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**BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL NO. 3
HEALTH AND WELFARE PLAN**

SUMMARY PLAN DESCRIPTION

Effective July 1, 2006

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INTRODUCTION

This booklet describes your benefits under the Bricklayers and Allied Craftworkers Local No. 3 Health and Welfare Plan.

The Plan is maintained for the exclusive benefit of employees and administered by a Board of Trustees, which is made up of 6 union and 6 management representatives. The Plan's actions must be approved by a majority of both the union and management trustees.

The Plan does not provide guaranteed rights. While the Trustees intend to continue the Plan, they can change or terminate rules and benefits at any time.

Your employers work under a collective bargaining agreement with Bricklayers and Allied Craftworkers Union Local No. 3, and make contributions to the Plan on your behalf. If all these contributions are discontinued, the Plan will be unable to provide the benefits after the fund's assets are exhausted.

The Plan currently offers you the option of an insured medical program from United of Omaha or one of two HMOs: PacifiCare HMO or Kaiser Permanente. Benefits from the United of Omaha plan are insured on an indemnity, pay as you go basis and benefits provided by each of the HMO options are provided on a pre-paid basis. You can find the group policy number and address for each of these HMOs and United of Omaha at the end of this booklet.

Medical benefits are described in the brochures provided by the medical program in which you are enrolled. These brochures also provide the appeals process in the event you are dissatisfied with the medical benefits you receive. The appeals process described in this booklet tells you how to appeal actions of the administration office or the Board of Trustees.

This Plan does not replace coverage by Workers' Compensation insurance.

You should keep this booklet with the brochures provided by the medical program in which you are enrolled.

GENERAL INFORMATION

Enrollment Cards

When you first become eligible, you MUST complete an enrollment card for one of the medical plan options offered under the Plan: United of Omaha, PacifiCare HMO or Kaiser.

You will not be able to obtain medical care from any of the HMOs until you have completed an enrollment card. If you do not make a choice within 45 days of first becoming eligible, you will automatically be enrolled in the United of Omaha option. If you become automatically enrolled in United of Omaha, it is still important for you to complete an enrollment

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card. If you have Eligible Dependents, their coverage could be jeopardized if you have not reported them on an enrollment card.

The United of Omaha option allows you to obtain services from any doctor or hospital, but your out of pocket costs are higher if you use a provider outside the Blue Cross Prudent Buyer PPO Network.

When you start working, it is a good idea to tell the Administration Office your current address. This will ensure that you receive the information about your benefit options. The Administration Office's mailing address is:

B. A. C. Local No. 3
Health & Welfare Trust Fund
c/o Allied Administrators
P.O. Box 2500
San Francisco, CA 94126

Open Enrollment

At least once each year, the Board of Trustees will provide you with the opportunity to change your medical coverage.

You will receive information about this "open enrollment" period at the address the Administration Office has on file for you.

If you change your coverage during an open enrollment period, your new coverage will be effective for services provided in the following month.

Claim Assistance

If you are enrolled in the United of Omaha medical plan and need help filing your claim or an explanation of how your claim was paid, contact the Administration Office at:

Allied Administrators
633 Battery St., Second Floor
San Francisco, CA 94111
Phone: (415) 986-6276

The above office can also assist you with your dental claims.

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ELIGIBILITY RULES

Definitions

(1) **Participant** is someone who meets the eligibility requirements for coverage under the terms of the Plan. You are no longer a Participant if your coverage terminates or you lose eligibility.

(2) **Union** is the Bricklayers and Allied Craftworkers Union Local No. 3 (California).

(3) **Employer** is an individual owner, partnership or corporation that employs employees represented by Bricklayers and Allied Craftworkers Union Local No. 3 (the "Union") under a Collective Bargaining Agreement.

(4) **Collective Bargaining Agreement** is an agreement between an Employer and the Union concerning the terms of employment.

(5) **Covered Employment** is work of the type covered by a Collective Bargaining Agreement.

(6) **Pensioner** is any person who has retired and is receiving pension benefits from any pension plan administered and established under any trust to which the Union appoints trustees.

(7) **Non-Signatory Employer** is an employer who is not signed to a collective bargaining agreement.

Eligibility as an Employee

A. Eligibility Qualifications For You And Your Eligible Dependents

You become eligible for benefits when you:

(1) complete an enrollment card; and

(2) complete 330 hours of covered work under a Collective Bargaining Agreement for an Employer who makes contributions to the Plan on your behalf.

Your eligibility starts on the first day of the second month following the month in which you have completed 330 hours during the previous six-month period (provided your employer has made required contributions).

For example, if you start working for a contributing Employer on January 1st, and you complete 330 hours of work on March 31st, you are eligible to participate as of May 1st.

You must work a minimum of one hundred ten (110) hours per month to maintain eligibility. Any hours over 110 hours that you work during a month are accumulated in a reserve account.

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B. Reserve Account

- (1) The Plan keeps track of the number of hours you work each month.

After you work more than 110 hours in a month, additional hours go into your reserve account. You can have up to 550 hours in your reserve account. During periods when you cannot work, including labor disputes, you can use these hours to maintain eligibility for benefits.

Except as provided in subsection (2) below, if you use up all of your hours in your reserve account, you and your Eligible Dependents will no longer be eligible for benefits and you will have to reestablish your eligibility. If you die as a Plan Participant, your reserve account will continue to provide benefits to your Eligible Dependents until the account is run out.

- (2) You may be able to accumulate up to an additional 330 hours of eligibility, if your employer is delinquent in paying contributions on you during the 90 days before your reserve account runs out. If you think you are eligible for this extended eligibility, contact the Administration Office for more information.

C. Loss of Eligibility for Cause

- (1) You and your Eligible Dependents lose eligibility if you:

- (a) accept employment for work in covered employment for a Non-Signatory Employer; or

- (b) go into business for yourself in the type of work covered by the Union's Collective Bargaining Agreements without being signed to such an agreement; or

- (c) become a partner of or a corporate officer of any Non-Signatory Employer who engages in work that is Covered Employment; or

- (d) accept employment in a trade or occupation other than that within the craft jurisdiction of the Union's collective bargaining agreements.

You lose coverage and the hours in your reserve account the first day of the month after one of the above events occur. If you enter into another trade because you become disabled and are unable to work in Covered Employment, you will not lose your reserve account upon approval by the Trustees and proof of your disability.

- (2) If you are working for a delinquent employer and the Union asks you to stop working, you must do so or your eligibility (and your Eligible Dependents') will end. Your reserve account hours also will be canceled.

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(3) If the Union asks you to work for a Non-Signatory Employer as part of the Union's organizing activities and makes contributions on your behalf to the Trust, you will not lose any hours in your reserve account because of that employment.

(4) If your coverage ends for cause or because you did not elect continuation coverage, you will again be eligible for participation the month when you complete 660 hours of work under the terms of a collective bargaining agreement that requires contributions to the Trust. The work must be performed within a subsequent 12-month period.

D. Failure to Maintain Eligibility

Your coverage under the Plan terminates at the end of the month in which your reserve account falls below the 110 hour minimum, or if you enter into military service (other than a temporary tour of duty not exceeding 30 days). You may be eligible for continuation coverage (COBRA), as described in Section IX of this booklet.

E. Reinstatement of Eligibility

You can reinstate eligibility as of the second calendar month following the month in which you work at least 110 hours, if you do so within six calendar months following the end of your coverage.

If your coverage is not reinstated within the above-mentioned 6-month period, you must complete the initial eligibility qualification rules in order to become covered under the Plan again.

EXCEPTION: If you have been covered under the Plan's disability coverage provisions and you return to work before that coverage expires, your regular Plan coverage is reinstated when the combination of hours you work and your reserve bank totals 110 hours. You will not have to meet the initial eligibility requirements.

F. Coverage During a Period of Disability

There is a special provision under the Plan for disability coverage. If you are a Participant and you become disabled, you can receive up to 6 months of coverage without withdrawing any hours from your reserve account.

The actual number of months of this special disability coverage is equal to the period for which you were continuously covered as a result of hours worked immediately prior to the disability, up to six months.

If you exhaust your eligibility for disability coverage and remain Disabled, your reserve account hours can be used to continue your coverage.

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Once your reserve account falls below the minimum number of hours to maintain coverage, or 110, you may apply for continuation coverage (COBRA) as provided under Section IX of this booklet.

Only the Board of Trustees can make the determination as to whether you are disabled and, therefore, eligible for a disability benefit under the Plan. To be "Disabled," you must suffer from a disability that prevents you from working in any job and you must meet one of the following requirements:

- (1) Be receiving State Disability Insurance ("SDI") benefits; or
- (2) Be receiving temporary disability indemnity benefits or have been awarded "Qualified Injured Worker" status, under California Workers' Compensation Laws; or
- (3) Have a disability that would qualify you for SDI benefits but you are not receiving them because, as of the date you became disabled, you hadn't earned enough credits under that program to qualify. You must provide proof to the Administration Office of both your qualifying disability and the reason for your lack of SDI credits. Contact the Administration Office for more information on the type of proof you need to submit.

Disability coverage is not available to retirees; if you become disabled after you retire, you must begin making the required contribution for retiree coverage.

G. When Employee Coverage Ends

Your coverage ends on the earliest of the following dates:

- (1) the last day of the month in which your reserve account falls below 110 hours after deduction of 110 hours for the current month;
- (2) the date the Plan terminates;
- (3) the date you terminate your membership in one of the classes eligible for coverage;
- (4) the date the insurance policy or contract that provides your coverage under the Plan terminates. In this case, the Trustees may, but are not required to, find alternate coverage with another insurance company or health provider;
- (5) the date the class of persons you belong to is no longer covered under the insurance policy or contract that provides your coverage under the Plan;
- (6) the date you terminate your continuation coverage, if any, for any reason listed in Section IX;
- (7) the date you fail to make timely premium payments that you may owe for Plan coverage;
- (8) the date you become eligible for medical benefits under any other group insurance plan between a local union of the International Union of Bricklayers and Allied Craftsmen other than Local 3. However, your reserve account hours will not be canceled for a period of one year from the date of your last employment under the terms of a Collective Bargaining Agreement

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requiring contributions to this Trust. If you return within this period and notify the Administrator that you are no longer covered by any other group plan as described above, your coverage will begin on the first of the month following the month in which you give notice to the Administrative Office of the Trust until your reserve account hours are exhausted;

(9) the date you are terminated for cause, as provided in Section (C);

(10) the date of your death; or

(11) the date you enter full-time active duty in the Armed Forces. Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), your reserve account is automatically preserved until your return to covered employment after termination of your military service. You may purchase coverage for your Eligible Dependents for up to 24 months. This continuation rule is similar to COBRA. However, you may elect to waive your rights under USERRA. In that case, your reserve account may be applied to provide coverage for your Eligible Dependents. The months of coverage applied would no longer be available to provide coverage for you upon your return to covered employment.

H. Delinquent Contributions from Employers

Delinquent Contributions Paid Within 12 Months of the Period the Delinquent Hours Were Worked

- (i) If the calendar month during which the delinquent contribution is received is within twelve months of the period you worked the delinquent hours **and** you were covered by the Plan for at least one month in the six calendar months prior to the work month for which the delinquent contribution is received, then you will receive reimbursement for any COBRA payment you made for the delinquent month. The reimbursement rate shall be the lesser of (1) the amount of the COBRA payment you made or (2) 110 times the hourly contribution rate for work performed during the delinquent month (and any remaining hours worked in the delinquent month in excess of 110 will be added to your reserve account and available for prospective coverage). If you did not make a COBRA payment for the delinquent month, the delinquent payment will be added to your reserve account up to the reserve account maximum of 550 hours.
- (ii) If the calendar month during which the delinquent contribution is received is within twelve months of the period you worked the delinquent hours **and** you were not covered by the Plan for at least one month in the six calendar months prior to the work month for which the delinquent contribution is received and you have since established eligibility, the delinquent contributions will be added to your reserve account. If you have not established eligibility, the delinquent contributions will be counted toward initial eligibility.

Delinquent Contributions Paid More Than 12 Months After the Calendar Month the Delinquent Hours Were Worked

- (i) If your employer pays delinquent contributions more than twelve months after the period you worked the delinquent hours **and** your employer reports that you worked at least 110

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hours in covered employment in the 6 calendar months before the receipt of the delinquent contribution, then you will receive reimbursement for any COBRA payment you made for the delinquent month. The reimbursement rate shall be the lesser of (1) the amount of the COBRA payment you made or (2) 110 times the hourly contribution rate for work performed during the delinquent month (and any remaining hours worked in the delinquent month in excess of 110 will be added to your reserve account and available for prospective coverage). If you did not make a COBRA payment for the delinquent month, the delinquent payment will be added to your reserve account up to the reserve account maximum of 550 hours.

- (ii) If your employer pays delinquent contributions more than twelve months after the period you worked the delinquent hours **and** you have not been reported by any employer as having worked in covered employment for at least a total of 110 hours in the 6 calendar months prior to the receipt of the delinquent contribution, then you will not receive credit for the delinquent contribution. However, if the Trust receives 110 hours of contributions for work you perform within the 9 calendar months following the month in which delinquent contribution is received, you may apply to the Trustees to have the delinquent contribution credited to your reserve account up to a maximum of 550 hours. The Trustees have the discretion to approve or deny your application.

Eligibility as an Employer

Effective as of November 22, 2005, the Plan is closed to new non-bargaining unit participants, and any existing non-bargaining unit Participants are restricted from changing coverage to the United of Omaha plan. All non-bargaining unit Participants in the United Of Omaha plan as of July 1, 2006 are required to switch coverage to either Kaiser Permanente or PacifiCare, HMO, unless you are currently covered by Plan and live in an area in which neither of the Trust's HMO's are available. Please contact the Administration Office for more information about the eligibility rules for non-bargaining unit employees prior to November 22, 2005.

Eligibility as an Officer/Shareholder

If you are a Participant who becomes an officer or shareholder of an Employer, you may continue to participate in the Plan, provided:

- (1) the Board of Trustees approves your continued participation;
- (2) you are working with the tools of the trade;
- (3) your Employer is incorporated and employs at least one bargaining unit employee who has no ownership interest in the Employer and is participating in the Plan under the terms of a Collective Bargaining Agreement or in a plan that benefits workers in the masonry trade under the terms of a Collective Bargaining Agreement;
- (4) your Employer signs a participation agreement; and
- (5) your participation meets the requirements under applicable law.

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Eligible Dependent Coverage

Whenever you acquire a new Eligible Dependent, through marriage, birth or adoption, you need to advise the Administration Office and properly enroll them in your medical plan within 31 days of the marriage, birth or adoption. Failure to do this may mean a lapse in your Eligible Dependent's coverage.

Your Eligible Dependent's coverage becomes effective on the same date as your coverage and ends on the same date your coverage ends or when he/she is no longer an Eligible Dependents. However, if you should die while covered under this Plan, your Eligible Dependents will continue to be covered at no charge until the expiration of the coverage available under your reserve account. Thereafter, they may be eligible for Continuation Coverage under the COBRA provisions of the Plan.

"Eligible Dependent" means:

- (a) your lawful spouse; and
- (b) each unmarried child under the age of 19.

If your unmarried child is dependent on you for support and maintenance and is attending school or college as a full-time student, he/she will continue to be considered an Eligible Dependent to (i) the date he/she is no longer a full-time student or (ii) his or her 24th birthday, whichever is earlier. A full-time student is a student enrolled for a minimum of 12 units per semester or quarter at an accredited educational institution.

The term "spouse" means your husband or wife as recognized under California law. Your marriage must not have ended in a valid divorce decree or annulment.

The term "child" means:

- (1) your direct offspring; or
- (2) a stepchild who lives with you in a parent-child relationship and who qualifies as a dependent on your tax return;
- (3) a minor placed with you for the purpose of legal adoption. Such child shall be covered from the date he/she is placed in your physical custody or the date you have assumed a legal obligation to provide the child's support, if earlier. Coverage will end on the date this child is no longer in your custody or the date you no longer anticipate adopting the child;
- (4) a foster child or other child for whom you have assumed legal guardianship and who lives with you in a parent-child relationship and who qualifies as a dependent on your tax return.

Your spouse or child who is a full-time member of any country's armed forces may not be an "Eligible Dependent".

The child of an Eligible Dependent shall not be eligible for any benefits provided by this Plan, except as provided above.

If a person has dual coverage under the Plan (i) both as an Employee and an Eligible Dependent, or (ii) as the Eligible Dependent of two Employees, the total amount of benefits payable under the Plan will not exceed the scheduled amount for each benefit provided.

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Retiree Coverage

You will be eligible for retiree coverage if you were an active Participant as an Employee for five of the eight years immediately preceding your retirement, and you are receiving a pension from a pension plan administered and established under any trust to which the Union appoints trustees.

Retiree coverage options include Kaiser and PacifiCare HMO only. You must elect retiree coverage for you and your Eligible Dependents when you retire. If you get married after you begin retiree coverage, you can add your spouse by giving notice within 30 days of your marriage. Premium payments are due to the Trust Fund no later than the 20th of the month prior to the month of coverage. If you or your surviving spouse fails to make premium payments in a timely manner, coverage will be terminated.

Benefits paid to a Pensioner and his/her spouse are secondary to Medicare Part A and Part B, even if you are not enrolled in Medicare when first eligible to do so. To avoid loss of benefits, all Pensioners and Eligible Dependent spouses should enroll in both Part A and Part B of Medicare.

Regardless of whether the Pensioner enrolls in Medicare and regardless of the nature of the facility rendering service, the maximum benefits provided by the Plan to Pensioners eligible for Medicare, because of age, disability, or kidney failure, are the level of benefits that would be paid to a Medicare contracted hospital or the amount the Plan would have paid for other medical services if Medicare had paid primary benefits.

MEDICAL BENEFITS

Comprehensive Major Medical Benefits - Coverage Options – Active Participants

The Plan currently provides persons who are eligible for benefits as an Employee and their Eligible Dependents the option of an insured medical plan (PPO) underwritten by United of Omaha or one of two HMOs: PacifiCare HMO or Kaiser Permanente. Effective as of November 22, 2005, the Plan is closed to new non-bargaining unit participants, and any existing non-bargaining unit Participants are restricted from changing coverage to the United of Omaha plan.

All non-bargaining unit Participants in the United of Omaha plan as of July 1, 2006 are required to switch coverage to either Kaiser Permanente or PacifiCare. Please contact the Administration Office for more information about the coverage options for non-bargaining unit employees prior to November 22, 2005.

The benefits currently available under each of the three options are summarized below. Booklets and brochures have been prepared by each plan carrier and are available from the Administration Office describing each of these three options in greater detail. The summaries of each option provided below are subject to change. For an updated and complete statement of

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benefits and rules for the option you have selected or are considering, please refer to the current booklet or brochure prepared by that medical plan carrier.

Medical Benefits - United of Omaha

The benefits described in this section are insured by United of Omaha. If you participate in the United of Omaha program, you and your Eligible Dependents may choose any physician, hospital or other health care provider. If you use the services of a preferred provider, health insurance benefits may cost you less, as shown in the schedule of benefits chart below. Preferred providers (PPO) include primary care physicians, specialists, hospitals and other health care facilities.

Blue Cross Prudent Buyer of California is the PPO-provider for the United of Omaha plan. You may contact the Administration Office for a list of primary care physicians, specialists, hospitals and other health care facilities who participate in the Blue Cross Prudent Buyer network. You may also get that information by visiting the Blue Cross website at www.bluecrossca.com.

You may also visit providers who are not on the preferred list (known as non-PPO providers), but your out-of-pocket costs will be greater with non-PPO providers.

**Summary Of Benefits
United Of Omaha**

The following is a summary of benefits, deductibles, coinsurance schedules and limits for covered services under the insured plan with United of Omaha. You are responsible for a certain percentage of expenses incurred for covered services, known as the coinsurance, depending on the service and providers selected.

CATEGORY	SERVICE	COINSURANCE (Amount You are Responsible for)
DEDUCTIBLE	PPO providers (Blue Cross Prudent Buyer)	\$100 per person per calendar year \$300 per family per calendar year
	Non-PPO providers	\$200 per person per calendar year \$600 per family per calendar year
Common Accident Deductible: If two or more insured persons in a family are injured in the same accident, only one deductible will be applied for that accident.		
STOP-LOSS LIMIT	PPO providers (Blue Cross Prudent Buyer)	After the out-of-pocket expense by one insured person reaches \$600 in a calendar year, the Plan will pay 100% of covered expenses for the remainder of that year. For a family, the stop-loss limit is \$1,800 of out-of-pocket expense in a calendar year, after which the Plan will pay 100% of covered expenses for the remainder of that year.

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CATEGORY	SERVICE	COINSURANCE (Amount You are Responsible for)
STOP-LOSS LIMIT	Non-PPO providers	After the out-of-pocket expense by one insured person reaches \$1,700 in a calendar year, the Plan will pay 100% of covered expenses for the remainder of that year. For a family, the stop-loss limit is \$5,100 of out-of-pocket expense in a calendar year, after which the Plan will pay 100% of covered expenses for the remainder of that year.
MAXIMUM BENEFITS	Alcohol and Drug Abuse	\$30,000 per lifetime \$10,000 per calendar year
	Inpatient Hospice Care	\$10,000 per insured person lifetime
	All Injuries and Sicknesses	\$1,000,000 per insured person lifetime
COVERED HOSPITAL SERVICES	Hospital room and board, up to the semiprivate room charge.	10% PPO providers; 30% non-PPO providers
	Hospital services and supplies	10% PPO providers; 30% non-PPO providers
	Hospital outpatient services in connection with: (a) a surgical operation; or (b) emergency treatment within 48 hours after an accident.	10% PPO providers; 30% non-PPO providers
	Preadmission tests	no charge
COVERED SURGICAL SERVICES	Inpatient physician's services	10% PPO providers; 30% non-PPO providers
	Anesthesia services	10% PPO providers; 30% non-PPO providers
	Second surgical opinion	10% PPO providers; 30% non-PPO providers
OTHER COVERED SERVICES	Hospital outpatient services	10% PPO providers; 30% non-PPO providers
	Outpatient physician services	10% PPO providers; 30% non-PPO providers
	Services of a licensed physiotherapist	10% PPO providers; 30% non-PPO providers

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CATEGORY	SERVICE	COINSURANCE (Amount You are Responsible for)
OTHER COVERED SERVICES	Cost and fitting of external breast prostheses after a mastectomy	10% PPO providers; 30% non-PPO providers
	Ambulance services	10% PPO providers; 30% non-PPO providers
	Diagnostic x-ray and laboratory services	10% PPO providers; 30% non-PPO providers
	Oxygen and the rental of equipment for its administration	10% PPO providers; 30% non-PPO providers
	Blood or blood plasma and its administration	10% PPO providers; 30% non-PPO providers
	Casts, splints, braces, trusses and crutches	10% PPO providers; 30% non-PPO providers
	Rental (up to the purchase price) of a hospital bed for patient care and wheelchair	10% PPO providers; 30% non-PPO providers
	Radium, radioactive isotopes and X-ray therapy	10% PPO providers; 30% non-PPO providers
	Artificial limbs and eyes to replace natural limbs and eyes lost while the insured person is covered under this provision, initial placement of contact lenses required because of cataract surgery	10% PPO providers; 30% non-PPO providers
	Initial lens implant required because of cataract surgery	10% PPO providers; 30% non-PPO providers
OTHER COVERED SERVICES	Dental services by a physician or dentist for treatment of a dental injury to sound natural teeth	10% PPO providers; 30% non-PPO providers
SKILLED NURSING FACILITY	Maximum of 60 days each period of confinement	10% PPO providers; 30% non-PPO providers
HOME PRIVATE DUTY NURSING SERVICES	Maximum charge: \$22.50 for each hour of home private duty nursing services. Maximum number of hours: 1,000 hours for each insured person per calendar year	10% PPO providers; 30% non-PPO providers

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CATEGORY	SERVICE	COINSURANCE (Amount You are Responsible for)
HOME HEALTH CARE AND HOSPICE CARE SERVICES	Home Health Care: 100 visits for each insured person each calendar year. Maximum charge: \$60 per each call.	10% PPO providers; 30% non-PPO providers
	Counseling and Bereavement Maximum Counseling Charge: \$500 per family Maximum Bereavement Counseling Charge: \$250 per family	10% PPO providers; 30% non-PPO providers
	Inpatient Hospice Care Maximum of 185 days per person per lifetime	10% PPO providers; 30% non-PPO providers
MENTAL AND NERVOUS DISORDERS	Inpatient hospital services - maximum of 30 days per calendar year	10% PPO providers; 30% non-PPO providers
	All other covered inpatient services	10% PPO providers 30% non-PPO providers
	Outpatient services - maximum plan will pay per physician visit is \$35, maximum of 50 visits per calendar year	50% all providers
ALCOHOL AND DRUG ABUSE	Inpatient hospital or treatment center services	10% PPO providers; 30% non-PPO providers
	All other covered inpatient services	30% all providers
	Outpatient services - maximum plan will pay per outpatient treatment visit is \$25, maximum of 50 visits per calendar year	50% all providers
SPINAL TREATMENT (NON-SURGICAL)	Maximum spinal treatment benefit: one visit each day; \$1,000 maximum payable per calendar year	Member may be responsible for any charges in excess of the plan allowance.
BODY ORGAN TRANSPLANT	Recipient benefit and follow-up Limited to the following organs: kidney, heart, heart/lung combination, liver, pancreas, bone marrow and cornea.	10% PPO providers; 30% non-PPO providers
	Maximum donor benefit: \$5,000 for all donors each period of hospitalization in connection with transplant surgery	10% PPO providers; 30% non-PPO providers
PREVENTIVE HEALTH CARE	For Dependent Children under the age of 19 years: Benefits limited to 19 periodic physical examinations at approximately each of the following age intervals: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 3 years, 4 years, 5 years, 6	10% PPO providers 30% non-PPO providers

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	<p>years, 8 years, 10 years, 12 years, 14 years, 16 years and 18 years. Maximum medical payment: \$75 per each exam. Maximum Laboratory payment: \$50 per examination Maximum Inoculation payment: \$75 for all preventive inoculations with each periodic physical examination up to 30 months of age; \$75 each calendar year thereafter up to age 19.</p>	
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CATEGORY	SERVICE	COINSURANCE (Amount You are Responsible for)
PREVENTIVE HEALTH CARE	For Insured Persons age 19 years and older: One routine physical exam every two calendar years. Maximum benefit paid: \$75. Laboratory services in connection with a routine physical exam will be paid at a maximum of \$50 per calendar year. Member must use a PPO provider to receive this benefit	10% PPO providers; 30% non-PPO providers
	Pap smear benefit - one per calendar year maximum	10% PPO providers; 30% non-PPO providers
	Mammography benefits, limited to the following: (a) one baseline mammogram for women age 35 through 39; (b) one mammogram every two years (or more frequently based on the insured person's physician's recommendation) for women age 40 through 49; (c) one mammogram each year for women age 50 and older.	10% PPO providers; 30% non-PPO providers
PRE-EXISTING CONDITIONS	Benefits payable are limited to \$500 for pre-existing conditions until the day after a six consecutive month period has passed from the insured person's enrollment date.	
PRESCRIPTION DRUG BENEFIT	Generic drugs – retail	\$8 per prescription copay up to a 30-day supply
	Generic drugs – mail order	\$16 per prescription copay up to a 90-day supply
	Brand name drugs – retail	\$12 per prescription copay up to a 30-day supply
	Brand name drugs – mail order	\$24 per prescription copay up to a 90-day supply
	Prescriptions must be filled at pharmacies that accept the SAV-RX Card. Expense incurred for prescription drugs will not be used to satisfy the stop-loss limit and will not be paid at 100% once the stop-loss limit is reached. If your doctor has not specified a name brand drug and you request the name brand, you must also pay the difference between the cost of the available generic drug and the brand name drug.	

NOTE: If you live in a geographic area that is outside the Blue Cross Prudent Buyer Networks service area, then your coinsurance will be 80% of covered charges.

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EXCEPTION: If you are admitted to a Blue Cross Prudent Buyer contracted hospital and your primary surgeon is also contracted with the network, services of an anesthesiologist and/or assistant surgeon will be paid at the PPO rate regardless of whether the anesthesiologist and/or assistant surgeon is contracted with Blue Cross. If you receive covered services at the emergency room of a contracted hospital, services provided by a staff physician will be paid at the PPO rate even if the physician is not contracted with the Blue Cross Prudent Buyer network.

How to File Claims

Before benefits can be paid under this plan, United of Omaha must be given written proof of loss.

Completed claim forms must be sent to the Plan Administrator, Allied Administrators, at P.O. Box 2500, San Francisco, CA 94126.

The personnel at Allied are also available to assist you with filing your claim or to explain how your claim was paid. Further information can be found in the Claim Review Procedures section of this booklet.

Your provider may also submit claims electronically through Allied's secure electronic data interchange (EDI) system. Allied's EDI number is 94177. That is all the information your provider would need to file claims electronically.

Pre-Authorization

Any tests or treatments that will cost more than \$300 must be approved in advance by United of Omaha.

A preauthorization form may be obtained from either the Plan Administrator or from United of Omaha. The form must be completed by you and your physician. It must be returned to the Plan Administrator or to United of Omaha before the tests or treatment begins.

To review the testing or treatment plan, United of Omaha or the Plan Administrator may request clinical reports, charts and x-rays. They may also discuss the Plan with your provider. You and your physician will then receive written notice of the benefit amounts that will be payable.

The chart is a brief summary of the benefits available at the time this booklet was prepared and is not a guarantee of benefits available. Please refer to United of Omaha's certificate of coverage to learn about what is covered (including exclusions and limitations) and additional benefits that are not included in this summary.

If there is a discrepancy between this chart and United of Omaha's certificate of coverage, the benefits described in United of Omaha's documents will prevail.

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Medical Benefits – Kaiser Permanente

The Kaiser Permanente health care program is a prepaid group-practice HMO. Physicians and other providers are employed directly by Kaiser.

As multi-specialty group practices, the medical groups take direct responsibility for organizing and providing the care their members receive.

The Kaiser team of primary care physicians and specialists work together to integrate medical services in Kaiser’s hospitals, medical offices, pharmacies, and laboratories.

When necessary, Kaiser may contract with non-Kaiser Permanente providers for certain services.

A Kaiser Health Plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat your medical condition. The services and supplies must be provided, prescribed, authorized, or directed by a Kaiser Health Plan physician.

You must receive the services and supplies at a Kaiser Health Plan facility or skilled nursing facility inside the Kaiser Service Area, except where specifically noted to the contrary in Kaiser’s Evidence of Coverage.

You should choose a personal Plan Physician who will coordinate all health care needs, including hospital stays and referrals to specialists.

A personal Plan Physician may be chosen from the following specialties: internal medicine, obstetrics/gynecology, family practice and pediatrics.

For details on Kaiser’s benefit and claims review and adjudication procedures, please refer to Kaiser Health Plan’s Evidence of Coverage.

Summary Of Benefits Kaiser Permanente

The following is a summary of benefits and the co-payments for which you are responsible for certain services. Co-payments must be made to Kaiser at the time the service is received.

CATEGORY	SERVICE	COPAYMENT
Hospital Care	Room and board, including obstetrics	No charge
	Physician, surgeon, and surgical services	No charge
	Nursing care, anesthesia, imaging, lab tests, and medications	No charge
	Outpatient surgery	\$10 per procedure

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Outpatient Care	Primary care visits - includes routine and urgent care appointments	\$10 per visit
	Well-child preventive care visits (23 months or younger)	\$10 per visit
	Pediatric visits	\$10 per visit
	Specialty care visits	\$10 per visit
	Outpatient surgery	\$10 per procedure
	Allergy testing and injection visits	\$3 per visit

CATEGORY	SERVICE	COPAYMENT
Outpatient Care, continued	Immunizations	No charge
	Routine physical exams - one per calendar year	\$10 per visit
	Gynecological visits	\$10 per visit
	Scheduled prenatal care and first postpartum visit	\$10 per visit
	Imaging and lab tests	No charge
	Eye exams to provide a prescription for eyeglasses	\$10 per visit
	Hearing exams	\$10 per visit
	Physical, occupational, and speech therapy visits	\$10 per visit
	Health education for specific conditions	\$10 per visit
Emergency Department	Emergency Department visits - Kaiser facility For coverage of emergency services out of the Kaiser network, please see below.	\$35 per visit (waived if admitted to the hospital)
Prescription Drugs	Covered prescription drugs in accord with Kaiser's formulary when obtained at Kaiser pharmacies. For more information, please see the Special Note regarding Kaiser's drug formulary below.	\$5 (up to a 30-day supply or manufacturer's smallest package, whichever is greater)
	In addition, the following are provided in accord with Kaiser's formulary at Kaiser pharmacies:	
	Injectable and internally implanted, time-release contraceptives	\$5 per 1-month supply (not to exceed \$200)
	Oral contraceptives	\$5 (up to a 1-month supply)
	Contraceptive devices	\$5 per item
	Drugs related to the treatment of sexual dysfunction when prescribed by a Kaiser Physician	50% of Member rate (up to a 30-day supply or manufacturer's smallest package, whichever is greater)
Mental Health	Inpatient psychiatric care (up to 45 days per calendar year)	No charge

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	Outpatient visits:	
	Up to a total of 20 individual and/or group therapy visits per calendar year	\$20 per individual visit \$10 per group therapy visit
	Up to 20 additional group therapy visits that meet Medical Group criteria in the same calendar year	\$10 per group therapy visit

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CATEGORY	SERVICE	COPAYMENT
Alcohol and Drug Dependency	Inpatient detoxification	No charge
	Outpatient individual therapy visits	\$10 per visit
	Outpatient group therapy visits	\$10 per visit
Infertility Services	Office visits and outpatient surgery	\$10 per visit
	Outpatient lab tests, imaging, and special procedures	No charge
	Hospital care	No charge
Durable Medical Equipment	Covered DME according to our formulary	No charge
Optical Coverage	Eyeglasses every 24 months (frames and lenses)	\$175 allowance*
	Cosmetic contact lenses every 24 months in lieu of eyeglasses	\$175 allowance*
Additional Benefits	Home health care	No charge
	Hospice care	No charge
	Ambulance service when medically necessary	No charge
	Skilled nursing facility care (up to 100 days per benefit period)	No charge

*An allowance is the total expense of an item that is covered. If the cost of the item selected exceeds the allowance, you will pay the difference.

Annual Out-of-Pocket Maximum for Certain Services	\$1,500 per member per calendar year \$3,000 per family per calendar year
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The benefits described above are covered only if all the following conditions are met:

- (1) A Kaiser Physician determines that the services and supplies are medically necessary to prevent, diagnose, or treat your medical condition;
- (2) The services and supplies are provided, prescribed, authorized, or directed by a Kaiser Physician;
- (3) You receive the services and supplies at a Kaiser Hospital, Kaiser Medical Office, or skilled nursing facility inside the Kaiser Service Area, except where specifically noted to the contrary in your Evidence of Coverage.

Out-of-Kaiser-Plan Emergency Services

“Out-of-Kaiser-Plan-Emergency Services” are medically necessary health benefits that you receive immediately from a non-Kaiser provider for a sudden, unforeseen injury or illness. Kaiser will reimburse these expenses if you file a claim and Kaiser determines that:

- (1) the benefits would have been covered by Kaiser had they been authorized or prescribed by a Kaiser physician;

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- (2) the time required to reach a Kaiser hospital or Kaiser medical office would result in negative health consequences;
- (3) transfer to a Kaiser facility would pose serious risk to your health and would be unreasonable due to the nature of the condition and the distance involved. The decision to transfer the member to another facility is made at Kaiser's discretion with the attending physician's concurrence.

How to File a Claim for Out-of-Kaiser-Plan Emergency Services

If you receive Out-of-Kaiser-Plan Emergency Services, you must file a claim in order for Kaiser to pay for the services and supplies. To file a claim, you must:

- 1) Call Kaiser within 24 hours (or as soon as possible) after admittance to a non-Kaiser hospital. The number to call is printed on the Kaiser ID card. Kaiser will make arrangements for any necessary continued hospitalization, or for transferring the patient to an approved hospital, if necessary. If Kaiser is not notified of such hospitalization as soon as possible, the member risks becoming liable for payment for services and supplies received after transfer to a Kaiser facility would have been deemed possible.
- 2) Obtain an emergency claim form by calling Kaiser's Member Service Call Center at 1-800-464-4000. The claim form should be completed and mailed within 90 days or as soon as possible, but no later than 12 months after the event. All bills from the non-Kaiser providers should be attached.
- 3) Complete and return any forms that Kaiser sends to the member, including consents for the release of medical records, releases, assignments, and claims for any other benefits to which the member may be entitled.

Special Note Regarding Kaiser's Drug Formulary

The Kaiser drug formulary includes the list of drugs that have been approved by Kaiser's Pharmacy and Therapeutics Committee for Kaiser's members.

For information about whether a particular drug is included in Kaiser's drug formulary, you may call the Member Service Call Center at 1-800-464-4000.

This is only a brief summary of the benefits available at the time this booklet was prepared through the Kaiser Health Plan. This chart is not a complete or current description of benefits nor is a guarantee of benefits available.

You should refer to the Evidence of Coverage to learn about what is covered under each benefit (including exclusions and limitations), additional benefits that are not included in this summary and any modifications of Kaiser's claims procedures and rules.

In the event that there is a discrepancy between this chart and Kaiser's Evidence of Coverage, the benefits described in Kaiser's documents will control.

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Medical Benefits – PacifiCare

PacifiCare of California's HMO network includes physicians, medical groups, hospital, medical centers, and pharmacies. PacifiCare's HMO is a pre-paid health plan. Except in the case of a medically necessary emergency or an urgently needed service outside the PacifiCare service area, all care must be received from network providers and must be coordinated by your Primary Care Physician.

All members of PacifiCare are required to have a Primary Care Physician (PCP). If you do not select one when you enroll in the PacifiCare HMO, PacifiCare will select one for you. A Primary Care Physician can be from the following specialties: family practice, general practice, internal medicine, obstetrics/gynecology, or pediatrics. Nurse practitioners in family practice and/or pediatrics can also be Primary Care Providers.

All specialty care must be authorized by the member's PCP. If your PCP determines that you need to see a specialist, he or she will make an appropriate specialist referral. Your PCP will also determine the number of specialist's visits you require and will provide you with any other special instructions. You may receive a standing referral to a specialist if your PCP determines, in consultation with the specialty and the participating medical group's medical director or a PacifiCare Medical Director, that you need continuing care from a specialist. The standing referral will be made according to a treatment plan approved by your participating medical group or PacifiCare, in consultation with your PCP, the specialist, and you, if a treatment plan is considered necessary.

Your PCP will also arrange for medically necessary hospital or facility care, including transitional inpatient care or care provided in a subacute or Skilled Nursing Facility. If you have been referred to a specialist and the specialist determines you need hospitalization, your PCP and specialist will work together to coordinate your hospital stay.

The following benefit chart is a summary only. PacifiCare's Medical and Hospital group Subscriber Agreement must be consulted to determine the exact terms and conditions of coverage. A specimen copy of the contract will be furnished upon request and is available at the PacifiCare office and at the office of the Plan Administrator.

For details on PacifiCare's benefit and claims review and adjudication procedures, please refer to the Evidence of Coverage provided by PacifiCare.

Summary Of Benefits PacifiCare HMO

The following is a summary of benefits and of the co-payments for which a member is responsible for certain services. Co-payments must be made to the provider of the service at the time it is received. These services are covered as indicated when authorized through your primary Care Physician in your Participating Medical Group.

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General Features	Copayment
Calendar Year Deductible	\$0.00
Maximum Benefit	Unlimited
Annual Copayment Maximum ^a <i>(Three individual maximums per family.)</i>	\$2,000/individual
Office Visits	\$20 each visit
Hospitalization	No charge
Emergency Services	\$50 - waived if admitted as patient
Urgently Needed Services Medically necessary services required outside your service area. Please consult your brochure for additional details.	\$50 - waived if admitted as patient
Benefits Available While Hospitalized as an Inpatient	Copayment
Alcohol, drug, or other substance abuse or addiction <i>(Detoxification only)</i> <i>Maximum annual benefit for detoxification is limited to \$25,000 per person per calendar year, and \$35,000 per person lifetime.</i>	No charge
Bone marrow transplants <i>(Donor searches limited to \$15,000 per procedure.)</i>	No charge
Cancer Clinical Trials ^b	Paid at negotiated rate Balance, if any, is the responsibility of the Member
Hospice care <i>(Prognosis of life expectancy of one year or less)</i>	No charge
Hospital benefits ^c	No charge
Mastectomy/breast reconstruction <i>(After mastectomy and complications from mastectomy)</i>	No charge
Maternity Care	No charge
Newborn Care ^c	No charge
Physician Care	No charge

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Benefits Available While Hospitalized as an Inpatient	Copayment
Reconstructive Surgery	No charge
Rehabilitation Care (Including physical, occupational and speech therapy)	No charge
Mental Health Services (As required by state law, coverage includes treatment for Severe Mental Illness (SMI) of adults and the treatment of Serious Emotional Disturbance of Children (SED). Please refer to your Supplement to the PacifiCare Combined Evidence of Coverage and Disclosure Form for a description of this coverage)	No charge
Skilled Nursing Care (Up to 100 consecutive calendar days from the first treatment per disability)	No charge
Voluntary Termination of Pregnancy (Medical/ medication and surgical) - 1st trimester - 2nd trimester (12-20 weeks) - after 20 weeks	\$125 copayment \$125 copayment Not covered unless mother's life in jeopardy or fetus is not viable
Benefits Available on an Outpatient Basis	Copayment
Alcohol, Drug or Other Substance Abuse Detoxification	No charge
Allergy testing/treatment (Serum is covered)	\$20 Office visit copayment
Ambulance	No charge
Cancer Clinical Trials ^c	Paid at negotiated rate Balance, if any, is the responsibility of the Member
Cochlear implants (Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply)	No charge
Dental Treatment Anesthesia (Additional Copayment for outpatient surgery or inpatient hospital benefits may apply)	\$20 Office visit copayment
Dialysis (Physician office visit Copayment may apply)	\$20 Copayment per treatment
Durable medical equipment (\$5,000 annual benefit maximum per calendar year)	No charge

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Benefits Available on an Outpatient Basis	Copayment
<p>Family Planning/Voluntary Termination of Pregnancy</p> <ul style="list-style-type: none"> - vasectomy - tubal ligation (additional Copayment for inpatient hospital benefits may apply if performed on an inpatient basis) - insertion/removal of intra-uterine device (IUD) - intra-uterine device (IUD) - removal of Norplant - Depo-Provera injection - Depo-Provera medication - voluntary interruption of pregnancy <ul style="list-style-type: none"> 1st trimester 2nd trimester (12-20 weeks) After 20 weeks 	<p>\$50 copayment</p> <p>\$100 copayment</p> <p>\$20 Office Visit Copayment</p> <p>\$50 copayment</p> <p>\$20 Office Visit Copayment</p> <p>\$20 Office Visit Copayment</p> <p>\$35 Copayment</p> <p>\$125 copayment</p> <p>\$125 copayment</p> <p>not covered unless mother's life in jeopardy or fetus is not viable</p>
Health Education services	No charge
Hearing screening	\$20 office visit copayment
Home Health Care Visits (Up to 100 visits per calendar year)	No charge
Hospice Care (<i>Prognosis of life expectancy of one year or less</i>)	No charge
Immunizations (<i>for children under 2 years of age, refer to Well-Baby Care</i>)	\$20 Office Visit Copayment
Infertility services	Not covered
Infusion Therapy (Infusion Therapy is a separate Copayment in addition to a home health care or an office visit Copayment. Copayment applies per 30 days or treatment plan, whichever is shorter).	No Charge
Injectable Drugs (Outpatient Injectable Medications and Self Injectable Medications) (Copayment no applicable to allergy serum, immunizations, birth control, Infertility and insulin. The Self-Injectable medications Copayment applies per 30 days or treatment plan, whichever is shorter. Please see the PacifiCare Combined Evidence of Coverage and Disclosure Form for more information on these benefits, if any. Office visit Copayment may also apply)	\$50 Copayment per visit ^d
Laboratory Services (When available through or authorized by your Participating Medical Group)	No charge

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Benefits Available on an Outpatient Basis	Copayment
Maternity Care, Tests and Procedures	No charge
<p>Mental Health Services</p> <p>(As required by state law, coverage includes treatment for Severe Mental Illness (SMI) of adults and the treatment of Serious Emotional Disturbance of Children (SED). Please refer to your Supplement to the PacifiCare Combined Evidence of Coverage and Disclosure Form for a description of this coverage)</p>	\$20 Office Visit Copayment
Oral surgery services	No charge
<p>Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility</p> <p>(Including physical, occupational and speech therapy)</p>	\$20 Office Visit Copayment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	No charge
<p>Periodic Health Evaluations</p> <p><i>Physician, laboratory, radiology and related services as recommended by the American Academy of Pediatrics (AAP) and U.S. Preventive Services Task Force and authorized through your Primary Care Physician in your Participating Medical Group to determine your health status. For children under two years of age, refer to Well-Baby Care.</i></p>	\$20 Office Visit Copayment
<p>Prescription Drug Benefit</p> <p><i>Participating Pharmacy only – 100% after Copayment</i></p>	<p>Generic Formulary - \$5</p> <p>Brand Name Formulary - \$15</p> <p>Non-Formulary - \$30</p> <p>Mail Order 90-day Supply – 100% after 2 Copayments per 90 day supply</p>
<p>Physician Care</p> <p>(For children under two years of age, refer to Well-Baby Care.)</p>	\$20 Office Visit Copayment
Prosthetics and Corrective Appliance	No charge
<p>Radiation Therapy</p> <p>Standard: (Photon beam radiation therapy)</p> <p>Complex (Examples include, but are not limited to, brachytherapy, radioactive implants and conformal photon beam; Copayment applies per 30 days or treatment plan, whichever is shorter; GammaKnife and stereotactic procedures are covered as outpatient services. Please refer to outpatient surgery for Copayment amounts if any.</p>	<p>No charge</p> <p>No charge</p>

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Benefits Available on an Outpatient Basis	Copayment
Radiology Services Standard: Specialized scanning and imaging procedures: (Examples include but are not limited to, CT, SPECT, PET, MRA, and MRI – with or without contract media)	No charge No charge
Vision Screening/Refractions	\$20 Office Visit Copayment
Well-Baby Care <i>Preventive health service, including immunizations recommended by the American Academy of Pediatrics (AAP) and U.S. Preventive Services Task Force and authorized through your Primary Care Physician in your Participating Medical Group for children under two years of age.</i> (\$20 copayment applies to infants that are ill at time of services.)	No charge
Well-Woman Care <i>Includes Pap Smear (by your Primary Care Physician or an Ob-Gyn in your Participating Medical Group) and referral by the Participating Medical Group for screening mammography as recommended by the U.S. Preventive Services Task Force</i>	\$20 Office Visit Copayment
Chiropractic Benefits Participating ChiroCare Chiropractor and authorized when necessary by ASHP, up to the annual maximum benefit. Please see procedures listed below.	\$15 Copayment for Each Visit 20 Visits Annual Maximum Benefit

- a Annual copayment maximum does not include copayments for pharmacy and supplemental benefits
- b Cancer Clinical Trial services require pre-authorization by PacifiCare. If you participate in a Cancer Clinical Trial provided by a Non-Participating Provider that does not agree to perform these services at the rate PacifiCare negotiates with Participating Providers, you will be responsible for payment of the difference between the Non-Participating Provider billed charges and the rate negotiated by PacifiCare with Participating Providers, in addition to any applicable Copayments, coinsurance or deductibles
- c The inpatient hospital benefits Copayment does not apply to newborns when the newborn is discharged with the mother within 48 hours of the normal vaginal delivery or 96 hours of the cesarean deliver; please see the *Combined Evidence of Coverage and Disclosure Form* for more details
- d In instances where the negotiated rate is less than your Copyament, you will pay only the negotiated rate

Except in the case of a medically necessary emergency or an urgently needed service (outside your service area), each of the above noted benefits are covered when authorized by your Primary Care Physician in your Participating Medical Group. Where the recommended service involves hospital admission or referrals, your Physician’s recommendation may receive a second opinion review by a utilization review committee. The committee is designed to promote the efficient use of resources while maintaining quality care for a member.

Prior Authorization

Prior authorization is required for all mental health services, chemical dependency services

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and severe mental illness benefits. You do not need to go through your Primary Care Physician, but you must obtain prior authorization through PacifiCare Behavioral Health of California (PBHC), an affiliate of PacifiCare that specializes in mental health and chemical dependency benefits. PBHC is available to you toll-free, 24 hours a day, 7 days a week at 1-800-999-9585.

Second medical opinions must also be pre-authorized. The member can request a second medical opinion either through his or her doctor or directly to the participating medical group. Second medical opinions will be provided when the request is regarded as medically appropriate by your participating medical group or by PacifiCare.

PacifiCare's Case Management Program

PacifiCare's Case Management Program is a program in which PacifiCare of California has licensed registered nurses who, in collaboration with the member, member's family and the member's participating medical group help arrange care for PacifiCare members experiencing a major illness or recurring hospitalizations. The Case Manager will assess, plan, implement, coordinate, monitor and evaluate options to meet an individual's health care needs based on the health care benefits and available resources.

Emergency Medical Conditions

An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected by the member to result in any of the following:

- placing the member's health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part; or
- active labor, meaning labor at a time that either of the following would occur:
 - (1) there is inadequate time to effect safe transfer to another hospital prior to delivery; or
 - (2) a transfer poses a threat to the health and safety of the member or unborn child.

What to Do When You Require Emergency Services

If you believe that you need emergency services you should call 911 or go directly to the nearest medical facility for treatment.

You must notify PacifiCare or your participating medical group within 24 hours or as soon as reasonably possible after the initial receipt of emergency services to inform them of the location, duration and nature of the services provided. If you do not follow these notification procedures, you may become financially responsible for any services rendered.

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PacifiCare HMO – Prescription Drug Benefits

Formulary means a continually updated list of prescription medications which are approved by PacifiCare’s Pharmacy and Therapeutics Committee. The Formulary contains both brand-name drugs and generic drugs, all of which have Food and Drug Administration (FDA) approval.

You or your physician may contact PacifiCare at 1-866-316-9776 or visit PacifiCare’s website at www.pacificare.com, to determine if a particular drug is part of the Formulary or to obtain a list of Formulary drugs.

Participating Pharmacy means a pharmacy that has contracted with PacifiCare to provide outpatient prescription drugs to a covered person.

PacifiCare ChiroCare Benefits

PacifiCare makes available to you and your eligible Eligible Dependents, ChiroCare, a supplemental chiropractic benefit program. This program is provided through an arrangement with American Specialty Health Plan (ASHP). ASHP monitors the quality of the care provided by Participating ChiroCare Chiropractors.

How to Use the Program

- To begin chiropractic care, simply make an initial appointment with the Participating ChiroCare chiropractor of your choice. A listing of the Participating Chiropractors can be found in the ChiroCare directory. A referral from your PacifiCare Participating Medical Group or Physician is NOT necessary.
- At the time care is delivered, your chiropractor will collect your Copayment. Your chiropractor will bill ASHP for the remaining balance.
- If further treatment is necessary, your chiropractor will prepare a treatment plan and obtain the required preauthorization from ASHP for your continued care.

The ChiroCare Benefit covers the services described in this section when performed by a Participating ChiroCare Chiropractor and authorized when necessary by ASHP, up to the annual maximum benefit listed.

Covered Services

The following items are covered:

- An initial examination with a Participating Chiropractor to determine the nature of a Member’s problem and, if necessary, to prepare a treatment plan. A Copayment will be required.
- When authorized by ASHP, subsequent visits to Participating Chiropractors which may involve manipulations, adjustments, therapy, X-ray procedures and laboratory tests in various combinations. A Copayment will be required.
- Conjunctive Therapy, set forth in the treatment plan, involving therapies such as ultrasound, hot packs, cold packs, Electrical Muscle Stimulation and other therapies.

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- Re-evaluations to assess the need to continue extend or change the treatment plan under which Member is being treated. Re-evaluations may be performed during a subsequent visit or separately. If performed separately, a Copayment will be required.
- X-rays and laboratory tests are covered in full when prescribed by a Participating Chiropractor. X-ray interpretations or consultations are covered only when performed by a licensed Chiropractic or Medical Radiologist when determined to be Medically Necessary.
- Chiropractic Appliances are payable up to a maximum of \$50.00 per year when prescribed by a Participating Chiropractor.

General Exclusions and Limitations

The following items and services are excluded from coverage under this supplemental benefit:

- Any treatment or service not authorized by the American Specialty Health Plan (ASHP) except for an initial examination and Emergency Chiropractic Services.
- Any service or treatment not delivered by a Participating Chiropractor, except for Emergency Chiropractic Services.
- Services for examination and/or treatment of strictly non-neuromuscular skeletal disorders.
- Services not documented as necessary and appropriate or classified as Experimental or Investigational Chiropractic Care.
- Diagnostic scanning, including Magnetic Resonance Imaging (MRI), CAT scans, and/or other types of diagnostic scanning; thermography.
- Any services or treatment for a Temporomandibular Joint Disease (TMJ). TMJ is a condition of the jaw joint, which commonly causes headaches, tenders of the jaw muscles or dull aching facial pain.
- Treatment or service for pre-employment physicals or vocational rehabilitation.
- Any treatment or services caused by or arising out of the course of employment or covered under any public liability insurance, including, but not limited to, workers' compensation programs.
- Hypnotherapy, behavior training, sleep therapy and weight programs, educational programs, nonmedical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing.
- Air conditioners, air purifiers, therapeutic mattress supplies or any other similar devices or appliances.
- Vitamins, minerals, nutritional supplements or other similar-type products.
- Manipulation under anesthesia, anesthesia, hospitalization or any related services.

This is only a brief summary of the benefits available at the time this booklet was prepared through the PacifiCare HMO. This chart should not be construed as a complete or current description of benefits nor as a guarantee of benefits available. Please refer to the Evidence of Coverage to learn about what is covered under each benefit (including exclusions and limitations), additional benefits that are not included in this summary and any modifications of PacifiCare's claims procedures and rules. In the event that there is a discrepancy between this chart and PacifiCare's Evidence of Coverage, the benefits described in PacifiCare's documents will prevail.

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Retiree Medical Plans Available To Retirees With Medicare

Kaiser Permanente Seniority Plus

Contract No. 7748-02

Service Area: Alameda, Amador, Contra Costa, El Dorado, Fresno, Kings, Madera, Marin, Mariposa, Napa, Placer, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Solano, Sonoma, Stanislaus, Sutter, Tulare, Yolo, and Yuba counties in Northern California. Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Tulare, and Ventura counties in Southern California.

Pacificare Secure Horizons (Medicare+CHOICE Plan)

Service Area: covered zip codes in Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Nevada, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Sonoma, Stanislaus, Ventura, and Yolo counties.

PacifiCare Senior Supplement (Medicare Supplement Plan)

Service Area: those areas not covered under PacifiCare Secure Horizons.

The prescription drug benefits provided under the above plans are considered “creditable” with Medicare Part D, as of the date of this booklet. If you enroll in one of the above Medicare group plans through this Trust, you should **not** enroll in an individual Medicare Part D plan.

Retiree Medical Plans Available To Retirees Without Medicare

Kaiser Permanente Traditional Plan

Contract No. 7748-02

Service Area: Alameda, Amador, Contra Costa, El Dorado, Fresno, Kings, Madera, Marin, Mariposa, Napa, Placer, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Solano, Sonoma, Stanislaus, Sutter, Tulare, Yolo, and Yuba counties in Northern California. Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Tulare, and Ventura counties in Southern California.

PacifiCare Early Retiree HMO

Service Area: covered zip codes in Alameda, Contra Costa, El Dorado, Fresno, Imperial, Inyo, Kern, Kings, Tulare, Los Angeles, Madera, Marin, Merced, Nevada, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Ventura, and Yolo counties.

PacifiCare Out of Area PPO Plan for Early Retirees

Service Area: those areas not covered under the PacifiCare Early Retiree HMO.

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DENTAL BENEFITS

These benefits are self-funded by the Trust.

CLAIMS PAYMENT

All claims should be submitted to the Administration Office for reimbursement.

DEDUCTIBLE AMOUNT (per calendar year)

The deductible is \$25 per person up to a maximum family deductible each year of \$150. You must satisfy this amount of covered dental expense before benefits become payable under the Plan.

MAXIMUM PAYMENT (per calendar year)

The maximum payment for each covered person for all dental procedures, (except orthodontia), each calendar year is \$2,000.

After you have met the deductible, your and your Eligible Dependents' dental claims will be paid at 80% of the reasonable, usual and customary charges for Basic and Prosthodontics Services up to the calendar year maximum \$2,000 per covered individual.

An expense is incurred on the date the service is rendered. The "insert" date of an appliance shall be considered the date the charge was incurred. Where more than one procedure may be considered as alternate treatment, the applicable amount for the less expensive procedure will be considered the reasonable, usual and customary charge.

Bright Now! Dental PPO option

You may choose to receive services from one of the Bright Now! Offices. Bright Now! acts as a preferred provider (PPO) for dental services. Services received at a Bright Now! office are covered at **100%** after payment of the \$25 deductible up to the calendar year \$2,000 maximum.

You can call the Administration Office for an up-to-date list of Bright Now! locations.

If Bright Now! refers you to a specialist, those services received from the specialist will be covered at 80% after the deductible but not to exceed the \$2,000 maximum.

ORTHODONTIC SERVICES

You will be covered for 50% of the reasonable, usual and customary charges for Orthodontic Services provided to an Eligible Dependent child up to age 17, limited to payment of monthly or other periodic charges through completion of treatment or to age 19, whichever occurs first.

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The maximum amount payable for Orthodontic Services is \$1,000 per person per lifetime.

In all cases in which there are optional plans of treatment involving different fees, you will be paid the applicable percentage of the lesser fee.

COVERED DENTAL SERVICES

A. Basic Services

Diagnostic Services provide the necessary procedures to assist the dentist in determining the required dental treatment.

Preventative Care provides the necessary procedures to prevent oral disease. These services include prophylaxis once every six months and application of fluoride solutions.

Oral Surgery provides the necessary procedures for extractions and other dental surgery including pre-and post-operative care.

Restorative Dentistry provides for amalgam, synthetic porcelain and plastic restorations. Gold restorations, crowns and jackets will be provided when teeth cannot be restored with the above materials.

Endodontics provides necessary pulpal therapy and root canal filling (treatment of non-vital teeth).

Periodontics provides for treatment of the tissues supporting the teeth.

B. Prosthodontic Services

Prosthodontics includes the construction of bridges, and partial or complete dentures. Prosthodontic appliances will be provided once only in any five year period.

C. Orthodontic Services

Orthodontic services include treatment by a licensed dentist for the correction of malposed teeth.

Limitations on Orthodontic Benefits:

1. The obligation of the Trust to make monthly or other periodic payments for orthodontic treatment ends upon termination of treatment prior to completion of the case.

2. The Trust will not pay for repair or replacement of any orthodontic appliance furnished under this Plan.

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General EXCLUSIONS and LIMITATIONS

Dental Expense Benefits are **not** payable:

- for more than one oral examination and preventive service in any six month period;
- for services for congenital malformation or dental procedures for purely cosmetic reasons;
- for replacement of a denture, crown, or bridge for which benefits were paid by the Plan within five years, unless such replacement is made necessary by the initial placement of an opposing full denture or the extraction of natural teeth;
- for prosthetic services or devices (including crowns and bridges) which commenced before the date the person became covered under this Plan. X-rays and prophylaxis treatment shall not be deemed to commence a dental procedure;
- for any services for which payment is also available under a medical plan in which you are enrolled; any services for injuries or conditions which can be paid under Workers' Compensation or Employer's Liability laws; services provided the patient by any Federal or State Government Agency, or provided without cost to you or your Eligible Dependents by any municipality, county, or other political subdivision;
- for treatments which exceed generally accepted standards.

VISION BENEFITS

For Participants and their Eligible Dependents who are not enrolled in Kaiser, the Trust Fund provides vision benefits through a contract administered by Vision Service Plan, Inc. These benefits are described in a separate brochure from the Administration Office. If you have elected the Kaiser benefit option, you receive vision benefits through the Kaiser program.

Vision benefits are higher when you use providers in the Vision Service Plan network. You pay a \$10 deductible each time services are received. When you are eligible, you and your Eligible Dependents may receive an eye examination every twelve (12) months.

Lenses and frames are available every 24 months (\$120 allowance for frames and lenses are paid in full); however, if there is a significant change in your prescription, new lenses are available after twelve (12) months.

A \$120 allowance toward cosmetic contact lenses is available in lieu of glasses every 24 months.

You need to discuss with your provider which standard lenses and frames are covered by Vision Service Plan; you will be responsible for any additional cost for such things as oversized or tinted lenses or designer frames.

When you use providers who are not contracted with Vision Service Plan, you must submit your claim to Vision Service Plan at P.O. Box 997100, Sacramento, CA 95899-7100.

. You will be reimbursed according to a fixed schedule. You need to be aware that your out of pocket cost will probably be significant.

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CONTINUATION OF HEALTH COVERAGE
UNDER FEDERAL LAW (COBRA PROVISIONS)

You and your Eligible Dependents (known as “qualified beneficiaries” for purposes of COBRA continuation coverage) who are covered under this Plan on the day before a Qualifying Event have the right to elect continuation of health coverage (medical, dental and vision) if such coverage would otherwise end because of the Qualifying Event.

A. "Qualifying Event" is:

- (1) your death;
- (2) when your reserve account hours go below 110 (due to layoff, reduced hours, voluntary termination, disability, retirement or any other reason except if your employment is terminated for cause);
- (3) your divorce or legal separation;
- (4) your Eligible Dependent child no longer meeting the requirements of an Eligible Dependent (for example, because he or she reaches the limiting age of 19, or 24 if a full-time student, or is no longer a full-time student);
- (5) when you become entitled to Medicare benefits; or
- (6) the bankruptcy of your employer.

A child placed with you for adoption who is removed from your custodial care and whom you no longer intend to adopt is not entitled to this Continuation Coverage.

B. Period of Cobra Continuation Coverage

Qualifying Event	Qualified Beneficiary	Maximum Continuation Period
1. Reduction in hours or termination of your employment	You, your spouse and dependent children	18 months
2. Your death	Your spouse and dependent children	36 months
3. Your divorce	Your spouse and dependent children	36 months
4. Your dependent child’s loss of dependent status	Your affected dependent child	36 months
5. Your entitlement to Medicare after Qualifying Event described in 1	Your spouse and dependent children	36 months
6. Your entitlement to Medicare before a Qualifying Event described in 1	Your spouse and dependent children	Later of 18 months from the Qualifying Event or 36 months from the date of your Medicare entitlement

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C. Disability Extension

If you and your Eligible Dependents are entitled to 18 months of continuation coverage under the chart above and if one of you is determined by the Social Security Administration to be disabled at any time during the first 60 days of coverage, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months, provided you notify the Plan Administrator in a timely fashion. You will be required to pay the disability premium for such continued coverage.

You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.

D. Multiple Qualifying Events

If your family experiences another Qualifying Event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 total months. This extension is available to the spouse and dependent children if you die, enroll in Medicare (Part A, Part B, or both), or get divorced or legally separated.

The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child.

In all of these cases, you must make sure that the Plan Administrator is notified of the second Qualifying Event within 60 days of that second Qualifying Event.

E. Termination of COBRA Coverage

Your COBRA continuation coverage may stop before the end of the 18-, 29-, or 36-month period for any of the following reasons:

- The Plan terminates,
- You do not pay the premium for your continuation coverage on time (within the applicable grace period),
- You become covered under another group health plan (as an employee or otherwise) that does not contain an exclusion or limitation for any preexisting condition you may have,
- You become enrolled in Medicare, or
- Coverage has been extended for up to 29 months due to disability and there was a final determination by the Social Security Administration that the individual no longer is disabled.

You do not have to show that you are in good health to choose COBRA continuation coverage. However, continuation coverage is subject to your eligibility under the rules of the

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Plan. The Board of Trustees reserves the right to terminate your COBRA continuation coverage retroactively if you are determined to be ineligible. Once your continuation coverage ends for any reason, it cannot be reinstated.

F. Duty to Notify the Plan Administrator

The Plan offers COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is divorce, legal separation or a Eligible Dependent child's loss of eligibility for coverage as a Eligible Dependent child, you must notify the Plan Administrator within 60 days after the Qualifying Event occurs at the office listed on page 2 of this booklet.

G. Electing Continuation Coverage

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary has the right to elect continuation coverage. Under the law, you have 60 days to notify the Plan Administrator that you want COBRA continuation coverage.

This 60-day election period begins on the later of (a) the date you would lose coverage because of your Qualifying Event, or (b) the date you received the notice of your right to elect COBRA continuation coverage. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the Qualifying Event.

H. Paying for Continuation Coverage

(1) First payment for continuation coverage. If you elect continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the election notice is post-marked, if mailed.)

If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan.

You are responsible for making sure that the amount of your first payment is correct. Your first payment must cover the months from the date coverage would otherwise have terminated, including the month in which the initial payment is made.

(2) Continuing Payments. After you make your first payment for continuation coverage, you must make monthly payments to continue coverage. Monthly payments must be mailed by the 20th of the month preceding the month of coverage. If you do not make payment within 30 days of the beginning of the coverage month, your coverage will terminate and cannot be reinstated.

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CONVERSION PRIVILEGE

When the period of continued health coverage ends, you may have the right to convert hospital, surgical and medical coverage to an individual policy. Contact the Trust Administration Office or the HMO in which you are enrolled before your coverage terminates to determine if conversion to an individual policy is available.

CERTIFICATES OF FORMER COVERAGE

If you or your Eligible Dependents lose coverage under the Plan, you will receive a Certificate of Former Plan Coverage. You should retain this Certificate in a safe place, as you may need it if your new plan excludes coverage for pre-existing conditions. If you are entitled to COBRA coverage, the certificate will be mailed when a notice for a Qualifying Event under COBRA is required, and after COBRA coverage stops. You may also request a Certificate within 24 months after losing coverage.

LIFE INSURANCE BENEFITS

Benefits

Life insurance benefits are available to active employees only (no dependent coverage). The amount of the benefit payable is \$6,000. This benefit is insured by United of Omaha regardless of which option you elect for comprehensive major medical benefits. Retirees are not eligible for life insurance coverage.

If you die while insured under this provision, United of Omaha will pay benefits to the beneficiary you designate. Beneficiary designation cards are available from the Plan Administrator. If you do not designate a beneficiary or if no beneficiary survives you, benefits will be paid:

- (1) to your surviving spouse; if none, then
- (2) to your surviving natural and/or adopted children; if none, then
- (3) to your surviving parent(s); if none, then
- (4) to your estate.

Benefits will be paid equally among surviving children or surviving parents.

Mode of Payment

United of Omaha will pay benefits:

- (1) in a lump sum; or
- (2) in other than a lump sum if:
 - (a) another mode of payment is requested as described below; and
 - (b) United of Omaha agrees to it in writing.

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Beneficiary or Mode of Payment Change

The beneficiary and mode of payment may be changed unless this right has been given up. To make a change, you must make a written request to the Plan Administrator. The change will take effect as of the date the request is signed. However, the change will not apply to any payments or other action taken before the request was acknowledged.

Filing a Claim for Benefits

If you die, your dependents should contact Allied Administrators as soon as possible and request a claim form. Once Allied Administrators receives the completed claim form and a copy of the death certificate, benefits will be paid as described above.

OTHER PROVISIONS

Family & Medical Leave Act (FMLA)

If you work full-time for an employer who employs at least fifty employees, you may be eligible for FMLA leave in the event of serious illness (your own or that of your child, spouse or parent) or if you acquire a new dependent child. Information on FMLA is available from your employer.

If your employer grants you FMLA leave, verifies to the Administration Office that you qualify for such leave and makes the required payments, your medical benefits will be continued by the Trust. Your employer is responsible for making the appropriate contribution for your coverage during this time under rules determined by the Board of Trustees. Your Reserve Account will not be depleted.

Qualified Medical Child Support Orders

A court may, under a qualified medical child support order, require a Participant to cover the Participant's child under this Plan. The Plan will comply with any medical child support order which is "qualified" under federal law, as determined by the Administration Office or by the Trustees. However, no such order, assignment or claim may require the Plan to provide benefits to someone not eligible under the rules of the Plan or to provide benefits in excess of the amounts stated in the applicable description of benefits.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you enter full-time military service your coverage is terminated immediately. If that occurs, your reserve account is automatically preserved until your return to covered employment after termination of your military service. You may purchase coverage for your Eligible Dependents for up to 24 months. Please see the COBRA section on how to elect this continuation coverage and the cost.

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However, you may elect to waive your rights under USERRA. In that case, your Reserve Account may be applied to provide coverage for your dependents at the applicable rate for active employees. The months of coverage so applied would no longer be available to provide coverage for you upon your return to covered employment.

Maternity & Newborn Infant Coverage

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

The Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: All stages of reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; Protheses; and Treatment of physical complications of the mastectomy, including lymphedema. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, deductibles and coinsurance listed in the schedule of benefits applies. If you would like more information on WHCRA benefits, call your plan administrator (415) 986-6276.

COORDINATION OF BENEFITS

Members of a family are often covered by more than one group health insurance plan. As a result, two or more plans are paying for the same expense.

To avoid this costly problem, your health plan provides a Coordination of Benefits provision. This provision affects all forms of your health coverage.

How Does Coordination Work?

If you or your Eligible Dependents are also covered under another group plan, the total amount received from all plans will never be more than 100% of "allowable expenses." Benefits are reduced only to the extent necessary to prevent any person from making a profit on his insurance.

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If you or your Eligible Dependents are also covered under any automobile insurance policy for any injury or illness also covered by this Plan, the coverage provided by the automobile insurance policy shall be primary in all circumstances.

"Allowable Expenses" are any necessary and reasonable expenses for medical or dental service, treatment or supplies, covered by one of the plans under which you or your Eligible Dependents are insured.

Other group health care plans include:

- * Insurance or other health care benefits for individuals of a group;
- * Any coverage under labor-management-trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans;
- * Any government programs (**Enrollment in Medicare is required of retirees or disabled participants when they are eligible even if a premium payment is required**);
- * Any coverage required or provided by law including continuation coverage under COBRA for a pre-existing condition;
- * Coverage for students sponsored by, or provided through, a school or other educational institution;
- * "No fault" auto insurance; and
- * Third party liability insurance.

Which Plan Pays?

- (1) If the other plan has no guidelines for coordinating benefits, that plan will always pay benefits first.
- (2) The plan covering the patient as an employee will pay its benefits before a plan which covers that person as a Eligible Dependent (unless Rule 6 below applies). If you are insured as an employee under two plans, the plan which has insured you longer is primary (unless Rule 6 below applies).
- (3) If both parents have group health care plans, a Eligible Dependent's primary plan is determined by the parents' birthdays. The plan of the parent whose birthday comes first in the calendar year is the primary plan. For instance, if the father was born on May 15 and the mother on July 20, the father's plan would be primary. If the parents have the same birthday, the plan that has covered a parent for the longer period of time will be the primary plan.
- (4) In the case of divorce or separation, the child's coverage is under the plans of parents in this order:

A. If there is a court decree which establishes financial responsibility for the health and welfare of the claimant, the plan of the responsible parent will pay benefits first.

B. When there is no court decree specifying the parent with financial responsibility, the following rules apply:

1. If the parent with custody of the claimant has not remarried, that parent's plan will pay benefits first.

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2. If the parent with custody of the claimant has remarried, benefits will be paid first by that parent's plan, second by the plan of the step-parent and third by the plan of the parent without custody.

- (5) If none of the above rules apply, then the plan which covered the claimant longest will pay benefits first, unless Rule 6 applies. (Replacement of one carrier by a follow-on carrier does not constitute a new plan.)
- (6) When one plan covers the claimant as a laid-off or retired employee or a Eligible Dependent of such an employee, then that plan's benefits will be determined **after** the benefits of any other plan which covers the claimant as an employee who is not laid-off or retired or a Eligible Dependent of such an employee. This rule does not apply if both plans have this same provision.
- (7) If the plan is a "no fault" auto insurance or third party liability coverage, it is considered the primary plan.

Exceptions to the Above Rules: The Plan will be primary if you are eligible for Medicare Part A, actively employed by an employer who normally employs more than 20 employees and over the age of 65.

It will also be primary for the spouse of an actively employed person who works for an employer who normally employs more than 20 employees if the spouse is over the age of 65 and is eligible for Medicare Part A.

Whenever there is a conflict between state law, Plan provisions and federal law, federal law is preeminent.

COORDINATION OF BENEFITS WITH MEDICARE

For active employees and their spouses age 65 or older who are eligible for Medicare Parts A and B solely because of age, the Plan will provide primary benefits, and special provisions apply to Medicare coverage if you are employed by an employer who normally employs more than 20 employees. Refer to the Coordination of Benefits section.

In certain special circumstances for your Eligible Dependent who is entitled to Medicare benefits because of disability, the plan will coordinate with Medicare as described in this section.

In order to avoid payment of benefits greater than the expenses actually incurred, benefits provided under this Plan will be coordinated with the benefits provided under Medicare. This means that unless the Plan is primary, you will first receive benefits under the Medicare program. The combined benefit will never exceed the total benefits to which you are entitled under this Plan.

You will be considered to be insured under Part A and Part B of Medicare, whether or not you have registered for Part A or have enrolled in Part B.

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RIGHT TO RECEIVE AND RELEASE
NECESSARY INFORMATION

If the Plan pays benefits in good faith to any organization, it is not required to pay the same benefits again. The Plan also has the right to recover any overpayments made due to coverage under another plan. You must declare your coverage under other plans.

The Plan may recover overpayments from any participant, Eligible Dependent, insurance company, organization or person who benefited from them. In coordinating benefits, the claims processors may request claim information from you and release information to the other plan as needed, without notifying you.

WORKERS' COMPENSATION

The Plan does not cover work-related disabilities. However, if payment is made for such disabilities, the Plan may establish a lien up to the amount paid for the treatment of the injury or disease, which is the basis of the participant's claim under the workers' compensation law, occupational disease law, or similar legislation.

RIGHT OF REIMBURSEMENT

If you receive benefits under the Plan for treatment or services because of illness or injury and you receive payment from a third party who may be legally responsible for the illness or injury, then you are required to reimburse the Plan within thirty (30) days of payment by the third party. Reimbursement to the Trust shall not, when added to any amount recovered by the Trust from any person or organization who may be responsible for the illness or injury, exceed the cost to the Plan of the benefits provided to you. The Plan reserves the right to withhold benefits to you if you are paid by a third party for your illness or injury and you do not properly and timely reimburse the Plan.

SUBROGATION

The Plan has the right to file a subrogation lawsuit from a third party that may be responsible for your illness or injury.

This means the Plan takes legal action on your behalf to recover amounts owed by third parties responsible for your illness or injury. In the event of a subrogation action, you are required to fill out and return all necessary forms.

The Board of Trustees has absolute discretion to settle subrogation claims on any basis it determines to be appropriate under the circumstances. Failure to cooperate with the Plan can result in your loss of benefits.

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CLAIM REVIEW PROCEDURES

The Board shall have full discretionary authority to decide all matters, and its determination of the dispute, right or claim shall be final and binding upon all participants.

No employee, Eligible Dependent, beneficiary or other person shall have any right or claim to benefits under the Plan other than as specified in Plan's policies or in the rules and regulations of the Board of Trustees, or any right or claim to payments from the Trust other than as specified herein.

All disputes as to benefits, or any right or claim to payments from the Trust shall be resolved by the Board of Trustees under and pursuant to the Plan and the Trust Agreement, except that any dispute as to type or amount of benefits which are provided pursuant to a contract of insurance or service contract entered into by the Board of Trustees shall be resolved under the terms of such contract.

CLAIMS AND APPEAL PROCEDURES
FOR MATTERS WITHIN THE JURISDICTION OF THE BOARD OF TRUSTEES OF
THE BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL NO. 3 HEALTH &
WELFARE TRUST

These procedures apply to the following claims under the Plan:

- Claims and appeals regarding eligibility under the Bricklayers and Allied Craftworkers Local No. 3 Plan for any type of benefit;
- Claims and appeals regarding medical, prescription and vision benefits when the claimant has made a specific claim for medical, prescription 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 the Bricklayers and Allied Craftworkers Local No. 3 Plan;
- Claims and appeals regarding self-funded dental benefits.

There are three types of claims for medical benefits, each of which is subject to different rules.

- A **pre-service claim** is a claim for a benefit that requires prior approval under the terms of the plan, such as inpatient admission pre-certification and other pre-certifications as described above.
- An **urgent care claim** is a type of pre-service claim which, if the regular time periods for handling pre-service claims were followed: (1) could seriously jeopardize your life or health or your ability to regain maximum function or (2) would, in the opinion of a health care provider with knowledge of your condition, subject you to severe pain that could not be adequately managed without the care or treatment that is the subject to the claim.

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- A **post-service claim** is a claim for a benefit that does not require prior approval under the terms of the plan. A post-service claim involves a claim for payment or reimbursement for medical care or supplies that have already been received.

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

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

(c) NOTIFICATION OF CLAIM DECISION

(i) Time Limits and Requests for Additional Information.

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

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

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

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Administration Office needs to make the decision. If the Administration Office requires additional information, the claimant will have up to 45 days to provide the specified information. Once the specified information is provided, the Administration Office will notify the claimant of its decision within 15 days.

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

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

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

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

(d) APPEAL PROCEDURES

(i) GROUNDS FOR APPEAL: The claimant may appeal any adverse action within the jurisdiction of the Board of Trustees to the Board of Trustees. The Board of Trustees

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hears appeals on medical, prescription or vision benefits only about eligibility issues, and not about unfavorable determinations by Plan providers.

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

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

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

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

(v) NOTIFICATION

(A) TIME LIMITS FOR NOTIFICATION

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

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

(3) **Post-Service Claims:** The Board of Trustees will render a decision on the appeal at the regularly scheduled meeting immediately following the filing of the appeal, unless the appeal is filed within 30 days of the meeting, in which case the decision may be made at the second

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meeting following the appeal. The claimant shall be notified of the time and place of the meeting. Upon written request, the claimant (or authorized representative of his or her choice) shall be allowed to appear before the Board of Trustees at a hearing. The Board of Trustees does not need to make a verbatim record, but the Administrator shall prepare a summary of the claimant's presentation and keep it, along with any documents deemed pertinent or which the claimant requests to have included, in the file.

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

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

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

- (1) the specific reason(s) for the denial;
- (2) reference to the specific Plan provision(s) on which the denial is based;
- (3) if the decision relied upon an internal Plan rule, guideline, protocol or similar criterion, either the specific rule, or a statement that the specific rule was relied upon and that a copy of such rule will be provided free of charge upon request;
- (4) a statement that the claimant may view and receive copies of documents, records or other information relevant to the claim, upon request and free of charge; and
- (5) the claimant's right to bring civil action under ERISA section 502(a).

APPEALS TO HMO, PPO OR OTHER INSURANCE CARRIERS

If a claim for medical, prescription or vision benefits is denied on grounds other than eligibility under the Bricklayers and Allied Craftworkers Local No. 3 Health and Welfare Plan, the claimant may submit an appeal to the insurance carrier or HMO, pursuant to the appeals procedures of the insurance carrier.

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

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of the Board of Trustees on any matter within its discretion shall be final and binding on all parties.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

When your coverage ends you and/or your Eligible Dependent will automatically receive a certificate of creditable coverage.

ADMINISTRATION OF THE PLAN

The Plan described in this booklet are administered by a Board of Trustees consisting of six representatives of contributing employers and six representatives of Local 3 of the International Union of Bricklayers and Allied Craftsmen. The Trustees operate in conformance with the provisions of a Trust Agreement setting forth their powers and duties. A copy of the Trust Agreement may be obtained by request to the Administration Office of the Trust: 633 Battery Street, Second Floor, San Francisco, CA 94111. The Trustees have the power to amend or modify the provisions of the Plan, including terminating the Plan in its entirety or eliminating any benefits provided under the Plan, at any time that, in their discretion, they deem it appropriate to do so. Upon termination of the Plan, all monies remaining in the Trust and any and all other assets of the Trust, after the payment of all expenses, will be used for the continuance of one or more benefits of the type provided by the Plan for the exclusive benefit of the participants, until such monies have been exhausted, or shall be allocated among the participants in the manner provided by Title IV of ERISA and the Trust Agreement.

Any question you may have concerning the Plan should be directed to the Administration Office. The Trustees meet, periodically, throughout the year. Reports required by Federal law are prepared annually by the Trustees, and may be inspected by any Participant or employee on whose behalf contributions are made, at the office of the Trust. Further, copies of such reports may be obtained, upon request, by directing a request to the Administration Office of the Trust.

LIMITATIONS ON POWERS OF INDIVIDUALS TO INTERPRET THE PROVISIONS OF THE PLAN

Only the full Board of Trustees is authorized to interpret the benefit Plan described in this booklet. The Board has discretion to decide all questions about this Plan, including questions about your eligibility for benefits.

No Union officer, Employer, individual Trustee, the Administrator, or any employee of the Administrator, has the power to vary any of the written provisions of this Plan, and any interpretation by any such person that is in conflict with written provisions of the Plan shall not be binding upon the Trustees. If a Participant or employee desires an interpretation of any of the provisions of the Plan, an explanation of his rights under the Plan, or desires to know the number of hours in his reserve account, the inquiry should be made in writing and he may rely only upon

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written response from the office of the trust or from the Board of Trustees acting collectively. As a courtesy to you, the Administration Office also may respond informally to oral questions. However, oral information and answers are not binding upon the Board of Trustees and cannot be relied on in any dispute concerning your benefits.

This Booklet represents an effort to summarize the provisions of the Plan. The Board of Trustees, acting collectively, have the power to interpret the provisions of the Trust and the Plan and their collective interpretations, if not contrary to the plain language of the Plan, or palpably unreasonable, shall be final and binding upon any Employee, Participant, Eligible Dependent or other person claiming under the provisions of the Plan. Any conflicts regarding benefits are resolved in accordance with the evidence of coverage and disclosure document and the appeal procedures set forth in the booklet describing the benefits for the Kaiser, United of Omaha or PacifiCare benefit option you have selected.

RELATIONS BETWEEN THE PLAN AND HEALTH CARE PROVIDERS

No health care provider is an agent or representative of the Plan or the Board of Trustees.

The Plan does not control or direct the provision of health care services and/or supplies to Plan participants and beneficiaries by anyone.

The Plan makes no representation or guarantee of any kind that any provider will furnish health care services or supplies that are malpractice-free. This statement applies to all health care providers, including both preferred and non-preferred providers under the terms of the insured plan of benefits underwritten by United of Omaha. This statement also applies to all entities (and their agents, employees, and representatives) which contract with the Plan to offer services or supplies to participants and beneficiaries.

Nothing in this Plan affects the ability of any provider to disclose alternative treatment options to a participant or beneficiary.

Addresses of all Insurers and HMOs contracted with B.A.C. Local No. 3 Health and Welfare Trust Fund

United of Omaha Life Insurance Company 15260 Ventura Blvd., Suite 600 Sherman Oaks, CA 91403 Policy No. GUG-9L94	Kaiser Permanente No. California Region 1800 Harrison Street, 9 th Floor Oakland, CA 94612 Group No. 7413	PacifiCare PacifiCare of California 2300 Clayton Rd., Suite 1000 M/S CN71-010 Concord, CA 94520 Group No. 149920
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ADDITIONAL INFORMATION REQUIRED BY
THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

1. Name of Plan

The name of the Plan is the BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL NO. 3 HEALTH AND WELFARE PLAN.

2. Trust Fund's Employer Identification Number & Plan Number

The Internal Revenue Service Employer Identification Number (EIN) for this Trust is 23-7034407. The Plan Number is 501. The Plan is a group health plan.

3. Plan Year

The Plan Year ends on June 30.

4. Name and Address of Board of Trustees

Board of Trustees
Bricklayers and Allied Craftworkers Local No. 3 Health & Welfare Trust
c/o Allied Administrators
P.O. Box 2500
San Francisco, CA 94126

Board of Trustees

Employer Trustees

Ron Bennett
E&S Masonry
2882 Grove Way
Castro Valley, CA 94546

Elwood Smith
E&S Masonry
2882 Grove Way
Castro Valley, CA 94546

Don Ekstrom
c/o John Jackson Masonry
5691 B Power Inn Drive
Sacramento, CA 95824

Employee Trustees

Tom Spear, Chairman
BAC Local #3
8400 Enterprise Way #103
Oakland, CA 94621

Gary Peifer
BAC Local #3
7125 Governors Cr.
Sacramento, CA 95823

Randy Smith
BAC Local #3
461 Park Ave., #5
San Jose, CA 95110

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Robert Filippi, Secretary
American Terrazzo Co.
36 Wood Street
San Francisco, CA 94118

Dave Jackson
BAC Local #3
8400 Enterprise Way, #103
Oakland, CA 94621

Horst Mittelstadt
Milo Masonry
P.O. Box 6263
San Mateo, CA 94403

Dave Danner
7125 Governors Cr.
Sacramento, CA 95823

5. Plan Administrator

The Board of Trustees of the Bricklayers and Allied Craftworkers Local No. 3 Health & Welfare Trust is the Plan Administrator of the Plan. The Board is responsible for ensuring that information regarding the Plan is reported to governmental agencies and disclosed to Plan participants and beneficiaries in accordance with the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA"). The address of the Board of Trustees is set forth in paragraph 2 above.

The Board of Trustees has engaged the services of a contract administrator, Allied Administrators Inc., to provide administrative services to the Trust and Plan. The address and phone number of Allied Administrators is:

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

6. Agent for Service of Legal Process

George M. Kraw
Kraw & Kraw Attorneys
333 West San Carlos, Suite 200
San Jose, CA 95110

Service of legal process may also be made upon a Plan Trustee or the Board of Trustees.

7. Funding Contributions and Collective Bargaining Agreements

The Plan is maintained in accordance with Collective Bargaining Agreements between the Bricklayers and Allied Craftworkers Union Local No. 3 and signatory employers. The Collective Bargaining Agreements provide for contributions by the employers to the Bricklayers and Allied Craftworkers Local No. 3 Health & Welfare Trust on an agreed-upon cents-per-hour basis.

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There are no employee contributions except for continued coverage as described in Section IX of this booklet. Copies of the applicable collective bargaining agreements may be obtained from Allied Administrators or Bricklayers and Allied Craftworkers Union Local No. 3.

The Plan Office will provide any Plan Participant or beneficiary, upon written request, information as to whether a particular employer for whom the Participant is employed is contributing to the Trust which sponsors this Plan with respect to the work of the Participants in the Plan and, if the employer is a contributor, the employer's address.

8. Fund Medium

Assets of the Plan are held in trust by the Bricklayers and Allied Craftworkers Local No. 3 Health & Welfare Trust. The assets are invested by McMorgan & Company, the Trust's Investment Manager.

STATEMENT OF ERISA RIGHTS

As participants in the Bricklayers and Allied Craftworkers Local No. 3 Health And Welfare Trust, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Administration Office and at other specified locations, such as 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.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator 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 Eligible Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Eligible 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.

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Reduction or elimination of 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 welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to obtain copies of documents relating to the decision without charge and to have the Administrator review and reconsider your claim, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request material from the Plan and do not receive them within 30 days, you may file suit in 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 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. If it should happen that Plan fiduciaries misuse the Plan's money or other assets, 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.

If you file a lawsuit, the court may decide who should pay court costs and legal fees. If you are successful, the court may order the person(s) you have sued to pay your costs and fees. If you lose, the court may order you to pay the Trust's or other defendants' costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Trust Fund Office. If you have any questions about this statement or about your rights under ERISA or under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory. In San Francisco that office is located at 71 Stevenson

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Street, Suite 915, San Francisco, CA 94105. You may also contact 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.