NORTHERN CALIFORNIA TILE INDUSTRY HEALTH & WELFARE PLAN

SUMMARY PLAN DESCRIPTION

January 1, 2018

INTRODUCTION

This booklet is the Summary Plan Description ("SPD") of your Health and Welfare Plan, as in effect on January 1, 2018. 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, 2018. This is followed by the Claims and Appeals Procedures, administrative information, 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 self-funded benefits provided by the Plan, please contact the Plan Administration Office, BeneSys Administrators. For a complete description of all benefits provided through Kaiser or United HealthCare, see the separate booklets provided by Kaiser or United HealthCare.

PLAN ASSISTANCE FOR SPANISH SPEAKERS

ASSISTENCIA DEL PLAN PARA HABLANTES DE ESPAÑOL

Este folleto contiene un resumen en inglés de sus derechos y beneficios bajo el "Health and Welfare Plan." Si tiene dificultad entendiendo cualquier parte de este folleto, por favor contactese con Local 3 llamando a (510) 632-8781.

Important Information about the Plan

1. Active employees who meet the eligibility requirements of the Plan may select one of three options for medical coverage: the Self-Funded PPO Plan, Kaiser Foundation Health Plan or United HealthCare HMO. If you are a new member, you must choose an option by completing an enrollment form and returning it to the Plan Administration Office.

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, you may be required to wait until the next open enrollment period.

Contact the Plan Administration Office, 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 BeneSys Administrators may confirm your eligibility status or accept appeals to the Board of Trustees concerning the Self-Funded PPO Plan or your eligibility for benefits under Kaiser or United HealthCare.

Please be aware of the following time limitations regarding claims and appeals:

- Any claim for benefits under this Plan, together with proof of the claim, must be submitted no later than 12 months after the date of service, unless if the delay in submitting a claim was due to the terms of the network provider, Medicare, or other organizations respective agreement or governing legislation. In such cases, the time period may be extended.

- If you are dissatisfied with an action or decision of the Plan Administration Office or other agent of the Board of Trustees, you may appeal that action to the Board of Trustees within 180 days of receiving notification of the unfavorable action or decision. You must submit a written request for appeal of the unfavorable action or decision to the Plan Administration Office, or you will be deemed to have waived your objections to it. See the section entitled Claims and Appeals Procedures for details regarding how to file an appeal. The Board of Trustees' decision with regard to an appeal is final and binding on all parties.

- A law suit based on the Board of Trustees' denial of benefits or any other action or dispute must be filed within one year from the date the Board gives you notice of its decision.

Appeals on issues related to specific benefits and coverages provided by Kaiser or United HealthCare, such as medical necessity, must be submitted to either Kaiser or United HealthCare.

Class Actions: By participating in the Plan, you and your family members agree to waive, to the fullest extent permitted by law, whether or not in court, any right to commence, be a party in any way, or be an actual or putative class member of any class, collective, or representative action arising out of or relating to any dispute, claim or controversy relating to the Plan, and you and your family members agree that any dispute, claim or controversy may only be initiated or

maintained and decided on an individual basis.

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PLAN SERVICES 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:

BeneSys Administrators .....(925) 208-9999
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566

General Trust Information www.bac3tilebenefits.org

Local Union

The Union also provides assistance on Plan benefits:

Bricklayers and Allied Crafts Local Union No. 3 .....(800) 281-8781
10806 Bigge St.
San Leandro, CA 94577

Other Providers

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

United HealthCare (formerly PacifiCare) HMO.....(800) 624-8822
or HMO Website: www.uhcwest.com
UHC Website: www.myuhc.com

Blue Shield of California
For Utilization Review .....(800) 541-6652
For Preferred Providers .....www.blueshieldca.com

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

Sav-Rx.....(800) 228-3108
or www.savrx.com

Beat It!.....(800) 828-3939
or 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, when the contributions for those hours are reported and paid. A month of coverage under the Hour Bank "costs" 120 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 requirements 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 registered domestic partner, and your natural children, adopted children, and stepchildren, until the end of the calendar year in which the child reaches age 26, or through any age with a qualifying disability. Life insurance coverage for eligible dependents terminates on the dependent's 26th birthday.

What benefits are provided?

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

- The Self-Funded PPO Plan.
- United HealthCare HMO.
- Kaiser Foundation Health Plan (an HMO).

The Self-Funded PPO Plan pays benefits to you, or directly to your provider, for health care which is medically necessary and prescribed by a licensed provider. The Self-Funded PPO Plan pays benefits for most types of care, regardless of whom you use as providers, but you will pay significantly less if you use PPO providers. The Plan's current PPO is Blue Shield of California. Currently, contributing employers, non-bargaining unit employees, and their dependents

who meet the Plan's eligibility requirements for individual employer coverage may be enrolled in either the United HealthCare HMO or the Kaiser Foundation Health Plan, but may not be enrolled in the Self-Funded PPO Plan. The Self-Funded PPO Plan is also closed to new retirees, as of January 1, 2014.

Under both HMOs, you pay only a fixed fee for each covered visit, which may vary with the type of service. However, your choice of doctors and facilities is limited. Kaiser requires that you use only their doctors, hospitals and other facilities, and have all your health care directed by a primary care physician. United HealthCare generally requires you to use only participating doctors, and have all your health care directed by a primary care physician.

The Plan provides a variety of other benefits:

- Dental benefits are provided by the Self-Funded PPO Plan for all plan participants.
- Prescription benefits are provided by the medical option in which you enroll: either the Self-Funded PPO Plan, Kaiser or United HealthCare.
- Vision care benefits are provided through Vision Service Plan for all Plan participants.
- Life insurance and accidental death and dismemberment insurance are provided through Union Labor Life Insurance Company for all Plan participants.

All of these benefits are summarized below in this booklet beginning on page 16.

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 contributions for hours are reported and paid on your behalf to the Plan Administration Office, an "Hour Bank" is established for you. Each month, your Hour Bank reserve account 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.

If you are a new employee, or an employee returning to covered employment after a period of extended unemployment, you will become eligible for benefits on the first day of the second month following any three or fewer consecutive calendar months in which you are credited with a minimum of 360 total hours of work for participating employers.

For example, if you work at least 360 hours in 3 consecutive months, beginning in the month shown below:	**And your credited work hours reach the combined total of 360 in the month shown below:**	**Then you will be covered under the Plan in the month shown below:**
November	January >	March
January	March >	May

Your eligibility will continue so long as the combined total of your credited work hours and any hours in your reserve account equal at least 120. If you work more than 120 hours of covered employment in any month, the excess hours are added to your Hour Bank reserve account and can be used when you do not work 120 hours in a month. You may accumulate a reserve of up to 360 hours.

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

Self-Payments: For eligibility in calendar months through March 31, 2019, if the combination of your credited work hours and your reserve hours do not equal 120, you may continue your eligibility by making a Self-Payment of $450 for a maximum of 2 continuous months. To qualify to make Self-Payments, you must be on the out-of-work list and actually available for dispatch, and you must have been eligible for benefits in either (a) 8 of the 12 months before the month you lost eligibility, or (b) 14 of the 24 months before the month you lost eligibility.

Reinstatement: If you have been off Hour Bank coverage for less than six months, you do not have to work 360 hours of covered employment to be

covered again. Instead, you will be reinstated to Hour Bank coverage if you work 120 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. You may also be eligible for up to four months of coverage at no charge under the California Pregnancy Disability Leave Act.

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, California Family Rights Act, and New Parent Leave Act: If you work full-time for an employer and the Family and Medical Leave Act ("FMLA"), California Family Rights Act ("CFRA"), or New Parent Leave Act (NPLA) applies to your employer, you may qualify for health coverage. If any of these laws apply to your employer at your worksite, your employer is responsible to make contributions to the Plan for your coverage if you are eligible for, and take, qualifying leave under the FMLA, the CFRA, or the NPLA. If this applies to you, your Hour Bank will not be charged for coverage while you are on qualifying leave. If you believe this section applies to you, contact the Plan Administration Office for more information.

2. Loss of Coverage for Cause

Even if you would otherwise meet the eligibility requirements under the Plan, 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 any of these occur, all of your accumulated hours in your Hour Bank reserve will be cancelled, and you must requalify for coverage under the Plan as a new employee. 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

Retirees who meet the eligibility requirements under the Plan may be enrolled in retiree coverage under either of the HMO plans offered to active employees, and will also be eligible for dental and vision benefits. Medical coverage under the Self-Funded PPO Plan is not available for retirees.

Non-Medicare retirees who reside outside the geographical service areas of the HMO plans will be enrolled in the United Health Care PPO for such retirees. If you reside outside the HMOs' coverage areas, call the Plan Administration Office for a description of your benefits under the United Health Care out-of-area PPO plan.

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

a) you are actually receiving benefits from the Northern California Tile Industry Defined Benefit Plan; <u>and</u>

b) you are at least 60 years of age, or you retired under the Rule of 85 provisions of the Defined Benefit Plan; <u>and</u>

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 meet one of the three requirements in subparagraphs (i)-(iii), below:

(i) 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); or

(ii) effective for retirements on or after January 1, 2010, you are at least 65 year of age, are eligible for Medicare, were eligible for Health and Welfare Plan coverage as an active employee for at least 6 of the 24 months immediately preceding retirement, have been available for dispatch, were on the out-of-work list and actively seeking employment through the Union's hiring hall for all periods of unemployment from covered employment in the 24 months immediately preceding retirement, and have worked in Industry Service under the Northern California Tile Industry Defined Benefit Plan for at least 20 years; or

(iii) effective for retirements on or after October 1, 2010, you:

(A) retired under the Rule of 85 provisions of the Defined Benefit Plan, and

(B) were eligible for Health and Welfare Plan coverage as an active employee for at least 6 of the 24 months immediately preceding retirement, and

(C) have been available for dispatch, were on the out-of-work list and actively seeking employment through the Union's hiring hall for all periods of unemployment from covered employment in the 24 months immediately preceding retirement; and

e) you applied for coverage within 60 days of your retirement; and

f) if you are eligible for Medicare and covered under an HMO, you must elect the applicable Medicare advantage plan offered by your HMO, reside in the applicable Medicare advantage service area of your HMO, and assign your Medicare to your HMO.

Exceptions if you had disability coverage prior to retirement:

a) Effective for retirements on or after January 1, 2010, any period during the 12-month period immediately preceding your retirement in which you met the requirements for disability coverage will be credited toward the active coverage requirement in paragraph d)(i) above.

b) Effective for retirements on or after October 1, 2010, any requirement that you were available for dispatch and on the out-of-work list and actively seeking employment through the Union's hiring hall will not apply for any period during the 24-month period immediately preceding your retirement in which you met the requirements for disability coverage.

Additional exceptions:

a) If you are otherwise eligible for retiree coverage except that you were not eligible for Health and Welfare Plan coverage as an active employee for at least 6 of the 12 months immediately preceding retirement, with at least 3 of these 6 months due to active employment, you must provide the Plan Administration Office with proof that, during the 24 months prior to your retirement, you did not:

(i) work for a contractor in the Tile Industry who is not signatory to the applicable collective bargaining agreement unless so employed as part of an organizing drive certified by the Union; or

(ii) work as a contractor in the Tile Industry without being signatory to the applicable collective bargaining agreement.

Such proof must be in the form of tax returns filed for all tax years during the 24 months prior to retirement, including associated Forms W-2 and 1099.

b) 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.

NOTE TO RETIREES ELIGIBLE FOR MEDICARE: It is the retiree's and/or spouse's or domestic partner's responsibility to apply for, and enroll in, both Part A and Part B of Medicare when first eligible due to either age or disability. If the retiree and/or spouse or domestic partner does not sign up for Part B of the Medicare program, he or she may incur large medical expenses which will not be covered under the retiree coverage.

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 registered domestic partner (as part of domestic partner coverage, the Plan pays the incidental federal employment payroll taxes, in accordance with governing IRS and U.S. Department of Labor rulings); and

b) your child(ren) up to the end of the calendar year in which the child attains the limiting age, defined below.

The term "Child" means any of the following:

a) your natural child;

b) your stepchild or foster child, or child of your registered domestic partner, if such child depends chiefly on you for support and maintenance;

c) 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; or

d) 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 when you have been ordered to maintain their coverage in a court order called a "Qualified Medical Child Support Order" ("QMCSO") 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 the Plan Administration Office.

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

a) he or she lives outside the United States;

b) he or she is on active duty in the Armed Forces of any country.

For medical benefits, a dependent child is covered until the end of the calendar year in which he or she reaches age 26. Coverage may be continued after the end of the calendar year in which a dependent child reaches age 26, 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.

Eligible dependent children are covered until their 26th birthday for life insurance.

Coordination of Benefits: If you or your dependent is also covered by another health plan, the benefits under this Plan and the other plan will be coordinated. This means one plan pays its full benefits first, then the other plan pays. The complete Plan rules regarding Coordination of Benefits are found in the Formal Plan Rules document, available from the Plan Administration Office.

Coordination with Medicare. This Plan will be secondary with respect to Medicare for a covered person whenever allowed by law. When this Plan is secondary with respect to Medicare, Medicare benefits are determined first. Then, Plan benefits will be paid, but the combined Plan and Medicare benefits shall not exceed the amount that would have been paid by the Plan in the absence of Medicare.

Dual Coverage: When two spouses or domestic partners, or both of a child's parents, are covered under the Plan as employees, benefits will be paid in accordance with the Plan's Coordination of Benefits provisions. The combined benefits will not exceed 100% of the actual eligible charges incurred. Either spouse or domestic partner or parent may submit a claim.

5. Individual Employers and Non-Bargaining Unit Employees

An individual who meets these eligibility requirements under the Plan may be enrolled in any one of the HMO plans then offered to active employees, and will also be eligible for dental and vision benefits. Medical coverage under the Self-Funded PPO Plan is not available.

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 provide a copy of each California quarterly payroll tax report filed during the preceding 12-month period and any other documentation required by the Plan's Administration Office to confirm that all non-bargaining unit employees not covered under another collectively bargained health plan are enrolled under these rules; and

c) pay to the Fund, at the time of application for coverage, and then on or before the 10th day of each month thereafter, the amount determined by the Board of Trustees from time to time as the cost of such coverage, for the employer and for each qualified employee who is not covered under another collectively bargained group health plan.

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.

Notwithstanding the rules described above for establishing coverage, effective for coverage that begins in the 2011 calendar year, an employer who has made contributions for at least 1500 hours of bargaining unit personnel in a preceding twelve-month period as determined by the Board of Trustees may obtain coverage under these rules if all other requirements are met.

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) continues to make contributions for at least 3500 hours of bargaining unit personnel every twelve (12) months, to be reviewed annually by

the Plan Administration Office, except that, for an employer who actively worked in covered employment as a bargaining unit member during the 12-month period immediately preceding the establishment of coverage under these rules, the employer must make contributions for at least 1500 hours of bargaining unit personnel during the first 12-month period of coverage;

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. The employer must also provide the Plan Administration Office with a copy of each California quarterly payroll tax report filed during the preceding 12-month period, and any other documentation required by the Plan Administration Office each year, to confirm that all non-bargaining unit employees not covered under another collectively bargained health plan are enrolled under these rules.

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

6. COBRA Continuation Coverage

Covered persons who lose 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, dissolution of a domestic partnership with 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 the Plan Administration Office if you or any of your dependents will be losing coverage because of any of the following reasons:

a) your death;

b) your divorce or dissolution of your domestic partnership;

c) your child no longer qualifies as an eligible dependent, due to age, which occurs at the end of the calendar year in which he or she turns age 26, or because he or she 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.

You may elect "core coverage" (that is, all Plan benefits except dental care, vision benefits and life insurance and accidental death or dismemberment insurance), or full COBRA coverage (all Plan benefits, including dental and vision benefits, except life insurance and accidental death and dismemberment insurance). Your election of one type of coverage applies to your dependents as well. However, if you do not elect COBRA coverage, your dependent(s) may elect either form of coverage for themselves. If you have one or more dependents and initially elect full COBRA coverage, you may change your election to "core coverage" upon the termination of dependent status of one or more dependents as a result of divorce, dissolution of a domestic partnership or death.

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.

COBRA coverage is <u>not</u> 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 notice of COBRA continuation coverage rights.

7. Continuity of Care

If you or your dependent incur expenses for treatment by a physician who was a Preferred Provider, and during the course of such treatment, the physician's Preferred Provider contract was terminated, the Plan may continue to pay benefits for that treatment as though that physician is still a Preferred Provider, for certain conditions only. The complete Plan rules regarding Continuity of Care are found in the Formal Plan Rules document, available from the Plan Administration Office.

8. Third Party Reimbursement

If you or your dependent has an injury or sickness caused or allegedly caused by a third party's act or omission, the Plan will pay benefits for that injury or sickness, subject to its right to reimbursement from any amount recovered by reason of the third party's act or omission, on the following conditions: (1) that you or your dependent (or legal representative) will not take any action which would prejudice the Plan's reimbursement rights, and (2) that you or your dependent (or legal representative) will cooperate in doing what is reasonably necessary to assist the Plan in enforcing its reimbursement rights. The Plan's reimbursement right will be for 100% of benefits paid, regardless of whether or not you or your dependent has received full or any compensation, and will not be reduced because the recovery does not fully or partly compensate you or your dependent for all losses sustained or alleged, or the recovery is not described as being related to medical costs or loss of income.

The complete Plan rules regarding Third Party Reimbursement are found in the Formal Plan Rules document, available from the Plan Administration Office.

9. Reservation of Powers

The Board of Trustees has sole, full, and final discretionary authority to construe the terms of the Plan and all other documents relevant to the Plan for all purposes, including but not limited to the purposes of determining what benefits should be paid, the meaning and application of eligibility rules, the scope and application of the Plan's right to reimbursement, and the rights of assignees.

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:

- The Self-Funded PPO Plan (a preferred provider organization, or PPO).
- Kaiser Foundation Health Plan (a health maintenance organization, or HMO).
- United HealthCare HMO.

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

Contributing employers, non-bargaining unit employees, and their dependents who meet the Plan's eligibility requirements for individual employer coverage may be enrolled in either the United HealthCare HMO or the Kaiser Foundation Health Plan, but may not be enrolled in the Self-Funded PPO Plan.

Retired employees, and their dependents who meet the Plan's eligibility requirements for retiree coverage may be enrolled in either the United HealthCare HMO or the Kaiser Foundation Health Plan. The Self-Funded PPO Plan is also closed to new retirees.

How to Enroll Yourself and Your Dependents

New participants may choose from the available medical plan options 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 option and/or enroll dependents during open enrollment periods set by the Board of Trustees (usually once a year). Once you elect a medical plan option, you may only change it during open enrollment, 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, medical benefits will be paid only after you have completed an enrollment package for one of the medical plan options. If you do not return a timely enrollment form for an HMO option, you will automatically be enrolled in the Self-Funded PPO Plan. Also, if you fail to enroll your dependents within thirty days, your dependent(s) may not be able to receive medical benefits until the next open enrollment, unless your chosen medical plan option allows it.

Current Medical Plan Options

A complete description of all self-funded benefits provided by the Plan is contained in the Formal Plan Rules, which may be obtained from the Plan Administration Office. If there is any discrepancy between the summary provided in this booklet and the Formal Plan Rules, the Formal Plan Rules prevail.

Both Kaiser and United HealthCare prepare separate detailed summaries of the general benefit structure, limitations, and conditions for particular kinds of care which apply to coverage by that plan carrier. These detailed summaries are available free of charge from the Plan Administration Office or your chosen HMO 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 Kaiser or United HealthCare, 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 Kaiser or United HealthCare 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 for active employees:

SELF-FUNDED PPO PLAN
Under the Self-Funded PPO Plan, you pay annual deductibles before the Plan pays any benefits. You may see any doctor based on your medical need. However, if the doctor you choose is one of Blue Shield's preferred providers, you will generally pay 10% of a favorable contracted rate with in-network PPO providers. If the doctor you choose is out-of-network, you will pay 30% of a much higher rate, so it will benefit you to use PPO providers whenever possible. A list of

participating medical providers in Blue Shield's network is available, free of charge, as a separate document from the Plan Administration Office. You can also look for a doctor or other providers online at www.blueshieldca.com.

UNITED HEALTHCARE HMO

United HealthCare HMO's participating doctors use their own facilities and hospitals throughout the area of the Plan. Members in the United HealthCare HMO must be in the service area and 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 United HealthCare. After making a small co-payment, most services are covered at 100% and there are no deductibles. For active employees and early retirees, there is a $20 charge for most office visits, a $250 charge per day for a hospital stay, a $20 charge per prescription for generic drugs, and a $30 charge per prescription for brand name formulary drugs. For retirees, there is a $10 charge for most office visits, a $200 charge for a hospital stay, a $10 charge per prescription for most generic drugs, a $25 per prescription charge for preferred brand drugs, and a $50 charge per prescription for non-preferred brand and specialty drugs.

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 must meet Kaiser's service area residence requirement and 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. For active employees and early retirees, there is a $35 charge for office visits, a $250 charge per admission for hospital stays, a $10 charge per prescription for generic drugs, and a $25 charge per prescription for brand name drugs. For retirees, there is a $25 charge for office visits, a $250 charge per admission for hospital stays, a $10 charge per prescription for generic drugs, and a $25 charge per prescription for brand name drugs.

Self-Funded PPO Plan

Benefit Feature	PPO Provider	Non-PPO Provider
Annual Deductible Per Person: Per Family:	 $100 $200	 $300 $600
Additional Deductible for Non-Contracted Facility:		$200
Annual Medical Maximum Out-of-Pocket Per Person: Per Family:	 $600 $3000	 $6,300
Insured Percentages (After Deductible is Satisfied):		
Hospital Charges (additional $200 deductible applies to non-PPO provider)	90% 90%	70% 90% of UCR
Emergency Room	90%	70%
Ambulance	90%	70%
Urgently Needed Services	90%	70%
Physician Charges - Office Visits	90%	70%
Physician Charges - Hospital Visits	100%	70%
Well Child Care ($75 maximum benefit for office visit, $50 for laboratory services, $75 for immunizations; maximums do not apply to exams, lab services or immunizations which are a Preventive Service provided by a PPO Provider)	100%	70%
Well Woman Care	90%	70%
Lab/X-ray (100% for a Preventive Service provided by a PPO provider)	90%	70%
Imaging (MRI, CET, PET)		

Benefit Feature	**PPO Provider**	**Non-PPO Provider**
Routine Physical (for active employees only)	100% of PPO contracted rate	
Prescription Drugs Sav-Rx Card: $2000 annual benefit maximum per family. After the Sav-Rx card annual maximum has been reached, prescription drug benefits will be reimbursed at 80% coinsurance, except that Preventive Services will be reimbursed at 100%. (Retirees pay 20% of the Sav-Rx rate for all drugs, except that Preventive Services will be reimbursed at 100%.)	No charge for generic $10 for brand name $30 non-formulary brand name Out-of-Pocket Maximums: $6,250 per person $10,700 per family	
Mental Health - Inpatient	90%	70%
Mental Health - Outpatient	90%	70%
Substance Abuse Treatment - Inpatient Detoxification	90%	70%
Substance Abuse Treatment - Inpatient Rehabilitation (Coverage differs for employees with and without prior outpatient coverage under the Beat It! Program; see page 48 for more information about this coverage)	See page 48	70%
Substance Abuse Treatment - Outpatient	90%	70%
Durable Medical Equipment	90%	70%
Home Health Care	90%	70%
Skilled Nursing Facility/Admission into an Approved Hospice Program	100%	100% after $200 deductible
Outpatient Hospice	90%	70%

United HealthCare HMO for Active Employees and Early Retirees

Benefit Feature	**Amount**
Lifetime Maximum	Unlimited
Annual Deductible Per Person: Per Family:	 None None
Annual Maximum Out-of-Pocket Per Person: Per Family:	 $2,000 in co-pays $6,000 in co-pays
Hospital Charges - Inpatient	$250 co-pay per day
Emergency Room (waived if admitted)	$100 co-pay per visit
Ambulance	No charge
Urgently Needed Services (within service area)	$20 co-pay per visit
Preventive Care/Screening/Immunization	No charge
Physician Charges - Primary Care - Office Visits	$20 co-pay per visit
Physician Charges - Specialist - Office Visits	$40 co-pay per visit
Well Child Care	No charge
Well Woman Care (including routine prenatal care)	No charge
Lab/X-ray	No charge
Imaging (MRI, CET, PET)	$200 per procedure
Prescription Drugs	$20 generic/ $30 brand name formulary
Mental Health - Inpatient	$250 co-pay per day
Mental Health - Outpatient	$40 co-pay per visit
Substance Abuse Treatment - Inpatient	No charge
Substance Abuse Treatment - Outpatient	No charge
Durable Medical Equipment	No charge

Benefit Feature	**Amount**
Home Health Services (up to 100 visits per year)	No charge
Skilled Nursing Facility (up to 100 days per year)	$150 co-pay per day
Hospice	No charge
Eye Exam (once per 12 months)	$20 co-pay

United HealthCare HMO for Medicare Retirees

Benefit Feature	**Amount**
Lifetime Maximum	Unlimited
Annual Deductible	None
Annual Maximum Out-of-Pocket	$2,000
Hospital Charges - Inpatient	$200 per admission
Emergency Room	$50 co-pay per visit
Ambulance Services	$50 co-pay per trip
Urgently Needed Services	$35 co-pay per visit
Routine Physical/Annual Wellness Visit	No charge
Preventive Care/Screenings/Immunization	No charge
Physician Charges - Primary Care - Office Visits	$10 co-pay per visit
Physician Charges - Specialist - Office Visits	$20 co-pay per visit
Lab/X-ray	No charge
Prescription Drugs	$10 most generic drugs $25 preferred brand drugs $50 non-preferred brand and specialty drugs
Mental Health - Inpatient Mental Health - Outpatient	$200 per admission $20 co-pay
Substance Abuse - Inpatient Substance Abuse - Outpatient	$200 per admission $20 co-pay
Durable Medical Equipment	20% coinsurance
Home Health Agency Care	No charge
Skilled Nursing Facility Care (up to 100 days)	No charge for days 1-20 $50 co-payment per day for days 21-100
Prosthetic Devices	20% coinsurance

Benefit Feature	Amount
Routine Eye Exam (once every 12 months)	$20 co-pay
Routine Eye Wear (once every 24 months)	Glasses $130 allowance Contacts $175 allowance

Kaiser Foundation Health Plan for Active Employees and Early Retirees

Benefit Feature	**Amount**
Lifetime Maximum	Unlimited
Annual Deductible:	None
Annual Maximum Out-of-Pocket Per Person: Per Family:	 $1,500 in copays $3,000 in copays
Hospital Charges - Inpatient	$250 per admission
Emergency Room (waived if admitted)	$100 co-pay per visit
Ambulance Services	$50 per trip
Outpatient Surgery	$35 per procedure
Physician Charges - Office Visits	$35 co-pay per visit
Urgent Care Consultations and Treatment	$35 co-pay per visit
Preventive Care/Screening/Immunizations	No charge
Scheduled Pre-Natal Care Exams	No charge
Well Child Care (through 23 months)	No charge
Well Woman Care	No charge
Lab/X-ray	$10 per encounter
Imaging (MRI, CET, PET)	$50 per procedure
Prescription Drugs	$10 generic/ $25 brand name
Allergy Injections	$5 per visit
Mental Health - Inpatient Mental Health - Outpatient	$250 per admission $35 co-pay for individual therapy; $17 co-pay for group therapy

Benefit Feature	Amount
Substance Abuse Treatment - Inpatient	$250 per admission
Substance Abuse Treatment - Outpatient	$35 co-pay for individual therapy; $5 co-pay for group therapy
Durable Medical Equipment	No charge
Home Health Services (up to 100 visits per year)	No charge
Skilled Nursing Facility (up to 100 days per year)	No charge
Prosthetic and Orthotic Devices	No charge
Most Physical, Occupational and Speech Therapy	$35 per visit
Routine Eye Exams with Plan Optometrist	No charge
Hospice Care	No charge

Kaiser Foundation Health Plan for Medicare Retirees

Benefit Feature	**Amount**
Lifetime Maximum	Unlimited
Annual Deductible:	None
Annual Maximum Out-of-Pocket Per Person: Per Family:	 $1,500 $3,000
Hospital Charges - Inpatient	$250 per admission
Emergency Room	$50 co-pay per visit
Ambulance Services	$50 per tri
Physician Charges - Office Visits	$25 co-pay per visit
Routine Physical/Annual Wellness Visit	No charge
Preventive Care/Screenings/Immunization	No charge
Lab/X-ray	No charge
Prescription Drugs (100 day supply)	$10 generic/ $25 brand name
Mental Health - Inpatient	$250 per admission
Mental Health - Outpatient	$25 co-pay for individual therapy; $12 co-pay for group therapy
Substance Abuse Treatment - Inpatient	$250 per admission
Substance Abuse Treatment - Outpatient	$25 co-pay for individual therapy; $5 co-pay for group therapy
Durable Medical Equipment	No charge
Home Health Services (part-time, intermittent)	No charge
Skilled Nursing Facility (up to 100 days per year)	No charge

Benefit Feature	Amount
External Prosthetic and Orthotic Devices	No charge
Ostomy and Urological Supplies	No charge
Routine Eye Exams with Plan Optometrist	$25 per visit
Eye Glasses or Contact Lenses (every 24 months)	$150 allowance

INFORMATION ABOUT PARTICULAR MEDICAL BENEFITS UNDER ALL MEDICAL PLAN OPTIONS

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.

INFORMATION ABOUT PARTICULAR MEDICAL BENEFITS UNDER THE SELF-FUNDED PPO PLAN

(A) Alpha Feto Protein Benefits

This provision applies only when the covered person's pregnancy is covered under the Plan.

If, while covered under the Plan, you or your dependent participates in the Expanded Alpha Feto Protein program, the Plan will pay the expense incurred in the same manner and subject to the same conditions and limitations as any other covered service, except as described below.

Expenses for any alpha feto protein screening benefit that is a Preventive Service, as defined in (K) below, are not subject to the deductible and will be paid at 100% if the service is provided by a PPO Provider.

"Expanded Alpha Feto Protein" program means a statewide prenatal testing program administered by the State Department of Health Services.

(B) Clinical Trial Benefits

The Plan provides coverage for routine patient costs for items and services furnished to a covered qualified individual in connection with participation in a Clinical Trial, as defined below.

Clinical Trial means a Phase I, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition that:
(a) is conducted under an investigational new drug application reviewed by the Food and Drug Administration;
(b) is a drug trial that is exempt under federal regulations from having an investigational new drug application reviewed by the Food and Drug Administration; or
(c) is approved or funded by one of the following:
(1) one of the National Institutes of Health;
(2) the Centers for Disease Control and Prevention;
(3) the Agency for Health Care Research and Quality;
(4) the Centers for Medicare & Medicaid Services;
(5) a cooperative group or center of any of (1)-(4) above or the Department of Defense or the Department of Veterans Affairs;
(6) a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
(7) if the requirements of Section 2709(d)(2) of the Patient Protection and Affordable Care Act are met, any of the following: the United States

Department of Defense; the United States Department of Energy; or the United States Department of Veterans Affairs.

For purposes of this provision, "life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Exceptions
Benefits will not be provided for:
(a) the investigational item, device, or service itself;
(b) services other than health care services, such as travel, housing, companion expenses or other non-clinical expenses;
(c) any item or service provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient;
(d) any services specifically excluded from coverage under the Plan; or
(e) any services provided by the research sponsors free of charge.

(C) Cancer Screening Benefits

If, while covered under the Plan, you or your dependent incurs expense for any generally medically accepted cancer screening tests, the Plan will pay benefits in the same manner and subject to the same conditions and limitations as any other covered service, except as described below.

Expenses for any cancer screening benefit that is a Preventive Service, as defined in (K) below, are not subject to the deductible and will be paid at 100% if the service is provided by a PPO Provider.

(D) Diabetes Benefits

If, while covered under the Plan, you or your dependent incurs expense for the medically necessary treatment of:

(i) insulin-using diabetes;
(ii) non-insulin-using diabetes; or
(iii) gestational diabetes;

benefits will be payable as follows, even if the items are available without a prescription.

For these items, benefits are payable in the same manner and subject to the same conditions and limitations as any other covered service:

(i) blood glucose monitors designed to assist the visually impaired;
(ii) insulin pumps and all related necessary supplies;
(iii) pen delivery systems for the administration of insulin;
(iv) podiatric devices to prevent or treat diabetes-related complications; and

(v) visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

Note: prior approval of the Utilization Review Program is required before benefits are payable for insulin infusion pumps.

For these items, benefits are payable in the same manner and subject to the same conditions and limitations as any other prescription drug:
(i) ketone urine testing strips.

For diabetes outpatient self-management training, education, and medical nutrition therapy:
(a) necessary to enable a covered person to properly use equipment, supplies, and medication related to the person's treatment; or
(b) directed or prescribed by a physician; and
(c) provided by appropriately licensed or registered health care professionals;
benefits are payable in the same manner and subject to the same conditions and limitations as a physician's office visit.

Other diabetes benefits are provided under the Prescription Drug program, described elsewhere in this Summary Plan Description.

(E) General Anesthesia and Associated Facility Charges for Dental Procedures

If, while covered under the Plan, you or your dependent requires a dental procedure that is provided in a hospital or surgery center setting, the Plan will pay the expense incurred for:
(a) general anesthesia; and
(b) the associated hospital or surgery center charges;
in the same manner and subject to the same conditions and limitations as any other covered service, when the clinical status or underlying medical condition of the covered person requires dental procedures that would ordinarily not require general anesthesia to be rendered in a hospital or surgery center.

Conditions
The benefits described above are payable only for a covered person:
(a) who is a child under the age of 7;
(b) who is developmentally disabled, regardless of age; or
(c) whose health is compromised and for whom general anesthesia is medically necessary, regardless of age.

Exceptions
The Plan will not pay for:
(a) the dental procedure itself;
(b) the professional fee of the dentist;

(c) anesthesia or related facility charges for dental procedures that ordinarily would require general anesthesia; or
(d) anything excluded under the Exclusions listed in the Formal Plan Rules.

See also Dental Benefits, described below.

(F) Bariatric Surgery

Bariatric surgery benefits will be provided only in accordance with Medicare national coverage guidelines then in effect. Prior Utilization Review is required for bariatric surgery, whether performed on an in-patient or out-patient basis.

(G) Preventive Services

Benefits will be provided for the following Preventive Services:

1. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;
2. Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Centers for Disease Control and Prevention with respect to the individual involved;
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
4. With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Any new recommendation or guideline issued by the United States Preventive Services Task Force, the Centers for Disease Control or the Health Resources and Services Administration with respect to the services described above will be covered as a Preventive Service as of the first Plan Year beginning on or after the date that is one year after the date the new recommendation or guideline went into effect.

(H) Contraceptive Benefits

The Plan covers all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity as prescribed.

Contraceptive benefits are also provided under the Prescription Drug Program, described elsewhere in this Summary Plan Description.

UTILIZATION REVIEW PROGRAM

The Self-Funded PPO Plan requires prior Utilization Review for certain services, including all hospital admissions and overnight stays at any medical facility. Utilization Review has proven effective in helping patients avoid unnecessary effort and expense, while still getting quality medical services at the most appropriate level of care. Failure to obtain prior Utilization Review or to follow the recommendations of the Utilization Review Program may result in non-payment if the Utilization Review Program determines that the service is not covered.

It is your responsibility to notify the Utilization Review Program. You should contact the Utilization Review Program directly to verify that the admitting physician or hospital has made the required "notification." Utilization Review is provided by Blue Shield of California at (800) 541-6652.

In addition to hospital admissions, Prior Utilization Review is also currently required for the following services:
(a) Non-emergency Hospital Admission
(b) Outpatient Surgery
(c) Skilled Nursing Admission/Admission into an approved Hospice Program
(d) Non-PPO Home Health Care/Private Nursing/Outpatient Hospice Services
(e) Inpatient Mental and Emotional Illness Treatments
(f) Non-PPO Provider Home Infusion/Injectable Therapy
(g) Select Injectable Drugs, except injectable contraceptives (prior authorization not required) administered in the Physician office setting
(h) Durable Medical Equipment, including but not limited to motorized wheelchairs, insulin infusion pumps, and Continuous Glucose Monitoring Systems (CGMS), except breast pumps (prior authorization not required)
(i) Reconstructive Surgery
(j) Orthognathic Surgery of temporomandibular joint (TMJ) Services
(k) Hemophilia home infusion products and services
(l) The following radiological procedures when performed in an Outpatient setting on a non-emergency basis: CT (Computerized Tomography) scans, MRIs (Magnetic Resonance Imaging), MRAs (Magnetic Resonance Angiography), PET (Positron Emission Tomography) scans, and any cardiac diagnostic procedure utilizing Nuclear Medicine
(m) All Transplants
(n) All bariatric surgery
(o) Behavioral Health Treatment, Outpatient Partial Hospitalization, Intensive Outpatient Care and Outpatient ECT Services for the treatment of Mental Health Conditions
(p) Medically Necessary dental and orthodontic Services that are an integral part of Reconstructive Surgery for cleft palate procedures.

LIMITATIONS AND EXCLUSIONS

A. LIMITATIONS ON BENEFITS

Certain Covered Medical Charges are limited. These covered charges and their limitations are as follows.

a. Charges in connection with teeth, gums or alveolar process are covered only for:
(1) hospital charges for necessary inpatient care; and
(2) treatment of tumors.

b. Charges in connection with cosmetic surgery are covered only:
(1) within 12 months after and as the result of an injury;
(2) for the correction of a congenital defect of your dependent child; and
(3) for replacement of diseased tissue surgically removed.

c. Charges in connection with transplants or replacements of tissue or organs are covered only to the extent they are not considered experimental by the Health Care Financing Agency (HCFA) of the federal government.

If both the donor and the donee are covered under the Plan, the donor's and donee's charges are covered. The total of the donor's and donee's charges will not be more than any maximums under the Plan applicable to the donee.

If the donor is not covered under the Plan and the donee is covered under the Plan, the donor's charges will be covered only to the extent that the donor's charges are not covered under any other insurance. The total of the donor's and donee's charges will not be more than any maximums under the Plan applicable to the donee.

If the donor is covered under the Plan and the donee is not covered under the Plan, the donor's charges and the donee's charges are not covered.

B. EXCLUSIONS

No benefits will be paid for charges in connection with:

(a) services or supplies for which a covered person is not required to pay or charges made only because coverage exists;

(b) sickness or injury:
(1) for which benefits are paid or payable under workers' compensation or any similar law; or
(2) that is caused by, or connected in any way to, employment of the covered person;

(c) health exams that are not required for treatment of sickness or injury unless 1) specifically provided under the Plan, or 2) the exam is a Preventive Service and is provided by a PPO Provider;

(d) any act due to war, if declared or not, or arising out of service in the Armed Forces; or participation in a riot or insurrection; or participation in a felony, unless the charges resulted from an act of domestic violence or a medical condition;

(e) eye refractions, except as specifically provided under the Formal Plan Rules; eyeglasses or the fitting of eyeglasses; radial keratotomy or other surgical procedure to correct myopia; visual training; vision therapy; speech therapy, unless medically necessary due to a covered sickness or injury incurred while covered under the Plan; hearing aids or the fitting of hearing aids; shoes;

(f) diagnosis and treatment of weak, strained, or flat feet or the cutting or removal of corns, calluses and toenails (this will not apply to the removal of nail roots);

(g) educational testing or training; or behavior modification programs; or services primarily oriented toward treating a social, developmental or learning problem, except as specifically provided under the Plan;

(h) custodial care;

(i) sleep disorders, except when coordinated through the Utilization Review Program;

(j) charges incurred as a donor of an organ when the donee is not insured under the Plan;

(k) drugs and medicines that may be obtained without a written prescription;

(l) charges that are more than the reasonable and customary charges for the services and supplies furnished;

(m) hospital services and supplies when confinement is solely for diagnostic testing purposes;

(n) comprehensive preventive child care except 1) as specifically provided for, or 2) Preventive Services provided by a PPO Provider;

(o) any charge for treatment of sexual dysfunction;

(p) "stand-by" services of a physician or surgeon whether in the physician's or surgeon's office or a hospital;

(q) transportation, except as specifically provided under the Plan; or

(r) care, treatment, services or supplies, other than Preventive Services provided by a PPO Provider:
(1) not prescribed by a physician;
(2) not medically necessary;
(3) which are experimental as recognized in the United States or provided mainly for the purpose of medical or other research;
(4) received from a nurse which do not require the skill and training of a nurse;
(5) to the extent that benefits are payable under other provisions of the Plan;
(6) for which benefits are not paid due to the Deductible or Coinsurance provisions of the Plan:
(7) received in a hospital or institution owned or operated by the United States government or any of its agencies; or
(8) provided by or paid for by any governmental plan or law not restricted to the government's civilian employees and their dependents. (This will not apply to Medicaid or Medi-Cal.)

No benefit payment shall be made for charges incurred after the date the Plan is terminated, except as provided under any extended benefits provision of the Plan.

DENTAL PLAN

Dental benefits are provided to active employees under the Plan, covered non-bargaining unit employees and individual employers, eligible dependents, covered retirees, and COBRA participants who elect full coverage. An active employee or retiree may elect not to receive coverage for dental benefits by contacting the Plan Administration Office.
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 Plan's dental benefits, in effect when this booklet was published. Class A Services for active employees include exams, teeth cleaning, x-rays, extractions, oral surgery, fillings and root canals. Class B Services for active employees include crowns, first installation of fixed bridgework and partial or full dentures, and repairing of crowns, bridgework and dentures.

For covered retirees, Class A Services are routine exams, cleaning and x-rays only. Class B Services for covered retirees are all other covered dental services.

Please contact the Plan Administration Office for a complete description of current dental benefits, and a complete listing of Class A and Class B Services, as well as conditions of coverage, limitations, and exclusions.

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%
Lifetime 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, covered non-bargaining unit employees and individual employers, eligible dependents, retirees, and 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 – Group No. 00411800

Benefit	In Network	Out of Network
Eye Exam - each 12 months*	Covered in full**	Reimbursed up to $45**
Lenses - each 12 months*	Covered in full**	Single - Up to $30** Bifocal - Up to $50** Trifocal - Up to $65** Lenticular - Up to $100**
Contacts – each 12 months*	Necessary - Covered in full** Elective - Up to $150**	Necessary - Up to $210** Elective - Up to $105**
Frames - each 24 months*	Covered up to plan allowance**	Up to $70**

* from your last date of service
** subject to a $10 copayment

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 United HealthCare 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 $10 co-payment per prescription for generic drugs at Kaiser and a $25 co-payment for brand name drugs. There is a $20 co-payment per prescription for generic drugs charged by United HealthCare and a $30 co-payment for brand name formulary drugs. You may also use United HealthCare's mail order system, and pay one co-payment for a 90-day supply, instead of the 30-day supply available from your pharmacist. The mail order co-payments are $40 for generic drugs and $60 for brand name formulary drugs.

If you are enrolled in the Self-Funded PPO Plan, prescription drug benefit payments for you and your dependents are administered through Sav-Rx. To receive these benefits, you must use your Sav-Rx card at a participating pharmacy and pay the required co-payment as advised by the pharmacy.

(1) For the first $2,000 in prescription drug benefits combined for you and your family, the co-payments are as follows:

Actives: Generic drug: no charge
$10 for formulary brand drug
$30 for all other drugs

Retirees: 20% of the Sav-Rx rate, for all drugs

You may also use the Sav-Rx Mail Order system, and pay one co-payment for a 90-day supply, instead of the 30-day supply available from your pharmacist. The mail order co-payments are as follows:

Actives: Generic drug: no charge
$20 for formulary brand drug
$60 for all other drugs

Retirees: 20% of the Sav-Rx rate, for all drugs

Covered prescription drug charges are charges which are:
(a) due to sickness or injury, or are Preventive Services;
(b) incurred while you and your dependents are covered under the Plan;
(c) reasonable and customary;
(d) for drugs and medicines that require a physician's written prescription order or for covered Diabetes Benefits; and
(e) dispensed by a licensed pharmacist at a participating pharmacy.

(2) After $2,000 has been paid in prescription drug benefits for you and your family in a calendar year, benefits are paid at 80% after the $100 per year per person PPO Plan deductible has been satisfied. Continue to use your Sav-Rx card. The Plan administration office will collect any remaining unpaid deductible. There is no limit on your annual prescription drug benefit; however, there are exclusions, which are listed below.

A complete description of current prescription drug benefits under the Self-Funded PPO Plan, as well as conditions of coverage, and limitations is contained in the Formal Plan Rules, which may be obtained from the Plan Administration Office.

(3) Expenses for any prescription drug benefit that is a Preventive Service are not subject to the deductible and will be paid at 100%.

(4) Specialty Drugs: Specialty drugs are prescription medications that require special handling, administration or monitoring. All specialty drugs are subject to prior authorization. Specialty drugs are only available through a Sav-Rx Specialty Pharmacy and are limited to a maximum of a 30-day supply.

Certain specialty drugs are eligible for manufacturer-sponsored coupon programs that significantly reduce the cost of the medication. Through Sav-Rx's prior authorization process, Sav-Rx will identify specialty drugs that are eligible for a coupon program. Sav-Rx will then facilitate covered individuals prescribed such a specialty drug in enrolling in the manufacturer-sponsored coupon program. Only the amount paid by the covered individual will be counted toward the stop-loss limit.

(5) Prior Authorization Program: Certain drug classes including, but not limited to, specialty drugs, oral and topical dermatologicals, oral and topical pain, androgens for low testosterone, chemical dependency treatment, and stimulants for narcolepsy and attention deficit are subject to prior authorization by Sav-Rx.

(6) Mandatory Generic Program: For any brand name prescription drug that has a generic equivalent drug, as determined by the U.S. Food and Drug Administration, the Plan will only cover the cost of the generic equivalent drug. If a covered individual chooses the brand name drug, he or she will be responsible for paying the difference between the generic equivalent drug and the brand name drug. This difference in cost will not be counted toward the covered individual's annual stop-loss limit.

The Plan will waive the difference in cost between the brand name drug and the generic equivalent drug if a Letter of Medical Necessity from the prescribing physician is submitted to Sav-Rx.

(7) Step Therapy Program: For new medications prescribed on or after July 1, 2016, certain classes of prescription drugs are subject to the Step Therapy Program. The Step Therapy Program requires that cost effective therapeutically equivalent prescription drugs be tried before more expensive prescription drugs are authorized by Sav-Rx. Classes of prescription drugs requiring step therapy include, but are not limited to: Proton Pump Inhibitors, Statins for Cholesterol, ARB and Combination Antihypertensives, Beta and Calcium Channel Blockers, Triptans for Migraines, SSRI/SNRI Antidepressants, Cox 2 (Celebrex) and NSAID Anti-Inflammatory, Lyrica, Sleep Aids, Nasal Sprays, Glaucoma Eye Drops, and Osteoporosis Medications (Bisphosphonates). The classes falling within the Step Therapy Program are subject to change as more clinical and cost effective drugs become available.

Prescription drugs in one of the above-named classes prescribed before July 1, 2016 are not subject to the Step Therapy Program, however, they are eligible for the Therapeutic Interchange Program. The Therapeutic Interchange Program provides individuals receiving a brand name prescription drug, where a therapeutically equivalent generic drug is available, with information about the therapeutically equivalent generic prescription drugs available. If a covered individual elects to participate in the Therapeutic Interchange Program and switch from a brand name drug to a therapeutically equivalent generic drug, the covered individual shall receive the first two (2) fills at no cost.

(8) Stop-loss Limit: After the out-of-pocket expense for allowable prescription charges incurred by each insured person reaches $6,250 ($10,700 per family), the Plan pays 100% of the Allowable Expense which that insured person incurs for Covered Services for the rest of the calendar year.

(9) The Plan also participates in the following Sav-Rx programs:

Sav-Rx TIP Program: Sav-Rx notifies you and your physician regarding the drugs you have been prescribed, making recommendations for generic or brand name equivalents which are lower in cost.

Sav-Rx Therapeutic Quantity Limitation Program (TQLP): Sav-Rx identifies potential overuse/abuse problems by limiting certain drugs issued on a therapeutic basis to a 30 day supply.

(10) Diabetes Benefits

If, while covered under the Plan, you or your dependent incurs Expense for the medically necessary treatment of:

(i) insulin-using diabetes;
(ii) non-insulin-using diabetes; or
(iii) gestational diabetes;

benefits will be payable as follows, even if the items are available without a prescription.

Benefits for the following items are payable in the same manner and subject to the same conditions and limitations as any other prescription drug:

(i) blood glucose monitors and blood glucose testing strips;
(ii) blood glucose monitors designed to assist the visually impaired;
(iii) pen delivery systems for the administration of insulin;
(iv) lancets and lancet puncture devices;
(v) insulin syringes;
(vi) insulin;
(vii) prescriptive medications for the treatment of diabetes; and
(viii) glucagon.

(11) Contraceptive Benefits

If you or your dependent receives outpatient Contraceptives, the Plan will pay the Expense incurred in the same manner and subject to the same conditions and limitations as any covered drug.

Expenses for any contraceptive benefit that is a Preventive Service are not subject to the Deductible and will be paid at 100%.

"Contraceptives" means a variety of prescription methods, drugs or devices that are approved as contraceptives by the Federal Food and Drug Administration (FDA).

(12) Smoking Cessation Benefits

The Plan will pay 100% for all Food and Drug Administration (FDA) approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

(13) Exclusions:

Listed below are some of the significant exclusions under the Sav-Rx plan. Some of these items might be covered under the self-funded medical plan. See the Formal Plan Rules for a complete list of exclusions and limitations.

No benefits will be paid for:

(a) charges a covered person is not required to pay or charges made only because coverage exists (subject to the right, if any, of the United States government to recover reasonable and customary charges for care provided in a military or veterans' hospital).

(b) a sickness or injury:
(1) for which benefits are paid or payable under workers' compensation or any occupational disease or similar law whether such benefits are insured or self-insured; or (2) that is caused by, or connected in any way to, employment of the covered person. This includes self-employment or employment by others. It applies whether or not workers' compensation or any occupational disease or similar law covers the charges incurred. It applies whether the charges are covered on an insured or uninsured basis.

(c) most prescription non-legend drugs.

(d) most therapeutic devices or appliances.

(e) drugs or medicines lawfully obtainable without a prescription order of a physician, except insulin.

(f) immunization agents, biological sera, blood or blood plasma (this includes the giving of these items).

(g) drugs labeled: "Caution-limited by federal law to investigational use," or experimental drugs, even though a charge is made to the insured person.

(h) any charge for the administration of prescription legend drugs or injectable insulin.

(I) any medication, legend or not, which is consumed or administered at the place where it is dispensed.

(j) any amount of drugs or medicines dispensed that is more than a 34-day supply or a 100-unit dosage whichever is greater except that three months' supply will be dispensed if the Sav-Rx Mail Order Program is used.

(k) drugs that may be received at no charge under local, state or federal programs (this will not apply to drugs covered by Medicaid).

(l) drugs and medicines to be taken by or given to an insured person while he or she is confined in a hospital or institution.

(m) any prescription or refill in excess of the number specified by the physician, or any refill dispensed after one year from physician's original order.

(n) drugs prescribed for sickness or injury resulting from war or acts of war.

(o) anorectics (any drug used for the purpose of weight loss), unless prior authorization is obtained from Sav-Rx.

(p) growth hormones.

(q) infertility drugs or medications.

(r) Minoxidil (Rogaine) for the treatment of alopecia.

(s) Tretinoin, all dosage forms (e.g., Retin-A) for insured persons 26 years of age or older.

(t) Preventative and on demand treatments for Hereditary Angioedema including but not limited to C1 inhibitor concentrate, recombinant C1 inhibitor, bradykinin B2 receptor antagonist and kallikrein inhibitors which would include but not be limited specifically to Cinryze, Berinert, Kalbitor and Firazyr.

PHYSICAL EXAM BENEFIT

If you are enrolled in the Kaiser or United HealthCare HMOs, routine physicals are covered. There is a $35 co-payment per visit at Kaiser, and a $20 co-payment charged by United HealthCare.

If you are an active employee in the Self-Funded PPO Plan, the Plan pays 100% of the PPO contracted rate once each calendar year, for a routine physical. This benefit is not available to retirees or dependents unless the physical exam is a Preventive Service. This benefit is not available to participants in Kaiser or United HealthCare.

CHIROPRACTIC BENEFIT

If you are enrolled in the Self-Funded PPO Plan, 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, Kaiser or United HealthCare HMOs, which does not provide chiropractic benefits, the Self-Funded PPO 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 pre-authorized through Beat It!. These benefits are provided to bargaining unit employees, non-bargaining unit employees and individual employers, and the eligible dependents of those participants.

The following limitations apply to the benefits the Self-Funded PPO Plan will pay, and the patient is responsible for all charges not paid by the Plan. Different coverages and limitations apply if you are enrolled in an HMO option.

Inpatient Benefits for Rehabilitation After Detoxification

First confinement, without prior outpatient treatment under the Beat It! program:
Employee .....100% of contracted rate

Other Inpatient Benefits:
When you use a PPO Provider 90%
When you use a Non-PPO Provider..... 70%

Outpatient Benefits

When you use a PPO Provider 90%
When you use a Non-PPO Provider..... 70%

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

The Plan provides life insurance for active employees and dependents through group insurance policies purchased from Union Labor Life Insurance Company. COBRA participants and retirees are not eligible for Life and Accidental Death and Dismemberment benefits. The amount of life and accidental death and dismemberment 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 until age 26) $1,000
Dependent Child (under 6 months old) $500

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE:
Employee $5,000

These benefits are payable if you die, or your covered dependent dies, while eligible for benefits under the Plan, but only up to age 26 for your covered dependent children. "Child" means your natural child, your adopted child from the date the child is placed in your home, your dependent step-child or foster child, a child for whom you are the legal guardian, and a dependent child of your covered Domestic Partner. These benefits are subject to the exclusions described in the separate life insurance booklet. 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 the Plan Administration Office 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 United HealthCare HMO plans. Simply present your HMO card whenever you receive services, and make the applicable co-payment.

If you are covered under the Self-Funded PPO Plan, your provider should submit claims to the Plan Administration Office:

by mail: BeneSys Administrators
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566

Your provider may also submit claims electronically through a secure electronic data interchange (EDI) system.

Dental: Your dentist should submit claims directly to BeneSys Administrators. Your dentist may also submit claims electronically through a secure electronic data interchange (EDI) system.

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 the Plan Administration Office, 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.
- All appeals under the Self-Funded PPO Plan.

- Claims and appeals regarding a rescission of coverage.

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

Notice of Claim
You or your health care provider may file a claim for benefits by submitting written notice of a claim to the Plan Administration Office within 20 days after the date of the event for which the claim is made or as soon thereafter as is reasonably possible. This notice must give enough information to identify the insured person.

Claim Forms
When the Plan Administration Office receives the notice of claim, it will send the insured person the forms to be used in filing proof of claim. If these forms are not sent within 15 days, the insured person can still meet the requirements for proof of claim as long as he or she sends written proof satisfactory to the Board of Trustees of (a) the occurrence of the loss; (b) the nature of the loss; and (c) the extent of the loss. This proof must be given within the time limit stated in Proof of Claim below.

Proof of Claim
Written proof of claim satisfactory to the Board of Trustees must be given to the Plan Administration Office within 90 days after the date of the event for which the claim is made, or as soon thereafter as is reasonably possible. In any case, the proof required must be sent to the Plan Administration Office or the Board of Trustees no later than 12 months following the date of service. Any claim submitted more than 12 months after the date of service will be denied.

The Plan Administration Office will notify you of its determination within the following deadlines, unless it notifies you that it needs 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.

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, except that any claim or appeal involving either 1) a rescission of coverage or 2) a medical judgment with respect to coverage under the Self-Funded PPO Plan, shall be eligible for external review by an Independent Review Organization, as described in Appendix 3. For full claims and appeal procedures and rules, see Appendix 3.

A civil action related to a claim for benefits must be filed within one year from the date on which the Board of Trustees provides notice that the claimant's appeal has been denied, regardless of any state or federal statutes establishing provisions relating to limitations of actions.

By participating in the Plan, Participants, employees, beneficiaries, dependents, and retirees waive, to the fullest extent permitted by law, whether or not in court, any right to commence, be a party in any way, or be an actual or putative class member of any class, collective, or representative action arising out of or relating to any dispute, claim or controversy relating to the Plan, and Participants, employees, beneficiaries, dependents, and retirees agree that any dispute, claim or controversy may only be initiated or maintained and decided on an individual basis.

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

Board of Trustees
Northern California Tile Industry Health and Welfare Trust Fund
c/o BeneSys Administrators
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566
(925) 208-9999

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

The Benefit Consultant is Rael & Letson, 2800 Campus Drive, Suite 150, San Mateo, CA 94403.

TYPE OF ADMINISTRATION:
The Board of Trustees is assisted in the administration of the Plan by a contract administrator, BeneSys Administrators at the address and phone number listed above. Certain 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 life and accidental death and dismemberment insurance, and vision benefits, are insured by the plan carriers.

The Northern California Tile Industry Health and Welfare Plan offers a self-funded PPO medical and dental plan. It contracts with National Union Fire Insurance Company for stop loss coverage. The Board of Trustees has also hired health maintenance organizations and other providers to provide benefits or claims services under insurance contracts or service agreements. Their names and phone numbers appear on page 1 above.

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 Kraw, Attorney at Law
Kraw Law Group, APC605 Ellis Street, Suite 200
Mountain View, CA 94043
(650) 314-7800

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

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, Terrazzo, Marble and Restoration 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.
10806 Bigge St.
San Leandro, CA 94577

Employer Associations

Tile, Terrazzo, Marble and Restoration Contractors Association of Northern California, Inc.
15091 Wicks Blvd.
San Leandro, CA 94577

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 domestic partner, 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, EBSA, San Francisco Regional Office, 90 Seventh

Street, Suite 11-300, San Francisco, CA 94103, Telephone: (415) 625-2481, 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. Darin Compton
B.A.C. Local No. 3
10806 Bigge Street
San Leandro, CA 94577

Mr. Dorsey Hellums
B.A.C. Local No. 3
10806 Bigge Street
San Leandro, CA 94577

Mr. Dave Jackson
B.A.C. Local No. 3
10806 Bigge Street
San Leandro, CA 94577

Mr. Richard J. Romanski
1405 Crestwood Court
San Mateo, CA 94403

Mr. Steve Vogel
B.A.C. Local No. 3
10806 Bigge Street
San Leandro, CA 94577

Employer Trustees

Mr. Rich Della Maggiore
Della Maggiore Tile, Inc.
87 North 30th Street
San Jose, CA 95116

Richard N. Hill, Esq.
Littler Mendelson, PC
333 Bush Street, 34th Floor
San Francisco, CA 94104

Mr. David Newman
D & J Tile Company, Inc.
1045 Terminal Way
San Carlos, CA 94070

Mr. Richard Papapietro
De Anza Tile
45755 Northport Loop West
Fremont, CA 94538

Mr. William W. Ward, III
898 Avalon Court
Lafayette, CA 94549

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 or domestic partner, 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.

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

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 26.

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 domestic partner, 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, a dissolution of a domestic partnership, 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 Social Security Administration 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 or domestic partners, and parents may elect COBRA continuation coverage on behalf of their children.

You may elect "core coverage" (that is, all Plan benefits except dental care, vision benefits and life insurance and accidental death or dismemberment insurance), or full COBRA coverage (all Plan benefits, including dental and vision benefits, except life insurance and accidental death and dismemberment insurance). Your election of one type of coverage applies to your dependents as well. However, if you do not elect COBRA coverage, your dependent(s) may elect either form of coverage for themselves. If you have one or more dependents and initially elect full COBRA coverage, you may change your election to "core coverage" upon the termination of dependent status of one or more dependents as a result of divorce, dissolution of a domestic partnership or death.

Please inform the Plan Administration Office immediately if you acquire any new dependents through marriage, registration of a domestic partnership, 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 or domestic partner 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 or domestic partner 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 dissolves a domestic partnership, or if the dependent child loses dependent status, but only if the event would have caused the spouse, domestic partner 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 dissolution of a domestic partnership with 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. The period of time for which an employee or his/her dependent is eligible for COBRA coverage will be reduced by any months in which the employee or his/her dependent was covered due to the Plan's extended coverage options, including Self-Payments or Disability Coverage. Please refer to pages 4-5 of this 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
90 Seventh Street, Suite 11-300
San Francisco, CA 94103
Telephone: (415) 625-2481
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 BeneSys Administrators
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566
Telephone: (925) 208-9999

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, including:

(a) Claims and appeals regarding eligibility under this Plan for any type of benefit;

(b) Claims and appeals regarding medical and vision benefits when the claimant has made a specific claim for medical 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;

(c) Claims and appeals regarding all self-funded benefits; and

(d) Claims and appeals regarding a rescission of coverage as defined in Part 1, Article I, Section D of the Formal Plan Rules.

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 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, except that any claim or appeal involving either 1) a rescission of coverage as defined in Part 1, Article I, Section D of the Formal Plan Rules, or 2) a medical judgment with respect to coverage under the Self-Funded PPO Plan, shall be eligible for external review by an Independent Review Organization, as described in Part 1, Article IV of the Formal Plan Rules.

2. FILING A CLAIM: Participants, family members and assignees (hereinafter "claimants") may initiate a claim for benefits by submitting written notice of a claim to the Administration Office within 20 days after the date of the event for which the claim is made or as soon thereafter as is reasonably possible. This notice must give enough information to identify the insured person.

Claim Forms
When the Administration Office receives the notice of claim, it will send the insured person the forms to be used in filing proof of claim. If these forms are not

sent within 15 days, the insured person can still meet the requirements for proof of claim as long as he or she sends written proof satisfactory to the Board of Trustees of (a) the occurrence of the loss; (b) the nature of the loss; and (c) the extent of the loss. This proof must be given within the time limit stated in Proof of Claim below.

Proof of Claim
Written proof of claim satisfactory to the Board of Trustees must be given to the Administration Office within 90 days after the date of the event for which the claim is made, or as soon thereafter as is reasonably possible. In any case, the proof required must be sent to the Administration Office or the Board of Trustees no later than 12 months following the date of service. Any claim submitted more than 12 months after the date of service will be denied.

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. A claimant or claimant's representative may submit evidence, including written testimony, as part of his or her claim.

3. 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.

4. NOTIFICATION OF CLAIM DECISION

(a) TIME LIMITS AND REQUESTS FOR ADDITIONAL INFORMATION

(i) 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.

(ii) Pre-service claims: If a claimant makes a claim for benefits before care has been provided to the participant or family member, 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.

(iii) 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.

(b) 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:

(i) a statement of the specific reason(s) for the denial;

(ii) reference to the specific Plan provision(s) on which the denial was based;

(iii) 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;

(iv) 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;

(v) a description of the Plan's appeal procedures, including any expedited appeal procedures available if it is a claim for urgent care benefits;

(vi) if the claim involves either 1) a rescission of coverage as defined in Part 1, Article I, Section D of the Formal Plan Rules, or 2) a medical judgment with respect to coverage under the Self-Funded PPO Plan, a statement of the claimant's right to request an expedited external review, if the claim involves a medical condition for which the timeframe for completion of the Plan's appeal procedures would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function; and

(vii) a statement of the claimant's right to bring a civil action under ERISA § 502(a), if the appeal is unsuccessful.

5. APPEAL PROCEDURES

(a) GROUNDS 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 all appeals regarding self-funded PPO benefits, all appeals regarding eligibility under this Plan for any type of benefit, and appeals regarding medical and vision benefits when the claimant has made a specific claim for medical or vision care, and the HMO or other provider has denied the claim on the grounds that the claimant or family member is not eligible for the benefit under the terms of the Plan.

(b) 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. A claimant or claimant's representative may submit evidence, including written testimony, as part of his or her appeal.

(c) 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.

(d) 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.

(e) FULL AND FAIR REVIEW

(i) A claimant will be provided, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim, prior to notification of the Board of Trustees' determination of the appeal.

(ii) A claimant will be provided, free of charge, with any new or additional rationale on which the Board of Trustees' determination of the appeal is based, prior to notification of the Board of Trustees' determination of the appeal.

(f) NOTIFICATION

(i) TIME LIMITS FOR NOTIFICATION

(A) 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.

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

(C) 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.

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.

(ii) 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:

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

(B) reference to the specific Plan provision(s) on which the denial is based;

(C) 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;

(D) 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;

(E) 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;

(F) if the appeal involves either 1) a rescission of coverage as defined in Part 1, Article I, Section D of these Rules, or 2) a medical judgment with respect to coverage under the Self-Funded PPO Plan, the claimant's right to request external review, including the right to request expedited external review if 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 appeal concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility; and

(G) the claimant's right to bring a civil action under ERISA § 502(a).

6. EXTERNAL REVIEW PROCEDURES

(a) CLAIMS ELIGIBLE FOR EXTERNAL REVIEW. Claims that involve either 1) a rescission of coverage, as defined in Part 1, Article I, Section D of these Rules, or 2) a medical judgment with respect to coverage under the Self-Funded PPO Plan are eligible for external review. No other claims are eligible for external review.

(b) TIME LIMITS. A claimant must submit a request for external review within four months after receipt of denial of the claimant's appeal. If a claimant does not submit a request for external review within four months of receiving a denial of his or her appeal, he or she will be deemed to have waived any right to external review.

(c) PRELIMINARY REVIEW

(i) Within five business days of receipt of a request for external review, the Administration Office will conduct a preliminary review of the request, and will notify the claimant in writing of the result of the preliminary review within one business day of its completion.

(ii) If the request for external review is complete, but the claim is not eligible for external review, the notice will include the reasons for its ineligibility.

(iii) If the request for external review is not complete, the notice will describe the information or materials needed to make it complete. The claimant must submit the additional information required to make the request complete within the four-month filing period, or within the 48-hour period following receipt of notice of the result of the Preliminary Review, whichever is later.

(d) INDEPENDENT REVIEW ORGANIZATION

(i) REFERRAL BY ADMINISTRATION OFFICE.

If a request for external review is complete and the claim is eligible for external review, the claim will be referred to an Independent Review Organization (IRO) by the Administration Office.

(ii) CLAIM AND APPEAL DOCUMENTS AND INFORMATION.

Within five days after the claim is referred to an IRO, the Administration Office will provide the IRO with the documents and any information considered by the Board of Trustees in deciding the claim and appeal.

(iii) NOTIFICATION OF REVIEW AND SUBMISSION OF FURTHER INFORMATION.

The IRO will notify the claimant in writing that the request for external review was accepted, and that the claimant may submit additional information to the IRO in writing within 10 business days of receipt of the notice. The IRO will forward any information received from the claimant to the Administration Office within one business day.

(iv) STANDARD OF REVIEW.

The IRO will review all of the information and documents timely received, and other information and documents available that the IRO considers appropriate. In reaching a decision, the IRO will review the claim de novo and will not be

bound by any decisions or conclusions reached by the Board of Trustees during the Plan's internal claim and appeals process.

(v) NOTIFICATION OF EXTERNAL REVIEW DECISION.
Within 45 days after the IRO receives the request for external review from the Administration Office, the IRO will provide a written decision to the claimant and the Board of Trustees. The decision will contain:

(A) the reason for the request for external review;

(B) the date the review was referred to the IRO and the date of the IRO's decision;

(C) references to the evidence or documentation considered in reaching its decision;

(D) a discussion of the principal reason for its decision;

(E) a statement that the IRO's decision is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or the claimant;

(F) a statement that judicial review may be available to the claimant; and

(G) contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Patient Protection and Affordable Care Act.

(e) EXPEDITED EXTERNAL REVIEW

(i) CLAIMS ELIGIBLE FOR EXPEDITED EXTERNAL REVIEW.
A request for expedited external review may be made:

(A) after a claim is denied, if the claim is eligible for external review and involves a medical condition for which the timeframe for completion of the Plan's appeal procedures would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function; or

(B) after an appeal is denied, if the claim is eligible for external review and 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 appeal concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

(ii) PRELIMINARY REVIEW OF REQUEST FOR EXPEDITED EXTERNAL REVIEW.

Immediately upon receipt of a request for expedited external review, the Administration Office will determine whether the request meets the eligibility requirements for external review and notify the claimant of its determination.

(A) If the request is complete, but the claim is not eligible for external review, the notice will include the reasons for its ineligibility.

(B) If the request is not complete, the notice will describe the information or materials needed to make the request complete.

(iii) REFERRAL TO IRO AND PROVISION OF DOCUMENTS.

Upon determination that a request is eligible for expedited external review, the Administration Office will refer the review to an IRO and will provide the IRO with the documents and any information considered by the Board of Trustees in deciding the claim and/or appeal electronically, by fax, or by any other available expeditious method.

(iv) STANDARD OF REVIEW.

The IRO will review all of the information and documents received, and other information and documents available that the IRO considers appropriate. In reaching a decision, the IRO will review the claim de novo and will not be bound by any decisions or conclusions reached by the Board of Trustees during the Plan's internal claim and appeals process.

(v) NOTIFICATION OF EXPEDITED EXTERNAL REVIEW DECISION.

The IRO will provide notice of its decision in accordance with the requirements for a notice of decision of external review set forth in paragraph (d)(v) above within 72 hours after the review is referred to the IRO. If the notification is not in writing, the IRO will send written confirmation within 48 hours after notice of the decision is provided.

(f) PROVISION OF BENEFITS.

Upon receipt of a notice of an external review decision reversing the Board of Trustees' denial of a claim or appeal, the Plan will provide coverage or payment for the claim. The provision of benefits pursuant to an external review decision shall not waive the Board of Trustees' right to seek judicial review of the decision.

7. APPEALS TO HMO, PPO OR OTHER INSURANCE CARRIERS. If a claim for medical or vision benefits is denied by an HMO or other insurer on grounds other than eligibility under the Northern California Tile Industry Health and Welfare Plan, the claimant may submit an appeal to the HMO or other insurer, pursuant to the appeals procedures of that HMO or other insurer.

8. STATUTE OF LIMITATIONS. A civil action related to a claim for benefits must be filed within one year from the date on which the Board of Trustees provides notice that the claimant's appeal has been denied, regardless of any state or federal statutes establishing provisions relating to limitations of actions.

9. WAIVER OF CLASS, COLLECTIVE AND REPRESENTATIVE ACTIONS. By participating in the Plan, Participants, employees, beneficiaries, dependents, and retirees waive, to the fullest extent permitted by law, whether or not in court, any right to commence, be a party in any way, or be an actual or putative class member of any class, collective, or representative action arising out of or relating to any dispute, claim or controversy relating to the Plan, and Participants, employees, beneficiaries, dependents and retirees agree that any dispute, claim or controversy may only be initiated or maintained and decided on an individual basis.

IN WITNESS of the adoption of this Summary Plan Description as revised January 1, 2018, the Chairman and Secretary hereby subscribe their names, on the dates indicated.

_____ Date: _____
Chairman

_____ Date: _____
Secretary