

**NORTHERN CALIFORNIA TILE INDUSTRY
HEALTH & WELFARE PLAN**

SUMMARY PLAN DESCRIPTION

January 1, 2006

INTRODUCTION

This booklet is the Summary Plan Description ("SPD") of your Health and Welfare Plan, as in effect on January 1, 2006. The "Highlights" section briefly describes the eligibility rules and benefits available under the Plan. The next section is the detailed summary of the eligibility rules and benefits effective January 1, 2006. This is followed by the Claims and Appeals Procedures and a description of your rights under ERISA.

The summaries that follow are provided for your convenience and are not intended to differ from the Formal Plan Rules. If there is any apparent difference between this summary and the Formal Plan Rules, the Formal Plan Rules govern. All of the rules of the Plan are subject to modification by the Board of Trustees. Any amendments to the Formal Plan Rules, or changes to the contracts with Plan carriers, which are adopted by the Trustees after the publication of this booklet, supersede the summaries in this booklet.

For a complete description of all benefits provided through United of Omaha, see the complete Certificate of Coverage of United of Omaha. For a complete description of all benefits provided through Kaiser or PacifiCare, see the booklets provided by Kaiser or PacifiCare.

Important Information about the Plan

1. Plan members may select one of three medical plan carriers: Kaiser Foundation Health Plan, PacifiCare HMO and United of Omaha PPO. If you are a new member, you must choose a plan carrier by completing an enrollment form and returning it to Allied Administrators.
2. If you acquire a new dependent, you must enroll that dependent within 30 days to be assured of the right to enroll the dependent. If you do not meet that deadline, it is up to the chosen plan carrier whether or not you may enroll the dependent, or if you must wait until the next open enrollment period. Contact the Plan Administration Office, Allied Administrators, whenever you acquire a new dependent, or when any of the following events occur:
 - 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
3. Only Allied Administrators may confirm your eligibility status or accept appeals to the Board of Trustees concerning your eligibility for benefits. Appeals on issues such as medical necessity must be processed through your chosen medical plan carrier. Appeals for dental benefits must be processed through United of Omaha.

TABLE OF CONTENTS

PLAN SERVICE PROVIDERS	1
HIGHLIGHTS OF THE PLAN	2
ELIGIBILITY FOR BENEFITS	3
1. Employee Eligibility	3
2. Loss of Coverage for Cause	4
3. Retired Employee Eligibility	5
4. Dependent Eligibility	5
5. Individual Employers and Non-Bargaining Unit Employees	6
6. COBRA Continuation Coverage	8
7. Certificates of Former Coverage	9
8. Reservation of Powers	9
BENEFITS	10
MEDICAL PLAN OPTIONS	10
How to Enroll Yourself and Your Dependents	10
Current Medical Plan Options	11
INFORMATION ABOUT PARTICULAR MEDICAL BENEFITS	16
Maternity Benefits	16
Mastectomy Benefits	16
DENTAL PLAN	17
VISION CARE BENEFITS	18
PRESCRIPTION DRUG BENEFITS	19
PHYSICAL EXAM BENEFIT	20
CHIROPRACTIC BENEFIT	20
ALCOHOL AND DRUG DEPENDENCY TREATMENT THROUGH BEAT IT! ...	21
LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE	22
CLAIMS AND APPEALS PROCEDURES	24
How to Submit Claim Forms for Benefits	24
Claims and Appeals	24
ADMINISTRATIVE INFORMATION	26
YOUR RIGHTS UNDER ERISA	28
APPENDIX 1: BOARD OF TRUSTEES	30
APPENDIX 2: GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS	31
APPENDIX 3: CLAIMS AND APPEAL PROCEDURES	36

PLAN SERVICE PROVIDERS

Plan Administration Office

Eligibility, PPO medical plan claims, dental claims, life insurance and accidental death and dismemberment insurance claims, and appeals on matters under the discretion of the Board of Trustees:

Allied Administrators (415) 986-6276
P.O. Box 2500
San Francisco, CA 94126

Local Union

The Union also provides assistance on Plan benefits:

Bricklayers and Allied Crafts Local Union No. 3 (800) 281-8781
8400 Enterprise Way, #103
Oakland, CA 94621

Medical Plan Carriers

Kaiser Member Services (800) 464-4000
or www.kaiserpermanente.org

PacifiCare HMO (800) 624-8822
or www.pacificare.com

United of Omaha (800) 467-4917

Blue Cross of California (800) 274-7767
or www.bluecrossca.com

Vision Service Plan (800) VSP-7195 (800-877-7195)
or www.vsp.com

SavRx (800) 228-3108
or www.savrx.com

Beat It! (800) 828-3939
www.beatiteap.com

HIGHLIGHTS OF THE PLAN

Who is eligible to participate?

This Plan covers employees working under collective bargaining agreements in positions for which contributions are required to be made to this Plan. Eligibility is based on Hour Bank credits, which are earned for each hour of covered employment. A month of coverage under the Hour Bank "costs" 115 Hours.

The following other people may also participate:

- Employees who are working outside the geographical jurisdiction of the Union, if they have authorized reciprocity from their work area trusts, and their contributions have been received by this Plan.
- Qualified contributing employers who sign a Subscription Agreement and pay the required monthly charge, and their enrolled non-bargaining unit employees.
- Retired employees and retired employers who satisfy the appropriate eligibility rules for retiree coverage and who pay the required monthly charge which applies to their coverage.
- Eligible dependents of all of the above, including your lawful spouse (or California-registered domestic partner, for insured plan benefits only), and your natural children, adopted children, and stepchildren, until age 19 for medical benefits and age 21 for life insurance, until age 25 if a full-time student, or through any age with a qualifying disability.

What benefits are provided?

There are currently three options for medical, surgical, and hospital benefits:

- Kaiser Foundation Health Plan (a health maintenance organization, or HMO).
- PacifiCare HMO.
- United of Omaha PPO (a preferred provider organization, or PPO).

The Plan provides a variety of other benefits:

- Dental benefits are provided through United of Omaha.
- Vision care benefits are provided through Vision Service Plan.
- Life insurance and accidental death and dismemberment insurance are provided through United of Omaha.

All of these benefits are summarized below in this booklet beginning on page 10.

ELIGIBILITY FOR BENEFITS

1. Employee Eligibility - Bargaining Unit Employees

Eligibility for benefits as a bargaining unit employee is determined by your hours of covered employment. When you work in covered employment and have hours reported on your behalf into the Plan Administration Office, an "Hour Bank" is established for you. Each month, your Hour Bank is credited with the hours that you worked two months prior. For example, hours worked in February will be credited to your Hour Bank in April.

A new employee, or an employee returning to covered employment after a period of extended unemployment, will become eligible for benefits for the first time when his or her Hour Bank has been credited with 345 hours in a period of no more than three consecutive months. Continuing eligibility requires having an Hour Bank balance of at least 115 hours at the beginning of each month. If you work more than 115 hours of covered employment in any month, the excess hours are added to your Hour Bank Reserve and can be used when you do not work 115 hours in a month. You may accumulate a reserve of up to 345 hours.

In addition to regular Hour Bank coverage, there are several special eligibility rules for employees:

Self-Payments: If your Hour Bank goes below 115, you may maintain coverage by making monthly payments. If you are on the out-of-work list at B.A.C. Local Union No. 3, and available for dispatch at any time, you may self-pay for coverage for up to two consecutive months in a calendar year. Otherwise, you are eligible only for coverage under COBRA Continuation Coverage, at the full cost of coverage, for up to eighteen months (less any period of self-payments).

Reinstatement: If you have been off Hour Bank coverage for less than six months, you do not have to work 345 hours of covered employment to be covered again. Instead, you will be reinstated to Hour Bank coverage if you work 115 hours in time to restore your coverage before having a six-month gap.

Disability Coverage: If you become disabled, you may receive coverage at no charge for up to six months. To receive this coverage, you must either 1) be receiving State Disability Insurance ("SDI") benefits; or 2) be awarded "Qualified Injured Worker" status, under California Workers' Compensation laws; or 3) prove that you would qualify for SDI benefits, except that you did not have enough credits under that program to qualify for benefits when your disability commenced. If your proof of disability is pending, you must maintain coverage by making full COBRA payments. Then if you provide the necessary proof of your disability, you will receive a refund of up to six months of premiums.

Coverage During Military Service: No person is covered who is in active military service in the Armed Forces of the United States. If you are called to active military service, you may elect to:

- a) continue coverage for your dependents by payment of a monthly premium equal to the COBRA premium, until the earlier of 1) the end of the period during which you are eligible for reemployment under USERRA, or 2) 24 months after your entry into the Uniformed Services; or
- b) have your Hour Bank applied for coverage of your dependents until it is exhausted, and thereafter continue coverage for your dependents under COBRA; or
- c) waive all coverage for your dependents while in the Uniformed Services.

To make this election, you must give notice to the Plan Administration Office of your call to active duty. If you do not give proper notice, you will be deemed to have elected option (b).

Family and Medical Leave Act: If you work full-time for an employer who employs at least fifty employees, you may qualify for coverage under the Family and Medical Leave Act. If that law applies to your employer at your worksite, your employer is responsible to make contributions for your coverage if you are on leave because you have a qualifying medical condition or because you are caring for a family member with a qualifying medical condition, or for a newborn or newly adopted child. If this applies to you, your Hour Bank will not be charged for coverage while you are on qualifying leave. If you believe this law applies to you, contact Allied Administrators for more information.

2. Loss of Coverage for Cause

Even if you would otherwise satisfy the rules of eligibility, your eligibility for benefits will be cancelled if you do any of the following:

- a) you work for a contractor in the Tile Industry who is not signatory to the applicable collective bargaining agreement; or
- b) you work as a contractor in the Tile Industry without being signatory to the applicable collective bargaining agreement; or
- c) you continue to work for a signatory employer who is delinquent in its fringe benefit contributions, after you have been notified that you are required to quit working for that employer because of its delinquency.

If either of these occur, all of your accumulated hours will be cancelled, and you must requalify for coverage under the Plan as a new employee. You may not make self-payments during the three or more months that it takes to qualify again for coverage. The only coverage which may be available is COBRA coverage, and it is available only if you have had a qualifying event as defined in the law.

3. Retired Employee Eligibility

If you retire from covered employment on or after January 1, 2000, you will be eligible for retiree medical benefits if you meet all of the following conditions:

- a) you are actually receiving benefits from the Northern California Tile Industry Defined Benefit Plan; and
- b) you are at least 60 years of age, or you retired under the Rule of 85 provisions of the Defined Benefit Plan; and
- c) you had 5,000 hours of covered employment reported to the Northern California Tile Industry Trust Funds (or any predecessor Funds), or the BAC Local 29 Health and Welfare Trust Fund, or any combination of those Funds, on your behalf during the 10 years preceding your application for retirement; and
- d) you were eligible for Health and Welfare Plan coverage as an active employee for at least 6 of the 12 months immediately prior to retirement, with at least 3 of these 6 months due to active employment (not self-payments); and
- e) you applied for coverage within 60 days of your retirement.

If you retired before January 1, 2000, you will be eligible for coverage if you qualified to enroll under the rules in effect at the time of your enrollment, and you have maintained coverage continuously since enrollment.

To receive retiree coverage, you must pay a monthly charge, determined from time to time by the Board of Trustees, and you must continue to receive benefits from the Northern California Tile Industry Defined Benefit Plan. If you are eligible for Medicare, you must enroll in both Part A and Part B of Medicare.

4. Dependent Eligibility

The Plan provides benefits for your eligible dependents, subject to completion of the proper enrollment forms. Your eligible dependents are:

- a) your lawful spouse (or California-registered domestic partner, for insured plan benefits only); and
- b) your unmarried child(ren) who are chiefly dependent on you for support.

The term "Child" means any of the following:

- a) your natural child;

- b) your stepchild, child of your registered domestic partner, or any child under your legal guardianship, if the child depends chiefly on you for support and maintenance, and if the child lives with you in a parent-child relationship;
- c) any minor child placed with you for the purpose of legal adoption, from the moment the child is placed in your physical custody, or from the moment you have assumed and retained a legal obligation to provide total or partial support for the child in anticipation of adoption of the child, whichever is earlier.

The Plan also covers your natural or adopted children who are not in your physical custody, when you have been ordered to maintain their coverage in a court order called a "Qualified Medical Child Support Order" ("QMCSO," pronounced Q-MixO) or equivalent. If the Plan receives a Medical Child Support Order, it will review it promptly to determine if it is qualified. The determination that an order is not a QMCSO is appealable to the Board of Trustees. The Plan procedures for review of QMCSOs are available free of charge from Allied Administrators.

Your dependent is not eligible for coverage if any of the following conditions apply:

- a) he or she lives outside the United States or Canada;
- b) he or she is on active duty in the Armed Forces of any country; or
- c) he or she has coverage under the Plan as a participant or as a dependent of another person, and 1) the dual coverage is at the expense of the Plan; or 2) the chosen medical plan's coverage rules do not allow dual coverage.

Dependent children are covered until their 19th birthday for medical benefits and until their 21st birthday for life insurance. Coverage may be continued until a dependent's 25th birthday if he or she is a full-time student and dependent on you for support. Coverage may also be continued after a dependent's 19th birthday if he or she has a physical or developmental disability which began before coverage would otherwise have ended, and which makes him or her incapable of self-sustaining employment. Proof of the disability must be provided within 31 days of the termination of regular coverage of the dependent, and from time to time as requested by the Plan Administration Office thereafter.

5. Individual Employers and Non-Bargaining Unit Employees

To be eligible to participate, an Individual Employer must meet the following requirements:

- a) He or she must be a self-employed person or sole proprietor; or a bona fide member of a partnership or other unincorporated association; or a managing officer of a corporate employer; and
- b) He or she must be actively engaged in business in the Tile Industry; and

- c) He or she, or his or her company, must be party to, and in full compliance with, a Collective Bargaining Agreement with B.A.C. Local Union No. 3, which requires contributions to the Northern California Tile Industry Health and Welfare Trust Fund.

To enroll, an employer must:

- a) apply to the Plan Administration Office upon becoming signatory to a Collective Bargaining Agreement or at an annual open enrollment date;
- b) provide information about all employees not covered under the Collective Bargaining Agreement (name, address, Social Security Number, position, and if the employee is covered under another group health plan, the name and plan sponsor of the Plan); and
- c) pay to the Fund, for the Individual Employer and for each participating employee who is not covered under another group health plan, the amount determined by the Board of Trustees as the monthly cost of such coverage.

Coverage for the Individual Employer and all non-bargaining unit personnel for whom payment is made will begin on the first day of the third month following application for, and payment for, coverage.

Once coverage is established, it will continue as long as the Individual Employer:

- a) makes all required monthly payments in full for coverage by the 10th day of each month for the next month's coverage;
- b) makes contributions for at least 600 hours of employment of bargaining unit employees every six months for each person to be covered as an employer or non-bargaining unit employee;
- c) continues to be active in the Tile Industry;
- d) notifies the Plan Administration Office within 30 days of hire, or qualification for coverage, for each non-bargaining unit employee who is newly employed or who newly qualifies for coverage based upon the employer's reporting of a sufficient number of hours of bargaining unit personnel.

If coverage is terminated for failure to comply with any of these requirements, it may not be reestablished.

6. COBRA Continuation Coverage

Every covered person who loses coverage due to a qualifying event may be eligible for COBRA Continuation Coverage. Qualifying events include the death of the participant, divorce from the participant, ceasing to qualify as a dependent child, and loss of coverage due to termination of employment or low hours. Under certain circumstances, a dependent has a separate right to elect COBRA coverage.

If you become eligible for COBRA coverage on the grounds of termination of employment or low hours as a bargaining unit employee, the Plan Administration Office will notify you. If you are a covered Individual Employer or non-bargaining unit employee, and you will lose coverage because of termination of your employment or your low hours, you or your employer must notify the Plan Administration Office, and then you will be given notice of your rights under COBRA.

To be eligible for COBRA coverage on any grounds other than termination of employment or low hours, you or your dependents must provide notice of the qualifying event within 60 days. You or your dependents must notify Allied Administrators if you or any of your dependents will be losing coverage because of any of the following reasons:

- a) your death;
- b) your divorce;
- c) your child no longer qualifies as an eligible dependent, because he or she has reached age 19, or is a full-time student and has reached age 25, or is no longer enrolled in a qualifying educational program, or is no longer disabled; or
- d) you have become eligible for Medicare.

You or your dependents must also return your COBRA election form within 45 days of receiving it, and pay the premium retroactively to your qualifying event.

It is your responsibility to meet the deadlines of COBRA coverage.

You and/or your dependents will lose the right to COBRA coverage if you or they fail to give a required notice of a qualifying event, or fail to make a COBRA election in the time allowed, or fail to make a payment on time.

COBRA coverage is available for up to 18 months, in the case of termination of employment or low hours, 29 months in the case of a qualifying disability, or 36 months in other cases. If a second qualifying event occurs while under COBRA coverage, a dependent may elect to receive the remaining months of the 36-month period. However, all of these periods are reduced by any time in which you had other self-paid coverage.

COBRA coverage is not available under the following circumstances:

- a) if an employee is terminated for working for a non-contributing employer, or for gross misconduct on the job; or
- b) if a non-bargaining unit employee loses coverage because the person's employer is no longer qualified to participate, voluntarily stopped participating, or failed to make a required payment.

COBRA coverage is available if an employer has closed his or her business, or terminated all of his or her connections to the business.

See Appendix 2 for the Plan's formal notice of COBRA continuation coverage rights.

7. Certificates of Former Coverage

If you or a dependent lose coverage under the Plan, you will be given a Certificate of Former Plan coverage. You may also request a Certificate within 24 months after losing coverage. If you become eligible for coverage under another group health plan, this Certificate may be used to prove when you had been covered under this Plan, so that you may be able to avoid pre-existing condition exclusions.

8. Reservation of Powers

The Board of Trustees reserves the power to revise all rules and procedures related to this Plan, including the power to terminate or change the coverage for any person or class of persons, to change the payment required for coverage, and to change the benefits payable by, or provided by, the Plan or by an insurance company, HMO, or other provider. Nothing in this summary should be construed to make any benefits under the Plan vested, or as a waiver of any discretion or power conferred upon the Board of Trustees under the Trust Agreement.

BENEFITS

MEDICAL PLAN OPTIONS

The Plan offers three medical plan options to all participants (provided that they live in the service areas of the plan carriers):

- Kaiser Foundation Health Plan (a health maintenance organization, or HMO).
- PacifiCare HMO.
- United of Omaha PPO (a preferred provider organization, or PPO).

You, and your dependents, will receive all of your medical, hospital and surgical benefits through the medical plan carrier you choose. The Board of Trustees has reserved the power to change the medical plan options; you will be notified if this occurs.

How to Enroll Yourself and Your Dependents

New participants may choose from the available medical plans and enroll dependents when they first become eligible for benefits. After initial enrollment, you may enroll new dependents within 30 days of the birth, marriage, or other event which makes a dependent eligible, and you may choose a new medical plan carrier and/or enroll dependents during open enrollment periods set by the Board of Trustees (usually once a year). Once you elect a medical plan, your choice of medical plan carrier will not change unless you change it during open enrollment, or unless the Plan terminates its contract with that medical plan carrier. If you make a change, it is not effective until the effective date announced for that open enrollment. At the beginning of every open enrollment period, you will get a notice of the medical plan choices available to you, the deadlines for submitting forms, and the effective date of your changes, if you make any.

You must complete an Enrollment Form.

If you are a new participant, you will receive medical benefits only after you have completed an enrollment package for one of the medical plan options. Likewise, if you fail to enroll your dependents within thirty days, you and/or your dependent(s) may not be able to receive medical benefits until the next open enrollment, unless your chosen medical plan carrier allows it.

Current Medical Plan Options

Each of the Plan's medical plan carriers prepares detailed summaries of the general benefit structure, limitations, and conditions for particular kinds of care for the HMO and PPO options currently available under the Plan. These detailed summaries are available free of charge from Allied Administrators or your chosen medical plan carrier. Below is a brief comparison of the options available when this booklet was published. The summaries and tables below are not intended to supersede the formal Evidence of Coverage documents ("the EOCs") of the HMOs or PPO, which are binding contracts. If there is any discrepancy between any table and an EOC, the EOC prevails.

Appeals of matters under the discretion of a plan carrier are handled directly through that plan carrier, and not through the Plan Administration Office or the Board of Trustees.

For more detailed information about the benefits available under the option in which you are enrolled, the conditions of treatment and/or payment, and the claims review and adjudication procedures, please refer to the Evidence of Coverage documents of your plan carrier or contact them directly.

The following options are currently available under the Plan:

KAISER FOUNDATION HEALTH PLAN HMO

Except in cases of life-threatening emergency, Kaiser requires that all medical care and benefits be provided at Kaiser facilities and with Kaiser providers. Services and supplies must be provided, prescribed, authorized or directed by a Kaiser physician. Members choose a personal Kaiser physician who will coordinate all medical care. After making a small co-payment, most services are covered at 100% and there are no deductibles. There is a \$10 charge for office visits, no charge for hospital stays, and a \$5 charge per prescription.

PACIFICARE HMO

PacifiCare HMO's participating doctors use their own facilities and hospitals throughout the area of the Plan. Members in the PacifiCare HMO must select a primary care physician, who will coordinate all your medical care. Any charges for services not approved by your primary care physician will not be covered by PacifiCare. After making a small co-payment, most services are covered at 100% and there are no deductibles. There is a \$20 charge for office visit, no charge for a hospital stay, and a \$10 charge per prescription.

UNITED OF OMAHA PPO

With this medical plan carrier, you pay annual deductibles before the Plan pays any benefits. The United of Omaha plan lets you see any doctor based on your medical need. However, the Trust currently contracts with Blue Cross Prudent Buyer for access to its PPO network. If the doctor you choose is part of this network, you receive a higher level of coverage and pay a lower deductible. A list of participating medical providers in the Blue Cross Prudent Buyer Network is available, free of charge, as a separate document from Allied Administrators. You can also look for a doctor or other providers online at www.bluecrossca.com.

Kaiser Foundation Health Plan

Benefit Feature	Amount
Lifetime Maximum	Unlimited
Annual Deductible Per Person: Per Family:	None None
Annual Maximum Out-of-Pocket Per Person: Per Family:	\$1,500 in co-pays \$3,000 in co-pays
Hospital Charges	No Charge
Emergency Room	\$35 co-pay per visit
Physician Charges - Office Visits	\$10 co-pay per visit
Routine Physical	\$10 co-pay per visit
Well Child Care From birth to age 2: After age 2:	\$5 co-pay per visit \$10 co-pay per visit
Well Woman Care	\$10 co-pay per visit
Lab/X-ray	No charge
Prescription Drugs	\$5 co-payment
Mental Health - Inpatient (up to 45 days per calendar year)	No charge
Mental Health - Outpatient (up to 20 visits per calendar year)	\$10 co-pay - individual therapy \$5 co-pay - group therapy
Substance Abuse Treatment - Inpatient (Only available through Beat It! Program; detoxification only)	No charge
Substance Abuse Treatment - Outpatient	\$10 co-pay - individual therapy \$5 co-pay - group therapy

PacifiCare HMO

Benefit Feature	Amount
Lifetime Maximum	Unlimited
Annual Deductible Per Person: Per Family:	None None
Annual Maximum Out-of-Pocket Per Person: Per Family:	\$1,000 in co-pays \$3,000 in co-pays
Hospital Charges	No Charge
Emergency Room	\$50 co-pay per visit
Routine Physical	\$20 co-pay per visit
Physician Charges - Office Visits	\$20 co-pay per visit
Well Child Care From birth to age 2: After age 2:	No charge \$20 co-pay per visit
Well Woman Care	\$20 co-pay per visit
Lab/X-ray	No charge
Prescription Drugs	\$10 co-payment
Mental Health - Inpatient (up to 30 days per calendar year)	No Charge
Mental Health - Outpatient (up to 30 visits per calendar year)	\$20 co-pay
Substance Abuse Treatment - Inpatient (Only available through Beat It! Program; detoxification only)	No charge
Substance Abuse Treatment - Outpatient	No charge

United of Omaha Group Policy for Medical Benefits

Group ID G0002A20 - Plan ID MEDPPO

Benefit Feature	PPO Provider	Non-PPO Provider
Lifetime Maximum	\$2,000,000	
Annual Deductible Per Person: Per Family:	\$100 \$200	\$300 \$600
Additional Deductible for Non-Contracted Facility: Additional Deductible for Failure to Use Utilization Review Program:	\$200 10%	
Annual Maximum Out-of-Pocket Per Person	\$600	\$6,300
Insured Percentages (After Deductible is Satisfied)		
Hospital Charges (additional \$200 deductible applies to non-PPO provider)	90%	70%
Emergency Room	90%	70%
Physician Charges - Office Visits	90%	70%
Physician Charges - Hospital Visits	90%	70%
Well Child Care (\$75 maximum benefit for office visit, \$50 for laboratory services and \$75 for immunizations)	90%	70%
Well Woman Care	90%	70%
Lab/X-ray	90%	70%
Routine Physical	\$200 benefit provided through the Trust Fund	
Prescription Drugs SavRx Card: \$2000 annual benefit maximum per family. After the SavRx card annual maximum has been reached, prescription drug benefits will be reimbursed by United of Omaha at 80% coinsurance. (Retirees pay 20% of the SavRx rate for all drugs.)	\$5 for generic \$10 for brand name \$20 non-formulary brand name	

Benefit Feature	PPO Provider	Non-PPO Provider
<p>Mental Health - Inpatient (20 days inpatient maximum per consecutive 12 months; 40 days lifetime maximum)</p> <p>Mental Health - Outpatient (25 visits per calendar year)</p>	<p>90% for 1st admission; 70% for subsequent admission</p> <p>80%</p>	<p>70%</p> <p>50%</p>
<p>Substance Abuse Treatment - Inpatient Detoxification (Only available through Beat It! Program; maximum of 2 detoxification treatments per lifetime)</p> <p>Substance Abuse Treatment - Inpatient Rehabilitation (Coverage differs for employees and dependents, with and without prior outpatient coverage under the Beat It! Program; see page 21 for a complete description of this coverage)</p> <p>Substance Abuse Treatment - Outpatient (Payable once per lifetime in lieu of inpatient treatment; 40 hours in a consecutive 12-week period)</p>	<p>85% for 1st confinement; 80% for 2nd</p> <p>See page 21</p> <p>100% to \$55/hr for Individual; 100% to \$35/hr for Group</p>	<p>N/A unless approved by Beat It!</p>

INFORMATION ABOUT PARTICULAR MEDICAL BENEFITS

Maternity Benefits Under the Newborn and Mothers Health Protection Act

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 as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mastectomy Benefits Under the Women's Health and Cancer Rights Act

In accordance with Federal law, women who have had a medically necessary mastectomy are entitled to coverage for:

1. all stages of reconstruction of the breast on which the mastectomy was performed; and
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prostheses; and
4. treatment of any physical complication of mastectomy, including lymphedemas.

The care covered under these rules is subject to the standard co-payment or co-insurance requirements which apply to other medical and hospital coverage provided by the plan in which the patient is enrolled.

DENTAL PLAN

Dental benefits are provided through a contract of insurance with United of Omaha. Dental benefits are provided to active employees under the Plan, to all covered non-bargaining unit employees and individual employers, to all eligible dependents, to retirees, and to COBRA participants who elect full coverage.

You may use any dentist when you need care. To file a Claim, get a claim form from the Union Office or the Plan Administration Office.

Below is a brief summary of the benefits under the Plan's United of Omaha Dental Benefits contract, as in effect when this booklet was published. Class A Services includes exams, teeth cleaning, x-rays, extractions, oral surgery, fillings and root canals. Class B Services includes crowns, first installation of fixed bridgework and partial or full dentures, and repairing of crowns, bridgework and dentures.

See the current United of Omaha Certificate of Insurance for the current benefits, for a complete listing of Class A and Class B Services, as well as conditions of coverage, limitations, and exclusions.

United of Omaha Group Policy for Dental Benefits Group ID G0002A20 - Plan ID DENIND	
Active Employees	
Annual Deductible (per person):	\$50
Percentage of Allowed Charges Paid (after deductible)	
Class A Services:	80%
Class B Services:	75%
Annual Maximum Benefits Paid:	\$1,500
Orthodontia Only:	
Percentage of Allowed Charges Paid (after deductible):	70%
Annual Maximum Benefits Paid:	\$2,000
Retirees Who Elect Full Coverage	
Annual Deductible (per person):	\$50
Percentage of Allowed Charges Paid (after deductible):	
Class A Services:	80%
Class B Services:	50%
Maximum per patient per calendar year:	\$1,500

VISION CARE BENEFITS

Vision care benefits are provided on an insured basis through Vision Service Plan (“VSP”) to active employees, to all covered non-bargaining unit employees and individual employers, to all eligible dependents, to retirees, and to COBRA participants who elect full coverage.

VSP benefits are paid for all covered vision care, but they work differently for VSP panel providers and non-panel providers. Briefly, when you see a VSP panel provider, there is no deductible for each covered visit. VSP covers the cost of the examination, frame, and lenses, or it pays an allowance toward contact lenses. When you see a non-panel provider, you must pay the provider’s bill at the time of service and, then, submit a claim for benefits to VSP. After deducting the co-payment, VSP reimburses you the allowed amounts toward your covered charges.

Whether you visit a VSP or non-VSP provider, you will be responsible for any charges in excess of what the Plan allows. In general, your out-of-pocket expense will be significantly lower if you use a VSP panel provider, because VSP panel providers have generally agreed to charge discounted rates to VSP members for services not covered by the Plan.

The following is a summary of the Plan’s Vision Care Benefits. Please note that this summary is presented for your convenience only, and does not supersede the VSP booklet or contract, as in effect at the time you receive vision care benefits.

VSP GROUP: Northern California Tile Industry Welfare Plan		
Benefits		
Co-payment per exam and first pair of glasses		\$0
Eye examination	Once each 12 months*	
Spectacle lenses or contact lenses	Once each 12 months*	
Frame	Once each 24 months*	
Additional Discounts		
Prof. services for contact lenses		15%
Non-covered glasses		20%

*from your last date of service

An *Evidence of Coverage* booklet is available from VSP, either directly or through the Plan Administration Office. VSP’s *Evidence of Coverage* states in detail the exact amounts of benefits paid, and any exclusions, limitations, and conditions for benefits. VSP’s Customer Service number, for booklets or assistance with claims, is (800) VSP-7195 (877-7195). You may also go to the VSP website, www.vsp.com, to check your own eligibility, get a list of participating doctors, and other information about your benefits and the VSP program.

PRESCRIPTION DRUG BENEFITS

If you are enrolled in the Kaiser or PacifiCare HMOs, you and your dependents will receive all of your prescription drug benefits from that carrier's contracted facilities. In the case of Kaiser, all prescriptions must be filled at Kaiser pharmacies. There is a \$5 co-payment per prescription at Kaiser, and a \$10 co-payment per prescription charged by PacifiCare.

If you are enrolled in the United of Omaha PPO, the first \$2,000 in prescription drug benefit payments for you and your dependents in a calendar year are self-funded by this Plan and administered through SavRx. To receive these benefits, you must use your SavRx card at a participating pharmacy and pay the required co-payment as advised by the pharmacy. For active participants, the co-payments for retail purchases are \$5 for a generic drug, \$10 for a formulary brand drug and \$20 for all other drugs. Benefits are limited to a 30-day supply for retail purchases. A 90-day supply is available through the mail order program. For active participants, the mail order co-payments are \$10 for a generic drug, \$20 for a formulary brand drug and \$40 for all other drugs. Retirees pay 20% of the SavRx rate for all drugs. The requirements and exclusions of the SavRx program in effect at the time of any covered purchase apply.

After \$2,000 has been paid in prescription drug benefits for you and your dependents in a calendar year, benefits are insured through United of Omaha and administered by Allied Administrators. To receive these benefits, you may purchase prescription drugs from any pharmacy, and then submit a claim form and receipt to Allied Administrators for reimbursement. Benefits are paid at 80% after you have paid the \$100 per year per person deductible for major medical benefits. There is no annual limit on prescription drug benefits. The requirements and exclusions of the insured prescription drug benefit are stated in the policy and Certificate of Coverage of the United of Omaha.

Prescription drug expenses are not counted toward any stop-loss limit, whether benefits were paid through SavRx or United of Omaha, and prescription drug expenses are never payable at 100%, even after a covered person has satisfied an otherwise applicable stop-loss limit.

PHYSICAL EXAM BENEFIT

If you are enrolled in the Kaiser or PacifiCare HMOs, routine physicals are covered. There is a \$10 co-payment per visit at Kaiser, and a \$20 co-payment charged by PacifiCare.

Routine physicals are not covered by the United of Omaha PPO. However, if you are an active employee who is enrolled in the United of Omaha PPO, this Plan pays 100% of the billed charges, up to \$200, once each calendar year, for a routine physical that is not otherwise covered under the United of Omaha contract. Benefits are payable when you submit a claim to Allied Administrators. This benefit is not available to retirees, dependents, or participants in Kaiser or PacifiCare.

CHIROPRACTIC BENEFIT

If you are enrolled in the United of Omaha PPO, chiropractic procedures are covered, after the deductible is satisfied, at 80% for a PPO provider or 70% for a non-PPO provider, up to \$1,000 per calendar year.

If you and your dependents are covered under a Plan HMO which does not provide chiropractic benefits, this Plan pays 80% of the charges for chiropractic care, up to \$1,000 per year per person.

ALCOHOL AND DRUG DEPENDENCY TREATMENT THROUGH BEAT IT!

Benefits for alcohol and drug dependency detoxification and rehabilitation are provided only when treatment is arranged through Beat It!, and when provided through providers under contracts with Beat It! Continuing benefits are subject to cooperation with the requirements of the Beat It! program. These benefits are provided to bargaining unit employees, non-bargaining unit employees and individual employers, and the eligible dependents of those participants. These benefits are not provided to retirees. Benefits are limited at any time to the amounts then in effect under the contracts between Beat It! and the providers. The following limitations apply to the benefits the Plan will pay, and the patient is responsible for all charges not paid by the Plan:

Inpatient Benefits for Detoxification

First confinement: 85% of contracted rate
Second confinement: 80% of contracted rate

Inpatient Benefits for Rehabilitation After Detoxification

First confinement, without prior outpatient treatment under the Beat It! program:

Employee: 100% of contracted rate
Dependents: 80% of contracted rate

First confinement, with prior outpatient treatment under the Beat It! program:

Employee: 80% of contracted rate
Dependent: 50% of contracted rate

Second confinement:

Employee: 80% of contracted rate
Dependents: 50% of contracted rate

Benefits for inpatient confinements are limited to two confinements per individual per lifetime.

Outpatient Benefits

Lifetime maximum benefit: 40 hours of counseling in a consecutive 12-week period.
(per person)

Individual counseling: 100% of covered charges, up to a maximum of \$55 per hr.

Group counseling: 100% of covered charges, up to a maximum of \$35 per hr.

Outpatient benefits are not available if a person has had both a first and second inpatient confinement. Outpatient benefits are available once only in a person's lifetime.

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

The Plan provides life insurance for active employees and dependents through group insurance policies purchased from United of Omaha. COBRA participants and retirees are not eligible for Life and Accidental Death and Dismemberment benefits. The amount of life insurance is reduced by 50% at your age 70.

The following is a summary of the benefits currently in effect. The complete rules of this benefit (the formal "Certificate of Coverage") are contained in a separate booklet provided with this booklet, or are available at no charge from the Plan Administration Office. Please note, however, that the terms of the policy and Certificate may change from time to time, and the actual benefits are determined by the policy and Certificate in effect at the time of a covered person's death. This summary is not intended to supersede that policy, and any changes to the policy and/or Certificate supersede this booklet.

Benefit Amounts: The following amounts of benefits are payable:

LIFE INSURANCE:

Employee	\$5,000
Dependent Spouse or Registered Domestic Partner	\$2,500
Dependent Child (6 months or older)	\$1,000
Dependent Child (under 6 months old)	\$500

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE:

Employee	\$5,000
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These benefits are payable if you die, or your covered dependent dies, while eligible for benefits under the Plan. Benefits are also payable under "Continuation of Insurance" provisions for thirty-one days after termination of eligibility, or beyond that if you exercise the Conversion Privilege, or if you qualify for, and comply with the requirements for Waiver of Premium Benefit in the Event of Total Disability.

Beneficiary for Life Insurance

You may designate anyone, or any number of people, to be your beneficiary for your life insurance benefit. If there is no designated beneficiary, your benefits will be paid to your estate. You are automatically the beneficiary for life insurance on your dependents.

Please note that the designation of beneficiary for Life Insurance under this Health and Welfare Plan is a different designation from the designation you may have made under the two pension plans or under other death benefits available through the Local Union. If you want to check on your designation of beneficiary under this Plan, or change your designation of beneficiary, contact the Plan Administration Office.

How to File a Claim for Life Insurance

You may request claim forms for life insurance benefits from the Local Union or the Plan Administration Office. Complete the form and send it, with an original certified death certificate, to the Plan Administration Office. Your claim form should be received by Allied Administrators within 90 days from the date of loss, if possible, or otherwise as soon as possible. **To avoid missing the claim deadline, file your claim as soon as possible.**

CLAIMS AND APPEALS PROCEDURES

How to Submit Claim Forms for Benefits

Medical: No claims forms are required for medical, hospital, and surgical benefits if you are covered under either the Kaiser or PacifiCare HMO plans. Simply present your HMO card whenever you receive services, and make the applicable co-payment. If you are covered under United of Omaha PPO, your provider should submit claims to the Plan Administration Office, Allied Administrators.

Dental: Your dentist should submit claims directly to Allied Administrators.

Vision: If you use a VSP participating panel provider, he or she will file claims directly with VSP. You just pay any excess charges for non-covered features. If you use a non-panel provider for vision care, pay the entire bill yourself and submit a claim to VSP for reimbursement of the allowable amount.

Life Insurance and Accidental Death and Dismemberment Insurance: Claim forms are available from Allied Administrators, and should be submitted to them, with supporting documents.

Claims and Appeals

The Plan provides for claims and appeals to the Board of Trustees for any matter within their discretion. These procedures apply in the following situations:

- Claims and appeals regarding Plan eligibility for any type of benefit;
- Appeals regarding medical, dental or vision benefits when the claimant has made a specific claim to a plan carrier, and the plan carrier has denied the claim on the grounds that the participant or family member is not eligible for benefits under the rules of the Plan.

The Board of Trustees does not hear appeals regarding adverse actions taken by the HMOs or insurance carriers, except if the grounds is your eligibility for benefits under the Plan. If a claim for Plan benefits is denied on grounds other than eligibility under Plan rules, such as medical necessity, a participant or provider may appeal directly to the insurance carrier or HMO, and that is the only available appeal.

You or your health care provider may file a claim for benefits by contacting the Plan Administration Office, Allied Administrators. They will notify you of their determination within the following deadlines, unless they notify you that they need more information or an extension:

- Urgent Care: 72 hours
- Non-Urgent Care: 15 days
- If you have already received the care: 30 days

If you disagree with the determination of the Plan Administration Office, you may appeal to the Board of Trustees by sending a letter to the Plan Administration Office, within 180 days of receiving the denial of benefits. The Board of Trustees will conduct an independent review of your appeal. **Failure to appeal a determination of the Plan Administration Office within the time allowed is deemed a waiver of all objections to that determination.**

The Plan Administration Office will notify you in writing of the Trustees' decision before the following deadlines, unless they notify you that they need more information or an extension:

- Urgent Care: 72 hours
- Non-Urgent Care: 30 days
- If you have already received the care: 5 days after the next regularly scheduled meeting of the Board of Trustees, unless the appeal is filed less than 30 days before the next meeting, in which case you will be notified 5 days after the second meeting of the Board of Trustees.

The Board of Trustees will authorize a hearing only if the Board determines that a hearing would be of assistance in its deliberation. These procedures are the only procedures you may use to appeal an adverse action taken by the Board of Trustees or other Plan fiduciary or agent. For full claims and appeal procedures and rules, see Appendix 3.

ADMINISTRATIVE INFORMATION

This Plan is known as the Northern California Tile Industry Health and Welfare Trust Fund or Northern California Tile Industry Health and Welfare Plan. The Internal Revenue Service Employer Identification Number (EIN) of the Trust Fund is 94-6173454 and the Plan Number is 501. The Plan Year runs from January 1 to December 31 of each calendar year.

PLAN ADMINISTRATOR:

The Plans are administered by a joint Board of Trustees consisting of four employee trustees appointed by the Bricklayers and Allied Crafts Local Union No. 3, I.U. of B.A.C. and four employer trustees appointed by the Tile Contractors Association of Northern California, Inc. The mailing address and other contact information for the Board of Trustees are as follows:

Board of Trustees
Northern California Tile Industry Health and Welfare Trust Fund
c/o Allied Administrators
P.O. Box 2500
San Francisco, CA 94126
(415) 986-6276

The names and addresses of individual trustees appear in Appendix 1.

The Benefit Consultant is David H. Walker Co., at the same address and phone number.

TYPE OF ADMINISTRATION:

The Board of Trustees is assisted in the administration of the Plan by a contract administrator, Allied Administrators, at the address and phone number listed above. All benefits are provided through contracts of insurance, administrative services contracts, or health service plans, as described above. The Board is also assisted in the administration of the Plan by Bricklayers and Allied Crafts Local Union No. 3, whose address appears below.

The Plan's medical benefits, life and accidental death and dismemberment insurance, and dental and vision benefits, are insured by the plan carriers. The first \$2,000 in prescription benefits per year are self-funded and administered through SavRx. The Plan also provides a self-funded physical exam benefit for active employees who are enrolled in the PPO plan.

AMENDMENT AND TERMINATION OF PLAN AND/OR TRUST FUND

Although there is no intention or expectation that this would occur, the collective bargaining parties have the power to terminate all contributions to the Plan. If this occurs, the funds already contributed shall be applied by the Board of Trustees, in their discretion, to provide benefits to covered individuals, either through the existing Trust Fund or through other collectively bargained plans offering similar benefits to employees working in the Tile Industry. In no event shall the termination of the Plan cause any contributions to revert to an employer.

AGENT FOR SERVICE OF LEGAL PROCESS:

Raphael Shannon, Attorney at Law
McCarthy, Johnson & Miller Law Corporation
595 Market Street, Suite 2200
San Francisco, CA 94105
(415) 882-2992

Service of legal process may also be made upon any of the Trustees, at his or her regular place of business, or on Allied Administrators.

FUNDING AND PLAN SPONSORSHIP:

This Plan is funded by contributions made pursuant to collective bargaining agreements between Bricklayers and Allied Crafts Local Union No. 3, I.U. of B.A.C. and the Tile Contractors Association of Northern California, Inc., the addresses of which appear below, as well as individual employers who are not affiliated with the association. A complete list of employers, employer associations, and labor organizations sponsoring the Plan may be obtained by participants and beneficiaries upon written request to the Plan Administration Office, subject to payment of a reasonable copying charge, and is also available for examination by participants and beneficiaries upon reasonable notice. A participant or beneficiary may also request information as to whether a particular employer, employer association, or labor organization is a sponsor of the Plan, and if so, the sponsor's address. Copies of collective bargaining agreements may be obtained by participants and beneficiaries upon written request to the Plan Administration Office, subject to payment of a reasonable copying charge, and are available for examination by participants and beneficiaries, upon reasonable notice. Reserve assets are under the management of Jacobs & Co. and Comerica.

The following organizations are party to the Master Labor Agreement under which this Plan is maintained:

Labor Organizations

Bricklayers and Allied Crafts Local Union No. 3, I.U. of B.A.C.
8400 Enterprise Way, #103
Oakland, CA 94621

Employer Associations

Tile Contractors Association of Northern California, Inc.
P.O. Box 5789
Novato, CA 94948

YOUR RIGHTS UNDER ERISA

As a participant in the Northern California Tile Industry 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 all plan participants are entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administration Office and at other specified locations, such as worksites and union halls, all 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 Benefits Security Administration.

Obtain, upon written request to the Plan Administration Office, 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 Administration Office may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or 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.

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 plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court, although your right to sue may be limited if you have not used the Plan's appeal procedures. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administration Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, which is the San Francisco Regional Office, 71 Stevenson Street, Suite 915, P.O. Box 190250, San Francisco, CA 94105 (415) 975-4600, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

APPENDIX 1: BOARD OF TRUSTEES

Employee Trustees

Mr. Jim Bresnahan
B.A.C. Local No. 3
8400 Enterprise Way, #103
Oakland, CA 94621

Mr. Dorsey Hellums
B.A.C. Local No. 3
8400 Enterprise Way, #103
Oakland, CA 94621

Mr. Tom Spear
B.A.C. Local No. 3
8400 Enterprise Way, #103
Oakland, CA 94621

Mr. S. Mark Wuelfing
B.A.C. Local No. 3
8400 Enterprise Way, #103
Oakland, CA 94621

Employer Trustees

Mr. Richard Papapietro
De Anza Tile
951 Commercial St.
Palo Alto, CA 94303

Richard N. Hill, Esq.
Littler Mendelson, PC
650 California Street, 20th Floor
San Francisco, CA 94108-2693

Mr. Jerry D. Riggs
Superior Tile
P.O. Box 2106
Oakland, CA 94621-0006

Mr. William W. Ward, III
700 Ygnacio Valley Road, Suite 260
Walnut Creek, CA 94596

APPENDIX 2: GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

This section contains important information for participants in the Northern California Tile Industry Health and Welfare Plan about the right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan.

This notice explains, in general:

- what COBRA continuation coverage is;
- what Qualifying Events trigger the eligibility for COBRA continuation coverage;
- when COBRA continuation coverage may become available to you and your family and for how long; and
- what you need to do to protect the right to receive it.

For additional information about your rights and obligations under the Plan and federal law, please contact the Plan Administration Office.

1. What is COBRA Continuation Coverage?

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "**Qualifying Event**." Specific examples of Qualifying Events are listed in Section 2 below.

After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "**Qualified Beneficiary**". You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for the coverage on their own. COBRA coverage is also coordinated with other forms of extended coverage, so that your period of COBRA coverage is reduced by any period of other extended coverage. [See Section 4, C.]

2. What Qualifying Events Might Trigger the Eligibility for COBRA Coverage?

If you are an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following Qualifying Events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because any of the following Qualifying Events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his/her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced from your spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both); or
- The child stops being eligible for coverage under the Plan as a "dependent child," which means the child has attained age 19 if not a full-time student, attained age 25 if a full-time student, or ceased to be full-time student between age 19 and 25.

3. When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administration Office has been notified that a Qualifying Event has occurred. You and your dependents' right to receive COBRA continuation coverage is contingent upon timely notifying the Plan of a Qualifying Event, promptly returning the COBRA election form and making all required payments.

A. The Employer's Duty to Give Notice of Some Qualifying Events

When the Qualifying Event is the end of employment or reduction of hours of employment, the employer must notify the Plan Administration Office within 30 days of the Qualifying Event. The Employer Report Form submitted to the Plan's Administration Office each month is sufficient to constitute such a notice.

Upon the death of the employee, the employer or the employee's dependent has 30 days to notify the Plan Administration Office.

If the Qualifying Event is the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan will usually be automatically notified.

IMPORTANT:

B. The Qualified Beneficiary's Duty to Give Notice of Other Qualifying Events

The duty to give notice of all other Qualifying Events falls on the Qualified Beneficiaries. The employee, the spouse or dependent children of the employee must notify the Plan Administration Office within **60 days** after any of the following Qualifying Events occurs:

- a) a divorce or a child's loss of dependent status under the Plan;
- b) occurrence of a second Qualifying Event entitling certain Qualified Beneficiaries to an extension of the COBRA maximum coverage period to up to 36 months [see section 4. A. b)]; and
- c) when a Qualified Beneficiary who is entitled to 18 months of COBRA has been determined by the SSA to be disabled at any time during the first 60 days of COBRA coverage [see Section 4. A. a)].

Your notice must include the following information:

- a) the nature of the Qualifying Event that has caused the loss of coverage under the Plan;
- b) the date when the Qualifying Event occurred;
- c) your name and signature; and
- d) the date when the notice was signed.

You must deliver this notice, either **by mail**, or **in person**, to the person and address provided in Section 6.

4. How is COBRA Coverage Provided?

Once the Plan Administration Office receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Please inform the Plan Administration Office immediately if you acquire any new dependents through marriage, having children born, adopted or placed with you for adoption.

A. Length of COBRA Coverage: 18 Months and May be Extended

Generally, when the Qualifying Event is (1) the end of employment or (2) reduction of the employee's hours of employment, COBRA continuation coverage lasts up to a total of **18 months**. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

a) Disability extension

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administration Office in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total **maximum of 29 months**. The disability would have 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.

b) Second Qualifying Event

If your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a **maximum of 36 months**, if notice of the second Qualifying Event is properly given to the Plan. The 36-month period is measured from the date of the first Qualifying Event.

This extension may be available to the spouse and any dependent child receiving continuing coverage if the employee dies, or becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced, or if the dependent child loses dependent status, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

B. Length of COBRA Coverage: A Total of 36 Months

When the Qualifying Event is (1) the death of the employee, (2) the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), (3) divorce from the employee, or (4) a dependent child's loss of dependent status, the Qualified Beneficiary may elect COBRA continuation coverage for up to a total of **36 months**.

C. Coordination with Other Coverage

The period of time for which an employee or his/her dependent is eligible for COBRA coverage is not reduced by any months in which the employee or his/her dependent was covered due to Hours Bank run-out, but is reduced for months of Self-Pay or Disability coverage. Please refer to the Plan's Summary Plan Description for a detailed description of other coverages.

5. Where Can You Get more Information?

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the person identified in Section 6. 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, you may also contact the nearest Regional or

District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area at:

EBSA, San Francisco Regional Office
71 Stevenson Street, Suite 915
San Francisco, CA 94105
Attn: Rebecca Marshall-Acting Director
Telephone: (415) 975-4600
Fax: (415)975-4589
Or visit the EBSA website at www.dol.gov/ebsa.

6. Plan Administration Office Contact Information

Northern California Tile Industry Health and Welfare Plan
c/o Allied Administrators
P.O. Box 2500
San Francisco, CA 94126
Telephone: (415) 986-6276
Fax: (415) 439-5858

IMPORTANT: Keep Your Plan Informed of Address Changes

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

APPENDIX 3: CLAIMS AND APPEAL PROCEDURES

Matters Within the Discretion of the Board of Trustees

1. The following claims and appeals procedures shall apply to all matters within the discretion of the Board of Trustees, filed on or after January 1, 2003, including:

- claims and appeals regarding eligibility under this Plan for any type of benefit;
- claims and appeals regarding medical, dental and vision benefits when the claimant has made a specific claim for medical, dental or vision care, and the HMO or insurance carrier has denied the claim on the grounds that the claimant or family member is not eligible for the benefit under the terms of this Plan;
- claims and appeals regarding self-funded benefits, including the physical exam benefit, the chiropractic benefit, and the self-funded portion of the prescription drug benefit.

2. The procedures specified in this section shall be the sole and exclusive procedures available to any individual who is adversely affected by any action of the Trustees, the Administration Office or any other Plan agent or fiduciary. The Board of Trustees reserves full discretionary authority to interpret Plan language and to decide all claims or disputes regarding right, type, amount or duration of benefits, or claim to any payment from this Trust. The decision of the Board of Trustees on any matter within its discretion shall be final and binding on all parties.

a) **FILING A CLAIM:** Participants, family members and assignees (hereinafter "claimants") may initiate a claim for benefits by contacting the Administration Office. An authorized representative may submit a claim on behalf of a claimant. In the case of a claim involving urgent care, a health care professional with knowledge of the claimant's medical condition may act as the authorized representative of the claimant.

b) **NOTIFICATION OF FAILURE TO FOLLOW PLAN PROCEDURES:** If the claimant fails to follow the Plan's procedures for filing a claim for benefits, the Administration Office will notify the claimant as soon as possible, but within 5 days following the failure, or if the claim is for urgent care, within 24 hours of the failure. This notification may be oral, unless the claimant or authorized representative requests it in writing.

c) NOTIFICATION OF CLAIM DECISION

(i) Time Limits and Requests for Additional Information.

(A) **Urgent Care Claims:** If a claim is for urgent care, the Administration Office will notify the claimant of its determination as soon as possible, but no later than 72 hours after receipt of the claim by the Administration Office.

If the claimant fails to provide sufficient information to determine whether benefits are payable under the plan, the Administration Office will notify the claimant what information is necessary as soon as possible, but no later than 24 hours after receipt of the claim by the Administration Office. The claimant will have 48 hours to provide the specified information. The Administration Office will notify the claimant of its decision as soon as possible, but no later than 48 hours after the Administration Office's receipt of the specified information.

(B) Pre-service claims: If a claimant makes a claim for benefits before care has been provided to the participant or family member, but the claim is not urgent, the Administration Office will notify the claimant of its decision as soon as reasonably possible, but no later than 15 days after the Administration Office received the claim.

The above 15-day time period may be extended for up to one additional 15-day period, but only due to matters beyond the Administration Office's control. If the Administration Office needs a 15-day extension, it will notify the claimant of the following: the reason for the delay; the expected date of decision; and any additional information the Administration Office needs to make the decision. If the Administration Office requires additional information, the claimant will have up to 45 days to provide the specified information. Once the specified information is provided, the Administration Office will notify the claimant of its decision within 15 days.

(C) Post-service claims: If a claimant makes a claim after care has been provided, the Administration Office will notify the claimant of its decision as soon as reasonably possible, but no later than 30 days after the Administration Office received the claim.

The 30-day time period may be extended for one additional 15-day period, but only due to matters beyond the Administration Office's control. If the Administration Office needs a 15-day extension, it will, before the end of the first 30-day period, notify the claimant of the following: the reason for the delay; the expected date of decision; and any additional information the Administration Office needs to make the decision. If the Administration Office requires additional information, the claimant will have up to 45 days to provide the specified information. Once the specified information is provided, the Administration Office will notify the claimant of its decision within 15 days.

(ii) CONTENTS OF CLAIM DENIAL NOTICE: The Administration Office will provide the claimant with written notice if his or her claim for benefits is denied. If the claim involves urgent care, the information described below may be given orally, so long as a written notification is provided within three days after the oral notification. The notice will include the following information:

- (A) a statement of the specific reason(s) for the denial;
- (B) reference to the specific Plan provision(s) on which the denial was based;

- (C) if the Administration Office's decision relied upon an internal Plan rule, guideline, protocol or similar criterion, either the specific rule, or a statement that the specific rule was relied upon and that a copy of such rule will be provided free of charge upon request;
- (D) a description of any additional information or documents that the claimant will need to submit if he or she wants the claim to be reconsidered, and an explanation of why that information is necessary;
- (E) a description of the Plan's appeal procedures, including any expedited appeal procedures available if it is a claim for urgent care benefits; and
- (F) a statement of the claimant's right to bring a civil action under ERISA § 502(a), if the appeal is unsuccessful.

d) APPEAL PROCEDURES

(i) **GROUND FOR APPEAL:** The claimant may appeal any adverse action within the discretion of the Board of Trustees to the Board of Trustees. The Board of Trustees hears appeals on medical, dental or vision benefits only about eligibility issues, and not about unfavorable determinations by Plan carriers. The Board of Trustees hears appeals regarding prescription drugs only when the claim is made under the self-funded portion of the prescription drug benefits.

(ii) **SUBMISSION OF APPEAL:** Appeals must be in writing, and state in detail the matter or matters involved. To submit an appeal, the claimant must send a letter with any documents and information that he or she wants the Board to consider, to the Administration Office.

(iii) **TIME LIMITS:** Claimants must submit an appeal within 180 days of receiving the denial of the original claim by the Administration Office. If a claimant does not submit an appeal within 180 days of receiving a denial, he or she will be deemed to have waived any objection to the denial.

(iv) **STANDARD FOR REVIEW:** The Board of Trustees has full discretionary authority to decide upon Plan benefits, to interpret the Plan language conclusively and to make a final determination of the rights of any participant, beneficiary, assignee, or other person with respect to Plan benefits. The Board of Trustees will take into account everything that the claimant submitted, even material that was submitted or considered in the initial benefit determination. The Board of Trustees will not give deference to the initial determination. Neither a person who made the initial determination nor such a person's subordinate shall have a vote in the decision on appeal.

In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment is medically necessary or appropriate, the Board of Trustees shall consult with a health care professional. The health care professional shall not have participated in making the initial benefit determination. The Board of Trustees shall, upon claimant's request, identify the health care professional, regardless of whether the Board of Trustees relied on his or her advice in making the decision.

(v) NOTIFICATION

(A) TIME LIMITS FOR NOTIFICATION

(1) Urgent Care Claims: The Administration Office will notify the claimant of the Board of Trustees' determination as soon as possible, but not more than 72 hours after receiving the claimant's request for an appeal.

(2) Pre-Service Claims: The Administration Office will notify the claimant of the Board of Trustees' determination as soon as possible, but not more than 30 days after receiving the claimant's request for an appeal.

(3) Post-Service Claims: The Board of Trustees will render a decision on the appeal at the regularly scheduled meeting immediately following the filing of the appeal, unless the appeal is filed within 30 days of the meeting, in which case the decision may be made at the second meeting following the appeal. The claimant shall be notified of the time and place of the meeting. Upon written request, the claimant (or authorized representative of his or her choice) shall be allowed to appear before the Board of Trustees at a hearing. The Board of Trustees does not need to make a verbatim record, but the Administrator shall prepare a summary of the claimant's presentation and keep it, along with any documents deemed pertinent or which the claimant requests to have included, in the file.

If special circumstances require further extension, the decision will be made no later than the third meeting following the filing of the appeal. In such cases, the Administration Office will notify the claimant in writing of the extension, describing the special circumstances and the date the determination will be made, before the extension begins.

The Administration Office will notify the claimant of the Board of Trustees' determination as soon as possible, but no later than 5 days after the decision is made. The Board of Trustees' response period will be extended by any additional time it takes for the claimant to provide requested information.

(B) CONTENTS OF NOTICE: The Administration Office will send the claimant written notice of the Board of Trustees' decision on appeal. If the appeal has been denied, the notice will include the following information:

(1) the specific reason(s) for the denial;

- (2) reference to the specific Plan provision(s) on which the denial is based;
- (3) if the decision relied upon an internal Plan rule, guideline, protocol or similar criterion, either the specific rule, or a statement that the specific rule was relied upon and that a copy of such rule will be provided free of charge upon request;
- (4) if the decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the Plan's terms to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- (5) a statement that the claimant may view and receive copies of documents, records or other information relevant to the claim, upon request and free of charge; and
- (6) the claimant's right to bring a civil action under ERISA § 502(a).

Matters Under the Discretion of Your Plan Carrier

If a claim for medical, dental or vision benefits is denied on grounds other than eligibility under this Plan, the claimant's only appeal is under the appeals procedures provided by the insurance carrier, HMO, or other provider which rendered the decision to which the claimant objects.