing with the person requiring treatment;
5. Any period of custodial care confinement in a Hospital or Skilled Nursing facility; or
6. Treatment to alter the insured person's physical characteristics to those of the opposite sex.

SELF-FUNDED (PPO) MEDICAL PLAN
PRESCRIPTION DRUG COVERAGE

Please note: Retirees and their dependents who are eligible for Medicare are NOT eligible for prescription drug coverage through this plan.

1. Prescriptions Filled at Your Participant Pharmacy through Caremark

An important part of your medical insurance program is the Caremark Retail prescription drug plan. Your prescription benefit is managed by Caremark. Under this plan, The Self Funded Medical Plan pays for a large part of the cost of medically necessary drugs and medicines. You and your dependents can buy the prescriptions you need to preserve your health.

You may fill your prescription at any of more than 50,000 pharmacies in the United States who transmit claim information via the Caremark Electronic System. Because of this technology, you will receive fast, accurate pharmacy service. Also, you will rarely need to submit a written claim form.

Getting stared is easy. Fill your prescriptions in three simple steps:

1. Select a pharmacy.
2. Present your benefit card to your pharmacist.
3. Pay your portion of the medication cost.

If you or your family member do not have the Caremark card when you go to the pharmacy, you may have the prescription filled if you give the pharmacy the carrier's name (CVS Caremark), group number (RX6644), RxBIN number (004336), RxPCN (ADV) the subscriber's social security number and the birth date of the family member the prescription is for. If there is any problem filling the prescription, you or the pharmacist can call the administrative office at (408) 288-4457 during business hours for immediate help.

Over 90% of all pharmacies are Caremark members. To find out if a certain pharmacy accepts your card, call the pharmacy directly or log on to www.caremark.com to find a nearby pharmacy. However, there may be a rare occasion when you might not utilize a member pharmacy. Under these circumstances, you will have to submit a claim form for reimbursement. These forms can be obtained from UAS at (408) 288-4457.

Your out-of-pocket cost at the retail pharmacy is $15.00 for a generic Drug, $30.00 for a Preferred Brand Drug and $50.00 for a Non Preferred Brand Drug for a 30 day supply. If a generic is available and you are prescribed a brand prescription, you will be required to pay the difference between the cost of the generic and the brand prescription. Your Participant pharmacy is a good choice for short term or one-time prescriptions.

2. **Mail Service Pharmacy – Caremark.com**

Members may save time and money by obtaining their prescription medication through the Mail Service Pharmacy. For the same co-payments as retail, you may obtain up to a 90-day supply of medication. The medication is mailed directly to your home. The Mail Service Pharmacy is designed mainly for maintenance type medication for treatment of chronic or long-term conditions such as diabetes, arthritis, heart conditions, and high blood pressure, but may be used for any prescription medication, including oral contraceptives.

The Mail Service Pharmacy is through Caremark.com, a home RX delivery from Caremark. Order envelopes which contain complete information about this service may be obtained from UAS at (408) 288-4457.

To get started with the Mail Service Pharmacy have you doctor write two prescriptions: one prescription for a short-term supply (e.g., 30 days) to be filled immediately at a participating retail pharmacy; and a second prescription for the maximum days' supply allowed (90 days) with as many as 3 refills (if appropriate) to mail to Caremark. Complete the mail service order form. Mail your order form, along with you original prescription, and payment, in the Caremark envelope. They accept VISA, MasterCard, Discover or American Express. You also can pay by check or money order.

Once you have sent in your doctor's prescription and the Mail Service order form, refills may be ordered over the telephone by calling 1-866-885-4944, or online at www.caremark.com.

Using the Mail Service Pharmacy not only saves you time and money, but also yields significant savings to your health benefit plan, due to the lower cost of prescriptions obtained through the Mail Service Pharmacy.

3. **Prescription Exclusions**

- Non-Prescription drugs, vitamins, minerals and nutritional supplements.
- Experimental substances and/or treatments not approved by the Food and Drug Administration, or investigative drugs or substances labeled "Caution – limited by Federal law to investigational use," even though a charge is made to the individual. Upon approval by the Food and Drug Administration they will be considered covered expenses from that time on.
- Non-legend or over the counter drugs other than insulin.
- Contraceptives, non-oral dosage forms.
- Therapeutic devices or appliances, support garments and other non-medicinal substances regardless of intended use.
- Hair growth stimulants.
- Prescriptions which are covered by workers' compensation laws, or other county, state or federal programs.
- Drugs dispensed or administered in an outpatient setting, including but not limited to outpatient hospital facilities and doctors' offices.
- Oxygen.
- Immunization agents, biological sera, blood or blood plasma.

- Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Any prescription refill in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order. Each prescription is limited to the amount normally prescribed by the physician but not to exceed a 34-day supply or 100-unit dose, whichever is greater.
- Drugs obtained outside the United States.
- Professional charges in connection with administering or injecting drugs.
- Devices, appliances and medical supplies.
- Medications for weight loss.
- Tretinoin topical (e.g., Retin A) for individuals 26 years of age or older.
- Anti-wrinkle agents.
- Cosmetic hair removal products.
- Infertility medications.
- Yohimbine.
- Prescription drugs provided to retirees and their dependents who are eligible for Medicare.

INTERNATIONAL PRESCRIPTION DRUG DISCOUNT PROGRAM

Please note: Retirees and their dependents who are eligible for Medicare are **NOT** eligible for prescription drug coverage through this plan.

CRX International is a discount prescription drug plan and is in addition to your Caremark prescription plan. As a safety measure, CRX only accept prescriptions that are **faxed directly from your doctor's office** and they ONLY supply **Brand Name medications,** dispensed in the **manufacturer's original sealed container**.

For more information call CRX toll free at 1-866-488-7874, Monday- Friday 5:30am- 3:30pm Pacific Time or Saturday 6am- 2:30pm Pacific Time. Website: www.crxintl.com.

COST CONTAINMENT MEASURES

Your Board of Trustees has implemented some very important cost containment measures in order to save YOU and YOUR TRUST FUND money. Their success depends upon you.

Preferred Hospital and Physician Program

Your Trust Fund has negotiated reduced rates for you and your Eligible Dependents at several Hospitals and with numerous Physicians through the Blue Cross of California Preferred Provider Organization (PPO). In obtaining treatment through a Blue Cross provider you will only have to pay 10% of the first $30,000.00 (up to $3,000) of covered expenses in excess of the deductible in a calendar year instead of 30% of the first $50,000.00 (up to $15,000) of covered expenses. Contact the Administrator's Office for a listing of the Blue Cross of California Network Hospitals and Physicians or go to the website at www.anthem.com.

Upon your first visit to a Blue Cross Physician, show the receptionist or billing clerk your Anthem Blue Cross identification card. The Physician will bill the Administrator's Office which will remit payment directly to the doctor based upon the Anthem Blue Cross allowances.

Remember that referral to any Physician or Hospital that is not an Anthem Blue Cross provider will be considered an out of network benefit (i.e., 70% of Usual and Customary Charges).

Precertification Review Program

Before you are hospitalized, you must have your Hospital admission certified through the Precertification Office at Blue Cross at (800) 274-7767. These instructions are on your identification card.

Second Surgical Opinion Program

Benefits will be paid for the actual, Usual and Customary Charges, including laboratory and x-ray examinations when you consult with a participating doctor for a second surgical opinion. The surgery for which the opinion is obtained must be of a non-emergency nature and be a covered expense under the policy.

If the second opinion does not confirm the need for the surgery, benefits are also payable for a third opinion. These charges are also reimbursed at 100% for the actual, Usual and Customary Charges.

Normal benefits will be paid under the Plan for covered expenses incurred for elective surgery, subject to the other terms and conditions of the Plan.

If you have any questions about the Cost Containment Measures or want a list of participating Hospitals, Physicians and laboratories, please contact the Administrator's Office at 6800 Santa Teresa Blvd Ste 100, San Jose, California 95119; telephone: (408) 288-4457.

DIABETIC SELF-MANAGEMENT EDUCATION BENEFIT

Notwithstanding any provisions to the contrary, the Plan shall provide coverage for diabetic self-management education programs subject to all applicable terms and conditions of the Plan including those pertaining to the deductible and coinsurance.

This coverage shall pertain only to programs directed and supervised by a licensed Physician who is Board certified in internal medicine or pediatrics, and shall not provide coverage for programs whose sole or primary purpose is weight reduction.

These programs must be provided by health care professionals including, but not limited to, Physicians, registered nurses, registered pharmacists and registered dietitians who are knowledgeable about the disease process of diabetes and the treatment of diabetic patients.

Coverage provided hereunder will be under the same terms and conditions, subject to all the foregoing, as coverage for any other Sickness provided under the Plan.

OPTIONAL HMO COVERAGE – KAISER

The Board of Trustees has made arrangements for members to elect hospital, medical and surgical coverage through a health maintenance organization ("HMO"), in place of the self-funded PPO Plan. The HMO option currently offered to active Employees and pre-Medicare retirees is the Kaiser Foundation Health Plan (“Kaiser”). For Medicare-eligible retirees, the option is the Kaiser Senior Advantage Plan. A separate booklet describing this program is available at no charge from the Trust Fund Office.

To elect coverage through Kaiser, you must complete a Plan election card and the enrollment packet of the HMO. You may elect HMO coverage when first eligible under the Plan or at the open enrollment period established by the Board of Trustees. Currently there is an annual open enrollment election period in July of each year, to be effective on September 1. If you do not actively enroll in an HMO, you will automatically be enrolled in the PPO Plan. Electing HMO coverage will have the following effects on the benefits you and your family receive:

1. If you elect hospital, medical and surgical coverage through Kaiser, neither you nor your dependent(s) is eligible for hospital, medical, or surgical benefits from the self-funded Plan.

2. To have your Eligible Dependents receive benefits from your HMO, you must enroll them when you enroll; or for a new dependent, you must enroll him or her within 30 days of the marriage, birth, adoption or other event which qualifies the person as an eligible dependent under the Plan. Failure to enroll a dependent in your HMO in a timely fashion may result in loss of coverage for that dependent until the next open enrollment date, unless late enrollment is accepted by the HMO.

3. If you elect Kaiser coverage, you will receive prescription drug, hearing aid and vision coverage only from Kaiser.

4. All Participants who elect coverage through an HMO remain eligible for life insurance and accidental death and dismemberment insurance.

The following Kaiser summaries are presented for your convenience only. Please refer to the Evidence of Coverage booklets for more details. Benefit amounts may change after these booklets are published.

KAISER DEDUCTIBLE HMO PLAN
BENEFIT SUMMARY

The Kaiser Deductible HMO Plan is available to:

- **Contractual & Non-Contractual Active Employees**
- **Early Retirees not on Medicare**

Plan Out-of-Pocket Maximum
For Services subject to the maximum, you will not pay any more Cost Share during a calendar year if the Copayments and Coinsurance you pay for those Services, plus all your payments toward the Plan Deductible, add up to one of the following amounts:

For self-only enrollment (a Family of one Member)	$3,000 per calendar year
For any one Member in a Family of two or more Members	$3,000 per calendar year
For an entire Family of two or more Members	$6,000 per calendar year

Plan Deductible
For Services subject to the Plan Deductible, you must pay Charges for Services you receive in a calendar year until you reach one of the following Plan Deductible amounts:

For self-only enrollment (a Family of one Member)	$1,000 per calendar year
For any one Member in a Family of two or more Members	$1,000 per calendar year
For an entire Family of two or more Members	$2,000 per calendar year

Professional Services (Plan Provider Office Visits)	**You Pay**
Most Primary Care Visits for evaluations and treatment	$30 per visit (Plan Deductible doesn't apply)
Most Specialty Care Visits for consultations, evaluations, and treatment	$30 per visit (Plan Deductible doesn't apply)
Routine physical maintenance exams, including well-woman exams	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Plan Deductible doesn't apply)
Family planning counseling and consultations	No charge (Plan Deductible doesn't apply)
Scheduled prenatal care exams	No charge (Plan Deductible doesn't apply)
Routine eye exams with a Plan Optometrist	No charge (Plan Deductible doesn't apply)
Hearing exams	No charge (Plan Deductible doesn't apply)
Urgent care consultations, exams, and treatment	$30 per visit (Plan Deductible doesn't apply)
Most physical, occupational, and speech therapy	$30 per visit (Plan Deductible doesn't apply)

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	20% Coinsurance after Plan Deductible
Allergy injections (including allergy serum)	No charge (Plan Deductible doesn't apply)
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter (Plan Ded. doesn't apply)
Preventive X-rays, screenings, and lab tests as described in the EOC	No charge (Plan Deductible doesn't apply)
MRI, most CT and PET scans	$50 per procedure (Plan Ded. doesn't apply)
Covered individual health education counseling	No charge (Plan Deductible doesn't apply)
Covered health education programs	No charge (Plan Deductible doesn't apply)

Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	20% Coinsurance after Plan Deductible

Emergency Health Coverage	**You Pay**
Emergency Department visits	20% Coinsurance after Plan Deductible

Ambulance Services	You Pay
Ambulance Services	$150 per trip (Plan Deductible doesn't apply)

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$10 for up to a 30-day supply (Plan Deductible doesn't apply)
Most generic refills through our mail-order service	$20 for up to a 100-day supply (Plan Deductible doesn't apply)
Most brand-name items at a Plan Pharmacy	$30 for up to a 30-day supply (Plan Deductible doesn't apply)
Most brand-name refills through our mail-order service	$60 for up to a 100-day supply (Plan Deductible doesn't apply)

Durable Medical Equipment (DME)	You Pay
DME items that are essential health benefits in accord with our DME formulary guidelines	20% Coinsurance (Plan Ded. doesn't apply)
DME items that are not essential health benefits in accord with our DME formulary guidelines	20% Coinsurance (Plan Ded. doesn't apply)

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	20% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	$30 per visit (Plan Deductible doesn't apply)
Group outpatient mental health treatment	$15 per visit (Plan Deductible doesn't apply)

Chemical Dependency Services	You Pay
Inpatient detoxification	20% Coinsurance after Plan Deductible
Individual outpatient chemical dependency evaluation and treatment	$30 per visit (Plan Deductible doesn't apply)
Group outpatient chemical dependency treatment	$5 per visit (Plan Deductible doesn't apply)

Home Health Services	You Pay
Home health care (up to 100 visits per calendar year)	No charge (Plan Deductible doesn't apply)

Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period)	20% Coinsurance (Plan Ded doesn't apply)
Prosthetic and orthotic devices	No charge (Plan Deductible doesn't apply)
All Services related to covered infertility treatment	50% Coinsurance (Plan Ded. doesn't apply)
Hospice care	No charge (Plan Deductible doesn't apply)

KAISER SENIOR ADVANTAGE HMO PLAN WITH PART D BENEFIT SUMMARY

The Kaiser Senior Advantage HMO Plan with Part D is available to:

- **Retirees on Medicare *(no prescription benefits)***

Annual Out-of-Pocket Maximum for Certain Services
For Services subject to the maximum, you will not pay any more Cost Share during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:
For self-only enrollment (a Family of one Member) .... $1,500 per calendar year
For any one Member in a Family of two or more Members .... $1,500 per calendar year
For an entire Family of two or more Members .... $3,000 per calendar year

Plan Deductible: None

Professional Services (Plan Provider Office Visits)	**You Pay**
Most primary care visits for evaluation and treatment	$20 per visit
Most and specialty care visits for consultations, evaluations, and treatment	$20 per visit
Annual wellness visit and the "Welcome to Medicare" preventative visit	No charge
Routine physical exams	No charge
Routine eye exams with a Plan Optometrist	$20 per visit
Hearing exams	$20 per visit
Urgent care consultations, exams, and treatment	$20 per visit
Physical, occupational, and speech therapy	$20 per visit

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$20 per procedure
Allergy injections (including allergy serum)	$3 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays, annual mammograms, and laboratory tests	No charge
Manual manipulation of the spine	$20 per visit

Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge

Emergency Health Coverage	**You Pay**
Emergency Department visits	$50 per visit

Ambulance Services	**You Pay**
Ambulance Services	No charge

Prescription Drug Coverage	**You Pay**
Most covered outpatient items in accord with our drug formulary guidelines	$10 for up to a 100-day supply

Durable Medical Equipment (DME)	**You Pay**
Covered durable medical equipment for home use	No charge

Mental Health Services	**You Pay**
Inpatient psychiatric care	No charge
Individual outpatient mental health evaluation and treatment	$20 per visit
Group outpatient mental health treatment	$10 per visit

Chemical Dependency Services	**You Pay**

Inpatient detoxification	No charge
Individual outpatient chemical dependency evaluation and treatment	$20 per visit
Group outpatient chemical dependency treatment	$5 per visit

Home Health Services	**You Pay**
Home health care (part-time, intermittent)	No charge

Other	**You Pay**
Eye glasses or contact lenses every 24 months	Amount in excess of $150 allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
External prosthetic and orthotic devices	No charge
Ostomy and urological supplies	No charge

DENTAL BENEFITS

The following dental benefits are available to participants:

Members of Local 40 and Local 95 have a dental plan through Delta Dental.

- Local 40- Journeymen Only
- Local 95- Journeymen and Apprentice Only

Eligibility for Contractual Employees.

Subject to the rules set forth below, each contractual employee working in employment covered by a collective bargaining agreement with Local 40 (Journeymen only are eligible) or Local 95 (Journeymen and Apprentices are eligible) and reported on the appropriate transmittal report is eligible for dental benefits with the Local for which the employee is a member.

A. **Initial Eligibility.** Dental benefits will begin on the first day of the second calendar month following the month for which the individual has accrued 120 hours. Hours are only accrued for which contributions are required and actually paid under a collective bargaining agreement.
B. **Reserve.** A special "reserve" is maintained for contractual employees and shall be separately calculated for the dental program as determined under paragraph B(3) on page 2 of this document .
C. **Failure to Maintain Reserve.** If a contractual employee's dental reserve falls below 120 hours, self-payments are allowed as described under paragraph B(6) on page 3 of this document. If no payment is received, eligibility will automatically terminate at the end of that month.

Eligibility for Non-Contractual Employees.

Non-contractual employees of participating employers in Local 40 and Local 95 may be eligible for the dental program.

Delta Dental of California
Group# 16014
Customer Service# 800-765-6003
www.deltadentalins.com

Call the Plan Administration Office for more information.

VISION BENEFITS

The Trustees of the Bay Area Roofers Health and Welfare Trust Fund have adopted a vision care benefits program through Vision Service Plan ("VSP") for eligible Participants and dependents who are not enrolled in the Kaiser Plan, which has its own vision coverage. VSP supplies brochures which may be obtained at the Trust Fund Office. Your VSP-participating optometrist can obtain eligibility and benefits information by phoning VSP directly and providing the Participant's name and Social Security Number. The VSP website can be found at www.vsp.com. The phone number is (800) 877-7195. A separate booklet, which has been provided to you, is available at the Plan Office with complete benefit coverage, limitations, and exclusions.

Vision Services Plan (VSP)
One Market Plaza, Suite 2625
Steuart Street Tower
San Francisco, CA 94105

Member Services:

(800) 877-7195; (800) 428-4833 (toll-free TTY for the hearing/speech impaired)
www.vsp.com

The Vision Service Plan (VSP) covers each eligible Participant and Dependent for a regular examination and lenses and frames when necessary for proper visual function or correction.

1. **To obtain services:** To obtain services of a Panel Doctor, an eligible Participant and/or Dependent is requested to contact a VSP participating doctor to make an appointment. Make sure you identify yourself as a VSP member; give your Social Security Number and the group name. The doctor's office will verify eligibility and benefits. If you need to locate a VSP participating doctor, call VSP at (800) 877-7195, or find one at www.vsp.com.

   VSP will pay the doctor directly. Except as otherwise provided in this section, you are responsible only for the applicable co-payment **and any additional costs for items only partially covered or not covered. No co-payment applies for contacts**.

   If you use a doctor from the VSP network, this assures direct payment to the doctor and guarantees quality and cost control; however, if you decide to use the services of a doctor who is not a VSP Panel Member, you should pay the doctor his or her fee. You will later be reimbursed by VSP in accordance with the VSP reimbursement schedule.

2. **Services and Materials:**

   a. **One Vision Examination per 12-month period.** The Plan provides for a comprehensive examination of your visual functions once every 12 months, including the prescription of corrective eyewear where indicated.

   b. **Lenses and Frames**. If the vision examination indicates that new lenses or frames or both are necessary for the proper visual health of a covered person, the Plan provides:

      (1) **Lenses**

Actives: available once each 12 months if a prescription change is warranted, Single vision, lined bifocal and lined trifocal lenses are covered.
Retirees: available once each 12 months if a prescription change is warranted, Single vision, lined bifocal and lined trifocal lenses are covered.

(2) **Frames**
Actives: available once each 12 months if replacement is necessary; frames of your choice are covered up to $120.00 plus 20% off any out-of-pocket expenses.
Retirees: available once each 24 months if replacement is necessary; frames of your choice are covered up to $120.00 plus 20% off any out-of-pocket cost if replacement is necessary.

3. **Contact Lenses Care:** When you choose contacts instead of glasses, your $120.00 allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of contacts. Current soft contact lens wearers may qualify for a special contact lens program that includes a contact lens evaluation and initial supply of replacement lenses. Learn more from your doctor or www.vsp.com.

4. **Your Co-Pay (subject to change): $15.00**

5. **Schedule of Benefits (VSP Provider)**

Exam	Covered up to VSP allowances every 12 months
Lenses	Covered up to VSP allowances every 12 months
Frames	Covered up to VSP allowances every 24 months
Contact Lenses (necessary)	Exam and materials covered every 24 months
Contact Lenses (elective)	Covered up to **$120** every 24 months; in lieu of lenses and frames

Schedule of Benefits (Non-VSP Provider)

Exam	Up to $45
Lenses:	
Single Vision	Up to $45
Bifocal	Up to $65
Trifocal	Up to $85
Lenticular	Up to $125
Frames	Up to $47
Contact Lenses (necessary)	Up to $210
Contact Lenses (elective)	Up to $105

These amounts may change at any time. Please call VSP for vision care request forms at (800) 877-7195 prior to visiting your provider or at www.vsp.com.

6. **Out-of-Network (Non-VSP)**: If you choose to receive vision care services and materials from a doctor who is not a panel member of VSP or from a dispensing optician, you will be reimbursed in accordance with the above schedule.

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

(Insured by Sun Life and Health Insurance Company)

The Plan provides death benefits for Employees and dependents, and accidental death and dismemberment benefits for Employees only.

To file a claim for death benefits or Accidental Death or Dismemberment Insurance, call the Trust Fund Office at (408) 288-4500.

"Employee" means:
For Active Full-Time Contractual and Non-Contractual Employees – Each active member of the Bay Area Roofers Health and Welfare Trust who is a U.S. Citizen or U.S. resident other than a temporary or seasonal employee
For all retirees, regardless of age – An employee whose employment with the employer has ended due to retirement

Date of Eligibility (Waiting Period):
Active Full-Time Contractual Employee – First day of the second calendar month following the month the employee has accrued 440 units in qualifying period
Active Full-Time Non-Contractual Employee – First of the month following 90 days from hire.
For Retired Employees, regardless of age– The policy effective date

EMPLOYEE LIFE AND AD&D INSURANCE

Classification of Employee	Amount of Life Insurance	Principal Sum of AD&D Insurance
All Active Full-Time Contractual Employees	$20,000	$20,000
All Active Full-Time Non-Contractual Employees	$20,000	$20,000
Retired Employees Under Age 65	$20,000	$20,000
Retired Employees Age 65 and Older	$6,000	$6,000

DEPENDENT LIFE INSURANCE (for all Employee Classifications)

Classification of Dependent	Amount of Dependent Life Insurance
Spouse	$3,000
Children:	
Birth but less than 6 months of age	$500
6 months of age and over	$3,000

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

A benefit will be paid while you are insured under the policy if you sustain bodily injuries:

1. That result directly from an accident and independently of all other causes;
2. That, within 365 days of the date of the accident, result in one of the losses listed below; and
3. That are not excluded in the "Restrictions" section below.

Loss	**Benefit**
Loss of life	The Principal Sum
Permanent loss of one hand by severance at or above the wrist joint	One-half the Principal Sum
Permanent loss of one foot by severance at or above the ankle joint	One-half the Principal Sum
The loss of the sight of one eye entirely, irrecoverably and uncorrectably	One-half the Principal Sum
Complete and permanent loss of movement of both upper and lower limbs	One-half the Principal Sum
Complete and permanent loss of movement of both lower limbs	One-half the Principal Sum
Complete and permanent loss of movement of both upper and lower limbs on the same side of the body (Hemiplegia)	One-quarter the Principal Sum
The loss of speech or hearing entirely, irrecoverably and uncorrectably	The Principal Sum
Two or more of the above losses in any one accident	The Principal Sum

Restrictions
The Plan provides that no benefits are payable for any loss that is caused, either directly or indirectly, or contributed to, by:
1. Physical or mental infirmity or disease.
2. Bacterial infection, unless the infection occurs simultaneously with and through an accidental cut or wound.
3. Suicide or an intentionally self-inflicted injury.
4. Participation in the commission of a felony.
5. War, declared or undeclared, or any act of war, or any resistance to armed invasion or aggression, or international police action with force of arms by any country or by the United Nations or any other assembly of nations.
6. Active participation in a riot.

Beneficiary
You may designate the beneficiary or beneficiaries of your choice. Such designation must be in writing and signed by you. It must be filed at the Trust Fund Office.

Unless you request otherwise, any benefit that becomes payable under the policy due to your death will be paid as follows:
1. Such benefit will be paid to the beneficiary or in equal shares to the beneficiaries living at your death. Payments will be made in accordance with the beneficiary designation you have most recently placed on file in the manner described above. Payments will be made in the following order of priority:

a) To your primary beneficiaries; or
b) To your contingent beneficiaries, if any, provided no primary beneficiary is living at your death.

2. If no named beneficiary survives you, or if you have not named a beneficiary, or if the beneficiary is disqualified from receiving such benefit, such benefit will be paid:
   a) To your surviving spouse; if none, then
   b) To your surviving children, in equal shares if more than one; if none, then
   c) To your parent or parents, in equal shares if both are living; if none, then
   d) To your executors or the administrators of your estate.

SUPPLEMENTAL ACCIDENT BENEFIT

If you or your dependent incurs Covered Expenses as listed below as the result of the Necessary Treatment of an Injury, the Plan will pay the amount of Covered Expenses incurred within a period of 90 days from the date of the Injury, but the Plan will not pay more than $500 per injury.

Covered Expenses

Covered Expenses with respect to this benefit consist of the following charges to the extent that they are Usual and Customary:

1. Hospital charges for daily board and bed or room and services.

2. Professional Participant ambulance service charges for transportation to a Hospital.

3. Charges made by a Physician for medical care and treatment for performing a surgical procedure.

4. Charges made by a Registered Nurse (R.N.).

5. Licensed practical nursing charges during Hospital confinement.

6. Charges made for the cost and administration of an anesthetic.

7. Charges made for x-ray examinations, microscopic tests, or any laboratory tests or analyses made for diagnosis or treatment purposes.

8. Charges made for treatments by a physiotherapist.

9. Charges made for the following supplies:

   (a) Drugs and medicines requiring the written prescription of a Physician and which must be dispensed by a licensed pharmacist.
   (b) Blood and blood plasma, except when replaced.
   (c) Artificial limbs or eyes (but not replacement thereof).
   (d) Casts, splints, trusses, crutches and braces (except dental braces).
   (e) Oxygen and rental of equipment for the administration of oxygen.
   (f) Rental of a wheel chair or Hospital bed.

10. Repair of sound, natural teeth, including replacement of such teeth.

HOW TO FILE A CLAIM

1. **Where to File a Claim**
   All Life and Medical claims should be sent to the Administrator's Office at:

   United Administrative Services
   6800 Santa Teresa Blvd Ste 100
   San Jose, California 95119
   Telephone (408) 288-4400

   Mailing address: PO Box 5057
   San Jose, California 95150

2. **When to File a Claim**
   You should file a claim as soon as you or one of your Eligible Dependents have incurred covered expenses for which the Plan provides benefits. You should not wait until the end of the year to submit your claim. **It is the member's responsibility to verify with their provider that the claim was filed on a timely basis.**

3. **Payment**
   Payment of the benefits to which you are entitled under the Plan will be paid directly to you unless you have assigned them to the doctor, Hospital or dentist, in which case you will be notified of the payments made by the Plan on your behalf so that you will know the amount paid toward your bills by the Plan and the balance, if any, due from you.

4. **Claim Forms**
   Obtain the proper claim form from the Administrator's Office, your Participating Union, or your employer and remember that a separate claim form must be submitted for each family member for whom a claim is being made.

   A. Medical Claims

      A signed claim form is necessary in order to make sure you receive the maximum benefits under the Plan. In order to help speed the processing of your claims, may we suggest you use the following procedure:

      a. Part 1 completed and signed by the Participant; if an accident, please give complete information as to date, time and place.
      b. The attending Physician must either complete the reverse side of Part 1 or attach his or her own form, or an itemized statement which contains an ICDA code.
         1. We do not need a claim form completed by the lab technologist, radiologist, or consulting Physician.
         2. Only one (1) claim is needed for an illness from an insured Person each calendar year.
         3. A new claim form is required for each accident.
         4. On all subsequent bills put your Participant Union, the name of the group (Bay Area Roofers Health and Welfare Plan) or the policy number (277070M001).

B. Vision Claims

If you go to a VSP participating doctor he or she will submit the claim to VSP. If services are received from a provider other than those in the listing, reimbursement will be made to the subscriber up to the schedule of allowances for like services and/or materials. Send a copy of the itemized bill(s) to VSP. The following information must also be included in your documentation:

- Member’s name and mailing address
- Member’s identification number (usually the social security number)
- Member’s group name (Bay Area Roofers Health and Welfare Plan)
- Patient’s name, relationship to member and date of birth

Please mail the itemized bill(s) and form to the following address:

Vision Service Plan
Attn: Out of Network Claims
P.O. Box 997100
Sacramento, CA 95899-7100

CLAIMS APPEAL PROCEDURE

I. General Rules

A. HMO Claims

(1) Plan Eligibility Rules. Issues regarding the Plan's eligibility for benefits rules will be decided in accordance with the eligibility rules of these claims procedures.

(2) Benefit Determinations. Issues regarding the benefits to be provided under an HMO contract will be decided in accordance with the claims procedures contained in that contract or adopted by the HMO.

B. Other Claims

(1) Plan Eligibility Rules. Issues regarding the Plan's eligibility for benefits rules will be decided in accordance with the eligibility rules of these claims procedures.

(2) Benefit Determinations. Issues regarding the benefits to be provided other than under an HMO contract will be decided in accordance with the benefit determination rules of these claims procedures.

II. Filing Initial Claim Forms

A. Initial Claims. Initial urgent care claims may be made orally. All other initial claims must be filed in written form or electronically using such forms or standards as the Plan may specify from time to time. If an urgent care claim or a pre-service claim does not contain all the necessary information, the Plan Administrator shall notify Claimant or the Claimant's authorized representative as soon as possible but not later than (1) 24 hours in the case of urgent care, or (2) 5 days in the case of pre-service claims. The Plan Administrator's notice of incomplete claims may be oral unless written notification is requested by the Claimant or the Claimant's authorized representative.

B. Written Urgent Care Claims. Any initial urgent care claim filed in written or electronic form should prominently designate on its cover that it is an urgent claim requiring immediate attention.

III. Time of Initial Claims Determinations

A. Urgent Care Claims.

(1) An urgent care claim is any claim for medical care or treatment with respect to which the time periods for making non-urgent care determination could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or in the opinion of a physician with knowledge of Claimant's medical condition would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(2) Any claim that a physician with knowledge of the Claimant's medical condition determines is an urgent care claim shall be treated as one provided that the Plan Administrator is notified of the physician's determination.

(3) If paragraph (2) above does not apply, whether a claim is an urgent care claim will be determined by the Plan Administrator or other entity to which the Joint Board has delegated this function applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(4) If an urgent care claim is incomplete, the Plan Administrator will notify the Claimant within 24 hours after receipt of the specific information necessary to complete the claim. The Claimant will be given at least 48 hours to provide the specified information.

(5) The Plan Administrator shall notify the Claimant of the Plan's initial determination as soon as possible, taking into account the medical urgency, but within the following time periods:

(a) If the claim was complete when filed, within 72 hours after receipt by the Plan

(b) If the claim was incomplete, within 48 hours after the earlier of the provision of specified information referred to in paragraph (4) or the end of the period afforded to the Claimant to provide such information.

B. Concurrent Care Decisions

(1) Concurrent care decisions can occur when the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments.

(2) Any decision by the Plan to reduce or terminate such a course of treatment before the end of such period of time or course of treatment must be given to the Claimant sufficiently in advance to allow the Claimant to appeal and obtain a decision on review before the benefit is reduced or terminated.

(3) Any request by a Claimant to extend the course of treatment that is a claim involving urgent care shall be decided as soon as possible, but within 24 hours, provided the claim is made to the Plan at least 24 hours prior to the expiration of the prescribed treatment.

C. Pre-Service Claims

(1) A pre-service claim is any claim for a benefit under the Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(2) The Plan Administrator or other entity to which the Joint Board has delegated this function shall notify the Claimant of the Plan's initial determination of a pre-service claim within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim.

(3) If the Plan Administrator or other entity to which the Joint Board has delegated this function determines that there is not sufficient information to determine the claim within the time limit in paragraph (2) and notifies the Claimant prior to the expiration of that time limit of the circumstances requiring an extension and the date by which a decision is expected to be rendered, then the time period for a decision can be extended for up to 15 days.

(4) If the extension described in paragraph (3) is necessary due to failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specify the required information and the Claimant will be given at least 45 days from receipt of the notice to provide the information.

(5) The time period limit in paragraph (2) may also be extended if Claimant voluntarily agrees to extension of the time period.

D. Post-Service Claims

(1) A post-service health care claim is any health care claim for a benefit under the Plan that is not a pre-service claim, a concurrent claim, or an urgent care claim.

(2) The Plan Administrator shall notify a Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim.

(3) If the Plan Administrator determines that there is not sufficient information to determine the claim within the time limit in paragraph (2) and notifies the Claimant prior to the expiration of that time limit of the circumstances requiring the extension and the date by which a decision is expected to be rendered, then the time period for a decision can be extended for up to 15 days.

(4) If the extension described in paragraph (3) is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specify the required information and the Claimant will be given 45 days from receipt of the notice to provide the information.

(5) The time period limit in paragraph (2) may also be extended if Claimant voluntarily agrees to extension of the time period.

E. Extension of Benefits For Disability Claims

(1) An extension of benefits for disability claim is any claim under the Plan for an extension of coverage due to total disability prior to the date coverage would otherwise terminate.

(2) The Plan Administrator shall notify a Claimant of any adverse benefit determination within a reasonable period of time but not later than 45 days after receipt of the claim.

(3) If the Plan Administrator determines that there is not sufficient information to determine the claim within the time limit in paragraph (2) and notifies the Claimant prior to the expiration of that time limit of the circumstances requiring the extension and the date by which a decision is expected to be rendered, then the time period for a decision can be extended for up to 30 days.

(4) If prior to the extension period referred to in (3) above, the Plan Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period may be extended for up to an additional 30 days provided the Plan Administrator notifies the Claimant prior to the expiration of the first extension the circumstances requiring the second extension and the date the Plan expects to render a decision.

(5) Any notice of extension with respect to an extension of benefits for disability claims shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and that the Claimant will be offered at least 45 days from receipt of the notice to provide the specific information.

F. New or Additional Rationale or Evidence. If the Plan bases an adverse benefit decision on new or additional rationale or evidence, Claimant must be provided:

(1) the new rationale or evidence as soon as possible, and

(2) reasonable opportunity to respond prior to the due date for the initial benefit decision.

G. Expiration of Time Periods. If a claim is not acted upon within the time periods prescribed by this Article III, the Claimant may proceed to the appeal procedure as if the claim were denied.

H. Right to Continued Coverage. If the Claimant initiates an internal appeal in compliance with the internal appeals process set forth herein and if the appeal concerns a previously approved ongoing course of treatments to be provided over a period of time or number of treatments, the Plan shall continue to provide such coverage pending the outcome of the internal appeal.

IV. Notification of Initial Internal Benefit Determination

A. Contents of Notification. The Plan's notification of an adverse benefit determination on an initial claim shall set forth, in a manner calculated to be understood by the Claimant, the following matters:

(1) The specific reason or reasons for the decision.

(2) Reference to the specific Plan provision on which the decision is based.

(3) A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary.

(4) A description of the Plan's review procedures and the time limits applicable to such procedures.

(5) If an internal rule, guideline, protocol or other similar criteria was relied upon, a statement that such document will be provided free of charge upon request.

(6) If the decision was based on medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's medical circumstances will be provided free of charge upon request.

(7) A statement of the Claimant's right to bring a court action under ERISA §502(a) following an adverse decision on review.

(8) For Plan years beginning on or after August 1, 2012, if ten-percent or more of the population residing in the county to which an adverse determination is being sent is

literate only in a non-English language (as determined in guidance published by the federal government) then the notice of adverse benefit determination must prominently state that the notice of adverse benefit determination will be provided upon request in that non-English language.

(9) For Plan years beginning on or after August 1, 2012, if ten-percent or more of the population residing in the county to which an adverse determination was sent is literate only in a non-English language (as determined in guidance published by the federal government) upon request, the Plan shall provide a notice of adverse benefit determination in that non-English language.

(10) For Plan years beginning on or after August 1, 2012, if ten-percent or more of the population residing in the county to which an adverse determination was sent is literate only in a non-English language (as determined in guidance published by the federal government) then the notice of adverse benefit determination must prominently state that any customer assistance services provided by the Plan will be provided in that non-English language.

(11) For Plan years beginning on or after January 1, 2012, if ten-percent or more of the population residing in the county to which an adverse determination was sent is literate only in a non-English language (as determined in guidance published by the federal government) then any customer assistance services provided by the Plan shall be provided in that non-English language.

(12) A statement of the Claimant's right in urgent care situations, or when Claimant is receiving an ongoing course of treatment, that Claimant shall be allowed to proceed with expedited external review at the same time as the internal appeals process if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the Claimant, or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal.

(13) A statement of the Claimant's right to bring a court action under ERISA §502(a) following an adverse decision on review.

B. Manner of Notification. The notification shall be in written or electronic form, except that the following special rules will apply to urgent care decisions:

(1) The information described in paragraph A may be provided to the Claimant orally within the time frame described in III-A, provided that written or electronic notification is furnished not later than 3 days thereafter.

(2) Any notification of an adverse determination concerning urgent care shall contain a description of the expedited review process available under V-B.

V. Internal Appeals of Initial Internal Adverse Benefit Determination

A. Claimant's Right to Internal Appeal. Any decisions affecting a Claimant's benefits under the Plan may be internally appealed under these claims procedures, including:

(1) A denial, reduction or termination of any Plan benefit.

(2) A failure to provide or make payment in whole or in part for any Plan benefit.

(3) A refusal to provide a Plan benefit based on a determination that the Claimant is not eligible under the terms of the Plan.

(4) A denial, reduction or termination of or failure to provide or make payment for a benefit resulting from the application of any utilization review.

(5) A failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

B. Named Fiduciary For Appeals. The named fiduciary for appeals under the initial appeal of adverse benefit determinations shall be the Plan's Joint Board of Trustees or Sub-Committee/Delinquency Committee depending on which body first meets after the appeal is filed

C. Generally. During the internal appeal of an initial internal adverse benefit determination, Claimants shall be provided:

(1) an opportunity to present evidence and written testimony or oral testimony if the named fiduciary for appeals chooses;

(2) reasonable access to and copies of all documents, records and other information that is relevant to the claim for benefits; and

(3) any new or additional rationale or evidence that the Plan used as a basis for an adverse benefit determination on appeal, as well as a reasonable opportunity to respond prior to the due date to appeal the benefit claims determination.

D. Pre-Service Urgent Care Claims. All adverse determinations of initial internal benefit claims for urgent care may be appealed by Claimants pursuant to the same rules or pre-service and post-service claims set forth below in Article V, Section D or under the following expedited procedures:

(1) A request for an expedited appeal of a denied urgent care claim may be made orally or in writing by the Claimant or his authorized representative. A written appeal should prominently designate on the cover that it is an urgent care claim requiring immediate attention.

(2) All necessary information, including the Plan's determination on review, shall be transmitted between the Plan and the Claimant by telephone, facsimile, e-mail or other available similarly expeditious method.

E. Pre-Service and Post-Service Claims. All adverse decisions of initial claims for both pre-service and post-service claims may be appealed by Claimants pursuant to the following rules:

(1) Claimants must file an appeal in writing within 180 days following receipt of a notice of an internal adverse benefit determination by the Plan.

(2) Claimants may submit written comments, documents, records or other information relating to the claim.

(3) Upon written request, Claimant will be provided, free of charge, reasonable access to and copies of any documents, records and other information if they (a) were relied upon in making the initial determination, (b) were submitted, considered or generated in the course of making the internal adverse benefit determination even if not relied upon, (c) demonstrate that the Plan provisions have been followed and applied consistently with respect to similarly situated individuals, or (d) constitute a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, whether or not relied upon.

(4) The appeal will take into account all comments, documents, records, and other information submitted by Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial determination.

(5) The appeal will not afford deference to the initial determination.

(6) The appeal will not be conducted by a person who is either the individual who made the initial adverse determination, or the subordinate of such individual.

(7) In deciding an appeal based in whole or in part on a medical judgment, the named fiduciary for appeals shall consult with a health care professional who has appropriate training and experience in the field of medicine involved, which individual shall not be either an individual consulted in connection with the initial adverse determination or the subordinate of any such person.

(8) Upon request, the named fiduciary for appeals will identify the medical or vocational experts whose advice was obtained in connection with the initial determination, whether or not it was relied upon.

(9) The Claimant shall have no right to personally appear before the named fiduciary for appeals unless the named fiduciary for appeals in its sole discretion concludes that such an appearance would be of value in enabling it to review the adverse initial determination.

F. Concurrent Care Claims. All adverse decisions of initial claims for concurrent care claims may be appealed by Claimants pursuant to the following rules:

(1) Claimants must file an appeal in writing within 30 days following receipt of notice of an internal adverse benefit determination by the Plan.

(2) Claimants may submit written comments, documents, records or other information relating to the claim.

(3) Upon written request, Claimant will be provided, free of charge, reasonable access to and copies of any documents, records and other information if they (a) were relied upon in making the initial determination, (b) were submitted, considered or generated in the course of making the internal adverse benefit determination even if not relied upon, (c) demonstrate that the Plan provisions have been followed and applied consistently with respect to similarly situated individuals, or (d) constitute a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, whether or not relied upon.

(4) The appeal will take into account all comments, documents, records, and other information submitted by Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial determination.

(5) The appeal will not afford deference to the initial determination.

(6) The appeal will not be conducted by a person who is either the individual who made the initial adverse determination, or the subordinate of such individual.

(7) In deciding an appeal based in whole or in part on a medical judgment, the named fiduciary for appeals shall consult with a health care professional who has appropriate training and experience in the field of medicine involved, which individual shall not be either an individual consulted in connection with the initial adverse determination or the subordinate of any such person.

(8) Upon request, the named fiduciary for appeals will identify the medical or vocational experts whose advice was obtained in connection with the initial determination, whether or not it was relied upon.

(9) The Claimant shall have no right to personally appear before the named fiduciary for appeals unless the named fiduciary for appeals in its sole discretion concludes that such an appearance would be of value in enabling it to review the adverse initial determination.

VI. Time of Internal Claims Appeal Determinations

A. Urgent Care and Concurrent Care Claims. The named fiduciary for appeals shall notify the Claimant of the decision on review as soon as possible taking into account the medical condition of Claimant, but not later than 72 hours after receipt of Claimant's appeal showing that it is an urgent care appeal.

B. Pre-Service Claims. The named fiduciary for appeals shall notify the Claimant of the decision on review within a reasonable period of time applicable to the medical circumstances, but not later than 30 days after receipt of Claimant's appeal.

C. Post-Service Claims.

(1) In general, the named fiduciary for appeals shall decide appeals at the next regularly scheduled meeting. However, if the appeal is received within 30 days preceding the date of such meeting, the appeal maybe decided by no later than the date of the second meeting following receipt of the appeal.

(2) If special circumstances require a further extension, the appeal will be decided not later than the third meeting following receipt of the appeal. Before the start of the extension the Plan Administrator shall notify the Claimant in writing of the extension describing the special circumstances and the date as of which the benefit determination will be made.

(3) The Plan Administrator shall notify the Claimant of the decision of the named fiduciary for appeals as soon as possible, but not later than 5 days after the appeal is decided.

D. Concurrent Care Claims. The named fiduciary for appeals shall notify the Claimant of the decision on review according to the following time periods:

(1) if the concurrent care claim concerns a reduction or termination of an initially approved course of treatment, before the proposed reduction or termination takes place; or

(2) for all other claims to extend a concurrent care treatment, the decision must be made in the time periods

(a) for urgent care appeals the notification period is based on the current urgency of the claim;

(b) for non-urgent pre-service and post-service concurrent appeals the time periods set forth under each standard.

E. Extension of Benefits For Disability Claims. Extension of benefits for disability claims appeals will be decided the same as post-service claims as provided in paragraph C.

VII. Notification of Appeals Decisions

A. Manner of Notification. Except in the case of urgent care decisions which may be made orally, decisions on appeals will be communicated to Claimants by written or electronic notification.

B. Contents of Notification. Adverse benefit determinations on appeal shall set forth in a manner calculated to be understood by the Claimant the following information:

(1) The specific reason or reasons for the decision.

(2) Reference to the specific Plan provisions on which the appeal is based.

(3) A statement that the Claimant is entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the Claimant's claim.

(4) If an internal rule, guideline, protocol or other similar criteria was relied upon in deciding the appeal, a statement that such document will be provided free of charge upon request.

(5) If the appeal is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claimant's medical circumstances will be provided free of charge upon request.

(6) For Plan years beginning on or after January 1, 2012, a statement describing the availability, upon request, for any diagnosis code(s) (such as an ICD code or DSM-IV code) and the treatment code(s) (such as a CPT code), and the corresponding meaning of such codes. A request for the diagnosis and treatment code information, in itself, shall not to be considered to be a request for an external appeal.

(7) For Plan years beginning on or after August 1, 2012, if ten-percent or more of the population residing in the county to which an adverse determination is being sent is literate only in a non-English language (as determined in guidance published by the federal government) then the notice of adverse benefit determination must prominently state that the notice of adverse benefit determination will be provided upon request in that non-English language.

(8) For Plan years beginning on or after August 1, 2012, if ten-percent or more of the population residing in the county to which an adverse determination was sent is

literate only in a non-English language (as determined in guidance published by the federal government) upon request, the Plan shall provide a notice of adverse benefit determination in that non-English language.

(9) For Plan years beginning on or after August 1, 2012, if ten-percent or more of the population residing in the county to which an adverse determination was sent is literate only in a non-English language (as determined in guidance published by the federal government) then the notice of adverse benefit determination must prominently state that any customer assistance services provided by the Plan will be provided in that non-English language.

(10) For Plan years beginning on or after August 1, 2012, if ten-percent or more of the population residing in the county to which an adverse determination was sent is literate only in a non-English language (as determined in guidance published by the federal government) then any customer assistance services provided by the Plan shall be provided in that non-English language.

(11) A statement of the Claimant's right to external review if the final adverse benefit determination involves either medical judgment or rescission of coverage.

(12) A statement of the Claimant's right in urgent care situations, or when Claimant is receiving an ongoing course of treatment, that Claimant shall be allowed to proceed with expedited external review if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or healthcare service for which the Claimant received emergency services, but has not been discharged from a facility.

(13) A statement of the Claimant's right to bring a court action under ERISA §502(a) after exhaustion of external review if external review is available.

VIII. External Review of Final Adverse Internal Appeals Decisions

A. Claimant's Right to External Review. Following issuance of a final adverse internal appeal decision, Claimant may request an external review by an Independent Review Organization (IRO) of the adverse internal appeal decision that involves either:

(1) medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and

(2) a rescission of coverage, whether or not the rescission has any effect on any particular benefit at that time.

B. Contract with Independent Review Organizations ("IRO") To Perform External Review. The Plan shall either:

(1) contract with at least two Independent Review Organizations ("IRO") by January 1, 2012 to perform external review services and contract with at least three IROs by July 1, 2012 to perform external review services; or

(2) contract with a third party administrator who contracts with at least two IROs by January 1, 2012 to perform external review services and contract with at least three IROs by July 1, 2012 to perform external review services, but only if the Plan Sponsor monitors the review process in order to confirm compliance.

C. General Rules for Requesting External Review. Claimants may request external review of final internal adverse benefit determinations, other than requests for expedited external review, pursuant to the following rules:

(1) Claimants must file a request for external review in writing within 4 months after receipt of adverse internal appeals decision.

(2) Claimant may supplement an incomplete request for external review at any time during the 4 month filing period, or, if expired, within 48 hours following receipt of the preliminary review determination notice.

(3) Claimants may submit written comments, documents, records or other information relating to the claim.

(4) The Plan Administrator shall, within 5 business days following receipt of external review request, make a preliminary review determination. The preliminary review shall determine whether:

(a) the Claimant has exhausted the Plan's internal appeals process;

(b) the benefit denial relates to the Claimant's failure to meet the Plan's eligibility requirements;

(c) the Claimant is or was covered under the Plan at the time the initial claim for health care was requested;

(d) the Claimant has provided all information and forms to process the external review.

(5) The preliminary review by the Plan Administrator shall take into account all comments, documents, records, and other information submitted by Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial determination or internal appeal.

(6) The Plan Administrator shall notify Claimant of preliminary review determinations (see "Time of External Review Determinations" below).

(7) The Plan Administrator shall as soon as practicable refer, on a rotating basis, a proper request for external review to one of the IROs with whom the Plan or the Third Party Administrator has contracted to perform external review services.

(8) The Plan Administrator shall provide IRO with all documents and information considered in making the benefit denial within 5 business days after the assignment date.

(9) The Plan Administrator shall monitor to assure that IRO notifies Claimant of:

(a) IRO's acceptance of claim for review, and

(b) Claimant's right to submit additional information to IRO within 10 days from receipt of notice.

(10) The Plan Administrator shall require that an IRO provide the Plan Administrator any information received from Claimant within 1 business day of receipt.

(11) The Plan Administrator may reconsider its initial adverse benefit claim decision or the fiduciary for appeals may reconsider its final adverse decision after receiving the additional information referred to in paragraph (10). If either, upon reconsideration, decides to reverse its adverse benefit claim decision, the Plan Administrator will provide written notice to Claimant and IRO within 1 business day of reconsideration, at which time IRO shall terminate the external review process.

(12) If, upon reconsideration, an adverse determination is not reversed, the Plan Administrator IRO shall issue a decision to the Claimant and Plan (see "Time of External Claims Appeal Determinations" below).

(13) The IRO's decision is binding on the Plan and Claimant, except to the extent that other remedies are available under State or Federal law.

D. <u>Expedited External Review</u>. Claimants may request an expedited external review of an adverse internal appeals decision pursuant to the following rules if:

- The expedited urgent care internal appeal timeframe would seriously jeopardize the Claimant's life or health or ability to regain maximum function and the Claimant has filed an expedited internal appeal; or
- The request for external review concerns an adverse decision of internal appeals involving:

  - ➢ A Claimant's medical condition where the standard external review timeframe would seriously jeopardize the Claimant's life or health or ability to regain maximum function; or

  - ➢ An admission, availability of care, continued stay, or health care item or service for which Claimant received emergency services, but has not yet been discharged.

The following expedited procedures will apply to expedited external reviews:

(1) Claimants must file a request for expedited external review in writing with the Plan Administrator.

(2) Claimants may submit written comments, documents, records or other information relating to the claim.

(3) The Plan Administrator shall immediately, upon receipt of expedited external review request, make a preliminary review determination. The preliminary review shall determine whether:

(a) the Claimant has exhausted the Plan's internal appeals process, if applicable;

(b) the benefit denial relates to the Claimant's failure to meet the Plan's eligibility requirements;

(c) the Claimant is or was covered under the Plan at the time the initial claim for health care was requested;

(d) the Claimant has provided all information and forms to process the external review.

(4) The preliminary review by the Plan Administrator shall take into account all comments, documents, records, and other information submitted by Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial determination or internal appeal.

(5) The Plan Administrator shall notify Claimant of preliminary review determinations (see "Time of External Review Determinations" below).

(6) The Plan Administrator shall immediately after completing its preliminary review and concluding that external review if appropriate refer, on a rotating basis, the request for external review to one of the Independent Review Organizations ("IRO") with whom the Plan or the Third Party Administrator has contracted.

(7) IRO shall issue a decision to the Claimant and Plan (see "Time of External Review Determinations" below).

(8) The IRO's decision is binding on the Plan and Claimant, except to the extent that other remedies are available under State or Federal law.

IX. Time of External Review Determinations

A. Preliminary Review Determination.

(1) Standard External Review. The Plan Administrator shall notify the Claimant of preliminary review determination within 1 business day of completion of preliminary review.

(2) Expedited External Review. The Plan Administrator shall immediately notify the Claimant of preliminary review determination.

B. IRO External Review Determinations.

(1) Standard External Review. The IRO shall notify the Claimant and Plan of the external review determination within 45 days of receipt of external review request.

(2) Expedited External Review. The IRO shall notify the Claimant and Plan of the external review determination as expeditiously as Claimant's medical condition or circumstances require, but no later than 72 hours following receipt of expedited external review request. The initial notice of decision on an expedited external review may be provided orally but written notice must be furnished no later than 48 hours after the oral notice.

X. Notification of External Review Determinations

A. Manner of Notification. Except in the case of urgent care decisions, which initially may be made orally, decisions on external review will be communicated to the Claimant and Plan by written or electronic notification.

B. Contents of Notification. External review determinations shall set forth in a manner calculated to be understood by the Claimant the following information:

(1) A general description of the reason for external review request, including:

- date(s) of service,
- provider,
- claim amount (if applicable),
- diagnosis and treatment codes (and meanings), and
- reason for prior denial;

(2) Date IRO received referral of request for external review;

(3) Date of IRO decision;

(4) References to evidence and documentation considered in reaching the decision, including specific coverage provisions and evidenced-based standards;

(5) Discussion of principal reason(s) for IRO's decision;

(6) Statement that the IRO's determination is binding, unless other remedies are available;

(7) Statement that judicial review may be available to Claimant;

(8) Contact information, including address and telephone number, for the applicable offices of health insurance consumer assistance or ombudsman.

C. No Further Appeals. Following issuance of the IRO's decision on external review, there is no further right under these procedures to appeal or arbitrate the decision.

D. Binding Effect of External Review. The decision of the IRO is binding except to the extent that other remedies may be available under state or federal law to the Plan or Claimant. Upon IRO's issuance of a notice of final external review, if the IRO reverses the Plan's final adverse benefit determination, the Plan must immediately provide coverage or payment for the claim regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

XI. Legal Proceedings

A. Legal Actions. Claimants may pursue their claims for benefits in court under ERISA §502(a) but only after they exhaust their administrative remedies as provided in these claims procedures. Failure of a Claimant to exhaust his or her administrative remedies will preclude further judicial review.

B. Legal Standards.

(1) The named fiduciary for appeals is given full discretionary authority (a) to finally determine all facts relevant to any claim, (b) to finally construe the terms of the Plan and all other documents relevant to the Plan, and (c) to finally determine what benefits are payable from the Plan.

(2) Any decision made by any named fiduciary for appeals shall be binding on all persons affected to the fullest extent permitted by law.

(3) No decision of a named fiduciary for appeals shall be revised, changed or modified by any arbitrator or court unless the party seeking such action is able to show by clear and convincing evidence that the decision of the named fiduciary for appeals was an abuse of discretion in light of the information actually available to it at the time of its decision.

(4) A decision of an IRO shall be final and binding unless a Court of competent jurisdiction determines otherwise.

IX. Miscellaneous Provisions

A. Authorized Representatives. A Claimant may appoint in writing an authorized representative to act on his behalf in pursuing a claim or appeal under these claim procedures, including a health care professional with knowledge of the Claimant's medical condition. There is no required form for this purpose. In the case of a claim involving urgent care, a health care professional with knowledge of the Claimant's medical condition shall be permitted to act as an authorized representative of Claimant even without written authorization by Claimant.

B. Plan Records. The Plan Administrator shall maintain records designed to ensure and verify that determinations are made in accordance with Plan documents and that where appropriate, the Plan provisions have been followed and applied consistently with respect to similarly situated Claimants. Plan participants' privacy will be protected at all times

C. Change in Claim Type. Generally, the claim type is determined at the time the initial claim is filed. If, however, the nature of the claim changes as it proceeds through the claim procedures, the claim may be re-characterized. For example: a claim that was initially characterized as an urgent care claim may be re-characterized as a pre-service claim if the urgency subsides.

D. Rights of Joint Board. The Joint Board retains the right to interpret and amend these Claims Procedures. Furthermore, if these procedures are ambiguous or do not provide an explicit procedure for a specific circumstance, the Joint Board is authorized to adopt such rules as it in its discretion deems necessary and appropriate to provide Claimants with appropriate initial determinations and an opportunity for a full and fair review of any adverse benefit determination.

CLAIMS APPEALS FOR KAISER

Kaiser Permanente has four different types of procedures for resolving disputes and grievances. The first procedure is used in order to request reconsideration of denied requests for payment, services or supplies. The second procedure is to request an immediate Peer Review Organization review if they deny coverage of continued stay in a Hospital because hospitalization is no longer necessary. The third procedure is used when members have complaints that have not been resolved satisfactorily regarding items other than claims for emergency or urgent care or other health care services or supplies. The fourth procedure is binding arbitration and is required when a member asserts any claim on account of medical or Hospital malpractice and premised liability.

Details of these procedures are contained in the booklet from Kaiser titled Disclosure Form & Evidence of Coverage. Refer to our website at www.roofersbenefits.com.

VSP GRIEVANCE SYSTEM

If a subscriber/enrollee (hereafter "enrollee") has a complaint/grievance (hereafter "grievance") regarding VSP service or claim payment, the enrollee may communicate the grievance to VSP by using the form which is available by calling VSP Customer Service Department's toll free number (1-800-877-7195) Monday through Friday, 6:00 a.m. to 6:00 p.m. Pacific Standard Time. Grievances may be filed in writing with VSP at 3333 Quality Drive, Rancho Cordova, California 95670.

Upon receipt of a verbal or written grievance, VSP will respond in writing to the enrollee acknowledging receipt and/or disposition of the grievance within five business days. If a resolution cannot be reached within thirty days, a fifteen-day interim notification will be sent to the enrollee informing him or her of the grievance's status. (VSP will keep all grievances and the responses thereto on file for seven years.)

DELTA DENTAL GRIEVANCE SYSTEM

If you have any questions about the services received from a Delta Dental Dentist, first discuss the matter with your Dentist. If you continue to have concerns, you may call or write Delta Dental. Delta Dental will provide notifications if any dental services or claims are denied, in whole or part, stating the specific reason or reasons for denial. Any questions of ineligibility should first be handled directly between you and your group. If you have any question or complaint regarding the denial of dental services or claims, the policies, procedures and operations of Delta Dental, or the quality of dental services performed by a Delta Dental Dentist, you may call toll-free at **800-765-6003**, contact Delta Dental on their website at: www.deltadentalins.com or write Delta Dental at P. O. Box 997330, Sacramento, CA 95899-7330, Attention: Customer Service Department.

If your claim has been denied or modified, you may file a request for review (a grievance) with Delta Dental within 180 days after receipt of the denial or modification. If in writing, the correspondence must include your group name and number, the Primary Enrollee's name and ID number, the inquirer's telephone number and any additional information that would support the claim for benefits. Your correspondence should also include a copy of the treatment form, Notice of Payment and any other relevant information. Upon request and free of charge, Delta Dental will provide the Enrollee with copies of any pertinent documents that are relevant to the claim, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in denying or modifying the claim.

COBRA GROUP HEALTH INSURANCE CONTINUATION PROVISION (As Federally Mandated)

What is Continuation Coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage at their own expense when there is a "qualifying event" that would result in a loss of coverage under a group health or employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan offers to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. Also, in the Health Insurance 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 or 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.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

How long will Continuation Coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to 18 months. In the case of losses of coverage due to an employee's death, divorce, or a dependent child ceasing to be a dependent under the terms of the Plan, coverage may be continued for up to 36 months. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage,
- the group ceases to provide any group health plan for its employees, or
- You or another family member on COBRA due to a disability extension is no longer disabled based on a determination made by Social Security. Your coverage will end as of the last day of the month in which you were no longer disabled.

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

How can you extend the length of COBRA Continuation Coverage?
If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is determined by Social Security to be disabled or a second qualifying event occurs. You must notify United Administrative Services of such a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability
An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. A qualified beneficiary must notify the plan of the SSA determination within 60 days of its issuance and within the original 18-month COBRA coverage period. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact immediately but no later than 30 days after SSA's determination.

Second Qualifying Event
An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee or divorce from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

California COBRA HMO Extension
If you are enrolled in an HMO in the State of California, you may have additional election rights. Please contact your HMO if you are covered on the HMO plan.

How can you elect COBRA continuation coverage?
To elect continuation coverage, you must complete the Election Form, which will be sent to you, and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children and pay the required premium. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?
Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan Participant or beneficiary who is not receiving continuation coverage.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at:
www.doleta.gov/tradeact/2002act_indez.asp.

Conversion
If you have health maintenance or insurance company coverage under the Plan, you have the right, when your group health coverage ends, to enroll in an individual conversion health insurance or HMO policy, without providing proof of insurability. The benefits provided under such an individual conversion policy may not be identical to those provided under the Plan. You may exercise this right in lieu of electing continuation coverage, or you may exercise this right after you have received the maximum continuation coverage available to you. You should note that if you enroll in an individual conversion policy you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your conversion policy ends. You must contact the HMO or insurance company directly to

receive individual conversion coverage. Time limits apply so you must contact the HMO or insurance company immediately upon the expiration of your health plan coverage.

Life Insurance

If elected, your continuation coverage may consist of medical and prescription drug coverage with vision coverage as an option. It does not include life insurance or accidental death and dismemberment benefits. To convert your life insurance and accidental death and dismemberment coverage to an individual policy contact United Administrative Services at 408-288-4400.

When and how must payment for COBRA continuation coverage be made?

Initial payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your initial payment for continuation coverage, retroactive to the date you lost your coverage, not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your initial payment for continuation coverage in full within 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your initial payment is correct. Your initial COBRA payment must cover the cost of continuation coverage from the time your coverage under the plan terminated up to the time you make the initial payment. You may contact United Administrative Services to confirm the correct amount of your initial payment.

Periodic payments for continuation coverage

After you make your initial payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The periodic payments are made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first day of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.

Grace periods, for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your initial payment and all periodic payments for continuation coverage should be sent to:

Bay Area Roofers Trust Funds
P.O. Box 5057
San Jose, CA 95150-5057
(408) 288-4400

All payments must include the member's name, Plan name and the last four digits of the member's Social Security Number.

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

Keep your Plan informed of address changes
In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

GENERAL PROVISIONS

Providing of Care. The Plan is not responsible for providing any type of hospital, medical or similar care, nor is it responsible for the quality of any such care received.

Independent Contractors. The Plan's relationship with providers is that of an independent contractor. Physicians, and other health care professionals, hospitals, skilled nursing facilities and other community agencies are not the Plan's agents nor is the Plan an employee or agent of any hospital, medical group or medical care provider of any type.

Non-Regulation of Providers. The benefits of this Plan do not regulate the amounts charged by providers of medical care, except to the extent that rates for covered services are regulated with participating providers.

Terms of Coverage

1. In order for you to be entitled to benefits under the Plan, both the Plan and your coverage under the Plan must be in effect on the date the expense giving rise to a claim for benefits is incurred.
2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.
3. The Plan is subject to amendment, modification or termination according to the provisions of the Plan without your consent or concurrence.

Free Choice of Provider. This Plan in no way interferes with your right as a Participant entitled to hospital benefits to select a hospital. You may choose any physician who holds a valid physician and surgeon's certificate and who is a member of, or acceptable to, the attending staff and board of directors of the hospital where services are received. You may also choose any other health care professional or facility which provides care covered under this Plan, and is properly licensed according to appropriate state and Participant laws. However, your choice may affect the benefits payable according to this Plan.

Continuity of Care. If the Plan terminates its contractual relationship with a participating provider and you are undergoing a course of treatment from that provider at the time the contract is terminated, you may be able to continue to receive services (but only if such provider agrees to continue to comply with the same contractual requirements that applied prior to termination). To qualify, you must have an acute or a serious chronic condition, a high risk pregnancy, or a pregnancy in the second or third trimester. You may request this continuity of care by calling us at the customer service telephone number listed on your ID card. If approved, services may be received for a limited period of time, but no longer than 90 days, unless you cannot be safely transferred to a participating provider. Coverage is provided according to the terms and conditions of this Plan applicable to participating providers.

Provider Reimbursement. Physicians and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. A participating physician may, after notice from us, be subject to a reduced negotiated rate in the event the participating physician fails to make routine referrals to participating providers, except as otherwise allowed (such as for emergency services). Hospitals and other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis.

Necessary Treatment. The benefits of this Plan are provided only for services which the Plan, or its agent for this purpose, determines to be medically Necessary Treatment. The services must be ordered by the attending physician for the direct care and treatment of a covered condition. They

must be standard medical practice where received for the condition being treated and must be legal in the United States.

Expense in Excess of Benefits. The Plan is not liable for any expense you incur in excess of the benefits of this Plan.

Benefits Not Transferable. Only the Participant and Eligible Dependents are entitled to receive benefits under this Plan. The right to benefits cannot be transferred.

Notice of Claim. You or the provider of service must send properly and fully completed claim forms to us within 90 days of the date you receive the service or supply for which a claim is made. Services received and charges for the services must be itemized, and clearly and accurately described. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. The Plan is not liable for the benefits if you do not file claims within the required time period. Claim forms must be used; cancelled checks or receipts are not acceptable.

Payment to Providers. The Plan will pay the benefits of this Plan directly to contracting hospitals, participating providers, coordination of expenses and medical transportation providers. Also, the Plan will pay non-contracting hospitals and other providers of service directly when you assign benefits in writing. If you are a Medical beneficiary and you assign benefits in writing to the State Department of Health Services, we will pay the benefits of this Plan to the State Department of Health Services. These payments will fulfill our obligation to you for those covered services.

Right of Recovery. When the amount the Plan pays exceeds its liability under this Plan, the Plan has the right to recover the excess amount. This amount may be recovered from you, the person to whom payment was made or any other plan.

Plan Administrator – COBRA and ERISA. United Administrative Services is the Plan Administrator and is contracted by the Bay Area Roofers Health and Welfare Plan to provide claim payment services based on the Plan design contained in this summary plan description.

Workers' Compensation Insurance. The Plan does not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance.

Confidentiality and Release of Medical Information. The Plan will use reasonable efforts, and take the same care to preserve the confidentiality of the participants' and beneficiaries' medical information. The Plan may use data collected in the course of providing services hereunder for statistical evaluation and research. If such data is ever released to a third party, it shall be released only in aggregate statistical form without identifying the member.

Medical information may be released only with the written consent of the Participant or as required by law. It must be signed, dated and must specify the nature of the information and to which persons and organizations it may be disclosed. Participants may access their own medical records.

The Plan may release your medical information to professional peer review organizations and to the group for purposes of reporting claims experience or conducting an audit of our operations, provided the information disclosed is reasonably necessary for the group to conduct the review or audit.

HIPAA PRIVACY RULE: PROTECTED HEALTH INFORMATION

1. **General Rules.** The Board of Trustees and the Trust Fund office will use Protected Health Information (PHI) in accordance with the Health Information Portability and Accountability Act (HIPAA). Specifically, the Board of Trustees will:

a. Protect your Protected Health Information ("PHI"). PHI means Health Information, including demographic and genetic information, that is (1) transmitted or maintained in any form or medium, (2) collected from an individual and created or received by a health care provider, health Plan, Employer, or health care clearinghouse, and (3) identifies the individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the individual involved. For example, you or your Eligible Dependent's name, address, birth date, marital status, birth certificate, Social Security Number, and choice of health plan would be considered PHI.

b. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, received, maintains or transmits on behalf of the Plan;

c. Ensure that adequate separation between the Plan and Board, as required by this Article and by governmental regulations (45 CFR §164.504(f)(2)(iii)), is supported by reasonable and appropriate security measures;

d. Ensure that any Business Associate including its subcontractor or agent to whom the Board of Trustees provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

e. Report to the Plan any breach of unsecured PHI including any security incidents of which it becomes aware.

2. **Disclosure of Summary Health Information**. The Trust Fund Office may disclose Summary Health Information to the Board of Trustees if the Board requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending or terminating the Plan.

3. **Disclosure of Enrollment Information**. The Trust Fund Office may disclose to the Board information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

4. **Permitted Uses of PHI by the Board**. PHI disclosed to the Board in accordance with this section may be used for the Plan administrative functions that the Board performs.

5. **Obligations of the Board.** In addition to the requirements stated above, the Board also agrees to:

a. not use or further disclose PHI other than permitted in this section or as required by law;

b. ensure that any of its agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Board;

c. not use or disclose PHI for employment-related actions or in connection with any other benefit or Employee benefit Plan;

d. report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses and disclosures in this section;

e. make PHI available to individuals in accordance with HIPAA's requirements;
f. make PHI available for individuals' amendment and incorporate any amendments to PHI in accordance with HIPAA;
g. make the information available that will provide individuals with an accounting of disclosures in accordance with HIPAA;
h. make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services for purposes of determining the Plan's compliance with HIPAA;
i. if feasible, return or destroy all PHI received from the Plan that the Board maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Board will limit further its uses and disclosures of the PHI to those purposes that make the return or destruction of the information infeasible; and
j. ensure that adequate separation between the Plan and the Board is established and maintained.

6. **Disclosure Only to Designated Parties**. Pursuant to this section, the Plan will disclose PHI only to the Board and/or to individual Trustee and professionals advising the Plan.

7. **Disclosure Only for Designated Purposes.** Access to and use of PHI by the parties described in paragraph 6 shall be restricted to Plan administration function that the Board performs for the Plan. Such access or use shall be permitted only to the extent necessary for these individuals to perform their respective duties for the Plan.

8. **Non-Compliance.** If any person does not comply with the provisions of this section or the provisions of HIPAA, the Board will provide a mechanism for resolving the issue of non-compliance, which may include disciplinary sanctions.

9. **Your Individual Rights.** Under HIPAA you and your Eligible Dependents have the following rights:

a. Right to Request Restrictions on how this Plan will use or disclose your PHI.
b. Right to request that the Plan communicate with you about medical matters in a certain way or at a certain location.
c. Right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care, for as long as this Plan maintains the PHI.
d. If you believe that your health information records are inaccurate or incomplete, you may request that the Plan amend the records.
e. Right to request a list of certain disclosures of your health information that the Plan is required to keep a record of under the Privacy Rule, such as disclosures for public purposes authorized by law or disclosures that are not in accordance with the Plan's privacy policies and applicable law.
f. Right to receive and the Plan is required to provide a Notice to you, as soon as reasonably possible, but no later than 60 days after discovery of a breach of your unsecured PHI.
g. If you paid for services out-of-pocket, in full, and you request the Health Care Provider not disclose your PHI related to those services to the Plan, the Health Care Provider

must accommodate your request, except where the Health Care Provider is required by law to make a disclosure.

10. **Individual Authorization**. Except as provided under the Plan's Notice of Privacy Practices or as permitted under HIPAA, the Plan will not disclose your PHI without your prior written authorization. Further, if you wish to authorize someone other than yourself to access information from the Trust Fund Office on your behalf, you must complete the Protected Health Information Authorization Form (available at the Trust Fund Office) and return it to the Trust Fund Office.

The Board of Trustees and the Trust Fund Office's uses and disclosure are more fully described in this Plan's Privacy Policy Statement and Notice of Privacy Practices. Copies of these documents can be requested from the Trust Fund Office.

TERMINATION OF COVERAGE

Unless terminated earlier under other provisions of the Plan, coverage for you and your dependents will terminate on the earliest of:

1. The last period for which you made any required self-payment;
2. The date you are no longer eligible for coverage under the Plan's Eligibility Rules.

PAYMENT ERRORS

If you or your dependent receive more than you are entitled to with respect to a particular claim, regardless of whose fault the overpayment is, you will have to return any excess over the correct amount. If it is not returned, such excess may be deducted from future claims payable to you or your dependents.

COVERAGE INQUIRIES

If you need information about specific benefit coverage, you may write or call United Administrative Services or write to the Board of Trustees. To avoid misunderstandings you should request a written response.

THIRD PARTY LIABILITY AND WORKERS' COMPENSATION

1. Non-Covered Roofing Service. No expenses incurred as a result of working in non-covered roofing service will be paid or advanced by this Plan regardless of when incurred.

2. Injuries in the Roofing Industry Not Covered by Workers' Compensation. No expenses incurred as a result of performing work in the roofing or waterproofing industry, whether or not such work is performed for pay, will be paid or advanced by the Plan if there is no Workers' Compensation policy in force to cover such expenses.

3. Injuries While Working for Participating Employer. Notwithstanding any other provision of the Plan, if an eligible individual has an Injury or Sickness arising out of or in the course of any employment for a Participating Employer who has Workers' Compensation insurance, the Plan will advance the amounts determined under the Plan rules and file a lien on the Participant's Workers' Compensation claim for reimbursement of that advance.

4. Third Party Liability. If an eligible individual is injured through the act or omission of another party, Plan benefits are provided only on the following conditions:

   a. Such eligible individual, or anyone receiving any Plan benefits as a result of the injury to the eligible individual, shall be required to pay to the Plan any and all proceeds whatsoever, including but not limited to proceeds designated as being for pain and suffering, received by way of judgment, settlement or otherwise (including receipt of proceeds under any uninsured motorists coverage) arising out of any claims for money or other damages by the eligible individual or his or her heirs, parents, or legal guardians, or anyone else acting on his or her behalf, to the extent of the payments made or to be made by the Plan for which the third party may be responsible. The assets so recovered shall be considered Plan assets and the recipient shall be under a fiduciary duty to pay them over to the Plan. The Plan shall be entitled to enforce this agreement by any legal or equitable remedy provided under federal or state law, specifically including, without limitation, equitable restitution, constructive trust or equitable lien by agreement. Furthermore, any make-whole rule of federal or state law is specifically rejected, so that the eligible individual need not be made whole before the Plan can enforce its rights.

   b. Any eligible individual, or anyone acting on his or her behalf, who accepts payments from the Plan, or authorizes Plan payments to be made to anyone else, or on whose behalf any benefits are paid with respect to the eligible individual's injuries, agrees that a present assignment of the eligible individual's rights against such third party is automatically made to the extent of the payments made by the Plan.

   c. These rules are automatic, but the Plan may require that any eligible individual or his or her representative sign an Agreement to Reimburse or Assignment of Recovery in such form or on such forms as the Plan may require. If an eligible individual, or his or her representative, refuses to sign an Agreement to Reimburse and/or Assignment of Recovery in a form satisfactory to the Plan, the eligible individual shall not be eligible for Plan benefit payments related to the injury involved. This remedy is in addition to all other remedies the Plan may have.

d. If Plan benefits are paid on behalf of an eligible individual and upon recovery of any proceeds from or on behalf of the third party such benefits are not reimbursed to the Plan as set forth above, then the eligible individual will be ineligible for any future Plan benefit payment until the Plan has withheld an amount equal to the amount which has not been reimbursed. This remedy is in addition to all other remedies the Plan may have.

e. Any eligible individual on whose behalf the Plan pays benefits agrees that the Plan may intervene in any legal action brought against a third party or any insurance company, including the eligible individual's own carrier for uninsured motorist coverage.

f. A lien shall exist in favor of the Plan upon all sums of money recovered by the eligible individual against any third party responsible for the injuries to the eligible employee. The lien may, but is not required to, be filed with the third party, the third party's agents, or the court. The eligible individual, and those acting on his or her behalf, shall do nothing to prejudice the Plan's rights as described above without the Plan's written consent.

g. If an eligible individual settles or compromises a third party liability claim in such a manner that the Plan is reimbursed in an amount less than its lien, or which results in the third party or its insurance carrier being relieved of any future liability for medical costs, then the eligible individual shall receive no further benefits from the Plan in connection with the medical condition forming the basis of the third party liability claim, unless the Plan or its duly authorized representative has previously approved the settlement or compromise, in writing, as one which is not unreasonable from the standpoint of the Plan.

h. In addition to all other remedies the Plan may have, the Plan shall be subrogated to the rights of the eligible individual against the responsible third party.

i. By accepting benefits under the Plan, a Participant and any eligible individual on whose behalf benefits are paid, agrees as a contractual matter enforceable under state or federal law, that upon receipt of recovery from the responsible third party, the person receiving the payment shall reimburse the Plan the amount of benefits it has paid to the eligible individual caused by the responsible third party.

COORDINATION OF BENEFITS

Our Group Health and Welfare Plan contains a Coordination of Benefits ("COB") provision which applies to this Plan when an individual has medical care coverage under more than one plan so that the total benefits available will not exceed, but in some cases can approach or equal 100% of the allowable expenses.

An Allowable Expense is any Usual and Customary Charge for a Necessary Treatment covered at least in part by one of the Plans.

"Plans" mean when benefit or services are provided by:

1. Group insurance or group-type coverage, whether insured or uninsured;
2. Employer sponsored Blue Cross, Blue Shield or other prepayment coverage;
3. Group-type contracts;
4. Coverage under a governmental plan;
5. Coverage required or provided by law; or
6. Medical benefits coverage in group or group type and individual automobile "no fault" type contracts, then, the same Benefits or Services will not be duplicated by this Plan.

"Plan" does not include:

1. A state plan under Medicaid;
2. Benefits under a law or plan when, by law, its benefits are in excess to those of any private insurance plan;
3. Individual or family coverage, except as provided above;
4. Medicare with respect to:
   a. Any actively employed employee age 65 and over or to any spouse age 65 and over of an actively employed employee; or
   b. Any disabled active employee or dependent of an active employee; nor
5. School accident type coverages. These cover grammar, high school, and college students for accidents only including athletic injuries, either on a 24-hour basis or on a "to and from school" basis.

All benefits described in this booklet for medical care and treatment are subject to this provision.

When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plan adjusts its benefits so that the total benefits available will not exceed the allowable expenses. No plan pays more than it would without the coordination provision.

A plan without a coordination provision is always the primary plan. If all plans have such a provision the following rules apply:

1. The plan covering the patient directly, rather than as a dependent, is primary and others are secondary;
2. When this Plan and another plan cover the same child as a dependent of different persons, called "parents":

a. The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of a plan of the parent whose birthday falls later in that year; but
b. If both parents have the same birthday, the benefits of the plan which covered the other parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

3. In the case of a child of separated or divorced parents, the designation of the plan which will be primary is determined as follows:
   a. The plan of the natural parent having legal custody of the child;
   b. The plan of the current spouse, if any, of the natural parent, having legal custody of the child;
   c. The plan of the natural parent not having legal custody of the child.
4. The plan covering a person as an active employee is primary to the plan covering the person as a retired or laid-off employee or any dependent thereof.
5. If 1., 2., 3. or 4. do not apply, the plan covering the patient longest is primary.

DEFINITIONS

The following is a brief listing of important definitions.

"Insurance Company" means Sun Life Insurance Company with respect to life insurance and accidental death benefits.

"Injury" means a bodily injury caused by an accident or other means.

"Sickness" means an illness or disease.

"Complications of Pregnancy" means:

(a) any condition resulting in Hospital confinement, the diagnosis of which is distinct from pregnancy, but is adversely affected or caused by pregnancy; or
(b) a nonelective Caesarean section, an ectopic pregnancy which is terminated, a spontaneous termination of pregnancy when a viable birth is not possible. A puerperal infection, eclampsia and toxemia.

False labor, occasional spotting, Physician prescribed rest, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with a difficult pregnancy are not complications of pregnancy.

"Hospital" means any general acute care Hospital which is licensed under any applicable state statute and must provide: (a) 24-hour inpatient care, and (b) the following basic services on the premises: medical, surgical, anesthesia, laboratory, radiology, pharmacy and dietary services.

"Mental and Nervous Disorders" means any mental or nervous condition which affects thinking, perception, mood and/or behavior. Such conditions are recognized by psychiatric symptoms that appear as distortions of normal thinking and/or perception, moodiness, sudden and/or extreme changes in mood, depression, and/or unusual behavior. Any condition meeting this definition is a Mental Disorder regardless of whether the psychiatric symptoms are caused by a psychiatric disorder, by a physical disorder, or by a combination of physical and psychiatric causes. Included within the definition of Mental Disorder, without limitation, are schizophrenia; manic depression and other conditions usually classified in the medical community as psychosis; depressive, phobic, manic and anxiety conditions (including panic disorders); bipolar affective disease, including mania and depression; obsessive compulsive disorders; autism; hypochondria; personality disorders (including paranoid, schizoid, dependent, antisocial and borderline); dementia and delirious states; post traumatic stress disorders; organic brain syndrome; and hyperkinetic syndromes (including attention deficit disorders).

"Skilled Nursing Facility" means an institution or that part of an institution which provides skilled nursing care and is certified as a Skilled Nursing Care Facility under Medicare.

"Physician" means a licensed practitioner of the healing arts. The term "Physician" also includes a Certified Nurse Midwife acting within the scope of her license.

"Necessary Treatment" means medical treatment which is consistent with currently accepted medical practice. Any confinement, operation, treatment or service which is not a valid course of treatment recognized by an established medical society in the United States is not considered "Necessary Treatment." No treatment or service, or expense in connection therewith, which is experimental in nature, is considered "Necessary Treatment".

The Plan may use Peer Review Organizations or other professional medical opinion to determine if health care services are:

1. Medically necessary;
2. Consistent with professionally recognized standards of care with respect to quality, frequency and duration; and
3. Provided in the most economical and medically appropriate site for treatment.

If services are not considered to be:

1. Medically necessary; or
2. Consistent with professionally recognized standards of care with respect to quality, frequency or duration, expenses related to those services will not be deemed "Necessary Treatment."

"Usual and Customary Charges" as used herein means a charge for a service or supply which is no higher than the 90th percentile of United Administrative Service's determination of the prevailing health care charges based on data it maintains. If such data are unavailable, Usual and Customary charges will be determined by the charges generally incurred for cases of comparable nature and severity in the particular geographical area covered.

PLAN INFORMATION

A. Name of Plan:

This Plan is known as the Bay Area Roofers Health and Welfare Plan.

B. Type of Plan:

This is a Health and Welfare Plan which includes the following types of benefits: medical, supplemental accident, vision, life insurance and accidental death and dismemberment.

C. Plan Administrator:

The Joint Board of Trustees is the official administrator and is responsible for the overall administration of the Trust. The Board employs a contract administrator, consultants, attorneys, accountants, and other necessary personnel to assist and advise them. The Joint Board makes rules and regulations, and all rights and benefits from the Plan are subject to such rules and regulations as may be adopted or amended from time to time by the Joint Board. Any representations of individual Trustees or others are not binding on the Joint Board unless specifically authorized by the Joint Board. The benefits established by this Plan have been adopted by the Joint Board based on the best information available to them as to the cost of benefits and the contributions which they anticipate receiving under applicable collective bargaining agreements. The Joint Board reserves the right to modify benefits at any time, or to reduce or even eliminate benefits if necessary to maintain the financial soundness of the Plan.

An attempt has been made to summarize pertinent provisions of the Plan as accurately as possible. In the event of any conflict between this booklet and the official Plan or insurance policy, the latter will govern. For specific information in regard to your rights under this Plan, you may contact the Administrator's Office, the address and telephone of which are shown below. The Administrator's Office can answer your questions authoritatively only if you furnish full and accurate information concerning your situation.

Name:	Joint Board of Trustees of the Bay Area Roofers Health and Welfare Trust
Address of Board and Trust Fund Office:	6800 Santa Teresa Blvd Ste 100 San Jose, CA 95119 Mailing Address: P.O. Box 5057 San Jose, CA 95150-5057
Telephone:	(408) 288-4400
Employer Identification No:	94-6074642
Plan Number:	501

D. Type of Administration:

This Plan is administered by the Joint Board of Trustees with the assistance of United Administrative Services, a contract administrative organization.

E. Name of Agent for Service of Process:

Service of legal process may be made on the Joint Board at the above address or upon any member of the Joint Board of Trustees.

F. Names and Addresses of Joint Board of Trustees:

LABOR TRUSTEES

Daniel Garcia, Local Union #95
2330-A Walsh Ave
Santa Clara, CA 95051
(408) 987-0440
dgarcia@roofer95.com

Bruce Lau (Secretary), Local Union #40
150 Executive Park Blvd Ste 3625
San Francisco, CA 94134
(415) 508-0261
brucelau@rooferslocal40.org

Carlos Opfermann, Local Union #81
8400 Enterprise Way Rm 122
Oakland, CA 94621
(510) 632-0505
carlosopf@aol.com

Robert Rios, Roofers Local #95
2330-A Walsh Ave
Santa Clara, CA 95051
(408) 987-0440
rrios@roofer95.com

Steven Tucker, Local Union #40
150 Executive Park Blvd Ste 3625
San Francisco, CA 94134
(415) 508-0261
rooferslocal40@gmail.com

Doug Ziegler, Local Union #81
8400 Enterprise Way, Room 122
Oakland, CA 94621
(510) 632-0505
dougz@unionroofers.com

MANAGEMENT TRUSTEES

William D. Callahan, Ph.D.
Associated Roofing Contractors of the Bay Area Counties, Inc.
1425 Treat Blvd, Ste C
Walnut Creek, CA 94597
(925) 472-8880 x100; director@arcbac.org

John Dissmeyer, Acme Roofing Company
1400 Wallace Ave
San Francisco, CA 94124
(415) 385-8703
john.dissmeyer@yahoo.com

Steve Henris, Henris Roofing Company
P.O. Box 138
Petaluma, CA 94952
(707) 763-1535
steve@henrisroofing.com

Richard J. Lawson, Lawson Roofing Co.
1495 Tennessee Street
San Francisco, CA 94107
(415) 285-1661
r_lawson@lawsonroofing.com

Larry Reardon, Enterprise Roofing Service
P.O. Box 5130
Concord, CA 94524-0130
(925) 689-8100
lreardon@enterpriseroofing.com

Keith Robnett, Blue's Roofing Company
182 Topaz St
Milpitas, CA 95035
(408) 240-0680
wkr@bluesroof.com

G. Sponsoring Organizations and Descriptions of Collective Bargaining Agreements:

The Plan is maintained pursuant to the terms of labor agreements between Associated Roofing Contractors of the Bay Area Counties, Inc. and Locals 40, 81 and 95 of the United Union of Roofers, Waterproofers and Allied Workers, AFL-CIO. These agreements provide that employer parties thereto will make the required contributions to this Fund for the purpose of enabling the employees working under the collective bargaining agreements to participate in Health and Welfare Benefits. Copies of any labor agreement can be obtained from the appropriate Participating Union Office or the Plan Administrator's Office. Participants and beneficiaries, upon written request, may obtain information from the Plan Administrator as to whether a particular employer or employee organization is a contributor to this Fund and if so, the employer's or the employee organization's address.

H. Source of Contributions:

For Contractual Employees, the Plan is funded through participating employer contributions, the amount of which is specified in the collective bargaining agreements, as well as employee contributions, which are fixed from time to time by the Board of Trustees. For Non-Contractual Employees the contribution rate is determined from time to time by the Board of Trustees and paid pursuant to the Employer's subscription agreement.

J. Entities Used for Accumulation of Assets and Payment of Benefits:

Benefits are provided from the Fund's assets which are accumulated under the provisions of the collective bargaining agreements and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable expenses.

K. Plan Year:

The fiscal year of the Plan is the twelve-month period ending each July 31st, and the Plan's records are maintained on that basis.

L. Plan Termination:

The Joint Board of Trustees may terminate the Plan, pursuant to its authority under the Trust Agreement. If the Plan if terminated, its remaining assets will be used to continue to provide its benefits for so long as Plan assets permit, or else they will be transferred to a successor plan providing health care benefits. However, the Joint Board would have the right to revise, reduce or otherwise adjust benefits in any reasonable manner in connection with such termination.

In no event will the termination of the Plan or Trust result in a reversion of any assets to any contributing employer.

M. Health Providers:

In accordance with the new disclosure requirements of the Health Insurance Portability and Accountability Act, we are informing you of the name and address of all Health providers for the Bay Area Roofers Health & Welfare Trust Fund and their roles (i.e., whether they guarantee the payment of benefits or provide administrative services).

United Administrative Services
6800 Santa Teresa Blvd Ste 100
San Jose, CA 95119

Administers the self-funded medical and prescription plans for active and retired employees. Does not guarantee payment of these benefits.

Kaiser Foundation Health Plan
Northern California Region
1950 Franklin St
Oakland, CA 94612

Provides prepaid medical benefits with guaranteed payment of these benefits for active and retired participants.

Caremark
9501 E Shea Blvd
Scottsdale, AZ 95260

Administers Pharmacy Plan for active and retired participants. Does not guarantee payment of these benefits.

Vision Service Plan
3333 Qualify Dr
Rancho Cordova, CA 95670

Administers vision plan for active and retired participants, and their Eligible Dependents. Does not guarantee payment of vision benefits.

Delta Dental of California
(Locals 95 & 40 Only)
3333 Qualify Dr
Rancho Cordova, CA 95670

Administers dental plan for active participants and their Eligible Dependents. Does not guarantee payment of dental benefits.

Beat It Program, Inc.
PO Box 20896
San Jose, CA 95160

Administers Drug and Alcohol Plan for active and retired participants, Does not guarantee payment of these benefits.

Blue Cross Prudent Buyer Plan
21555 Oxnard St
Woodland Hills, CA 91367

Administers the PPO and Utilization Management services. Does not guarantee payment of these benefits

Caremark.com
PO Box 961066
Fort Worth, TX 76161-9854

Administers mail-in Pharmacy Plan for active and retired participants. Does not guarantee payment of these benefits.

Sun Life and Health Insurance Company
175 Addison Rd
Windsor, CT 06095-0725

Administers life and AD&D benefits for active and retired participants, and their Eligible Dependents. Does not guarantee payment of these benefits.

CRX International
P.O. Box 44650
Detroit, MI 48244-0650

Administers discount brand prescription drug program. Does not guarantee payment of prescription benefits.

YOUR RIGHTS UNDER ERISA

As a Participant in the Bay Area Roofers Health and Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that Plan Participants are entitled to:

A. Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

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 assess a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report known as a Summary Annual Report ("SAR"). The Plan Administrator is required by law to furnish each Participant with this Summary Annual Report.

B. 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.

C. 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 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 any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a health and welfare or vacation benefit or exercising your rights under ERISA.

D. Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of certain 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, although your right to sue may be limited if you have not used the Plan's appeal procedures. 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 which is denied or ignored, in whole or in part, you may file a lawsuit. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If 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. Any such claim shall be limited to benefits due to him under the terms of the Plan, or to clarify his rights to future benefits under the terms of the Plan, and shall not include any claim or right to damages, either compensatory or punitive. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If your appeal has been denied or there has been a different form of adverse action taken against you, you have one year from the date of such denied appeal or adverse action to file a lawsuit. If you fail to do so, no lawsuit is permitted. This rule applies to and includes any and every claim to benefits from the Fund, and any claim or right asserted under the Plan or against the Fund, regardless of the basis asserted for the claim, and regardless of when the act or omission upon which the claim is based occurred, and regardless of whether the claimant is a “Participant” or “beneficiary” of the Plan with the meaning of those terms as defined in ERISA.

E. 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 Benefit Security Administration, U.S. Department of Labor, which is the San Francisco Regional Office, 90 7th Street, Suite 11-300, San Francisco, CA 94103 (415) 625-2481.

Office of Participant Assistance
U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Avenue NW
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. For single copies of publications, contact the EBSA Brochure Request Line at 1-866-444-3272 or contact the EBSA field office nearest you.

You may find answers to your questions and a list of EBSA offices at http://www.dol.gov/ebsa/welcome.html.

REQUIRED NOTIFICATIONS

Women's Health and Cancer Rights Act Annual Notice

The Women's Health and Cancer Rights Act of 1998 requires the coverage described below be made available under our health plan. The WHCRA requires that you be given this written notification on an annual basis. Notice must be made even though our plan already covers these types of services. The following coverage will be provided to plan participants having breast reconstruction in connection with a mastectomy:

- All stages of reconstruction of the breast on which the mastectomy was performed, and
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Coverage for prostheses and treatment of physical complications of the mastectomy, including lymphedema.

This coverage will be subject to all deductibles and coinsurance limitations consistent with those established for other benefits under the plan or coverage that are in effect at the time of claim for the type of service provided.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan. If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't

already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

MAINE – Medicaid	NEW YORK – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2016. Contact your State for more information on eligibility –

To see if any other states have added a premium assistance program since January 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
Centers for Medicare & Medicaid Services
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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