

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

SUMMARY PLAN DESCRIPTION

July 1, 2020

INTRODUCTION

This booklet is the Summary Plan Description (“SPD”) of your Health and Welfare Plan, as in effect on July 1, 2020. The “Highlights” section briefly describes the eligibility rules and benefits available under the Plan. The next section is the detailed summary of the eligibility rules and benefits effective July 1, 2020. This is followed by sections that summarize your options for medical coverage, dental benefits, vision care benefits, prescription drug benefits, and life insurance, the Plan's claims and appeals procedures, and a description of your rights under ERISA.

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

The Formal Plan Rules, including a complete description of all self-funded benefits provided by the Plan, may be obtained from the Plan Administration Office. For a complete description of all benefits provided through Kaiser, see the separate booklet provided by Kaiser.

**PLAN ASSISTANCE FOR SPANISH SPEAKERS
ASISTENCIA DEL PLAN PARA HABLANTES DE ESPAÑOL**

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

Important Information about the Plan

1. Active Plan members may select one of two options for medical coverage: the self-funded PPO Plan or Kaiser Foundation Health Plan. If you are a new member, you must choose an option by completing an Enrollment Form and returning it to BeneSys Administrators.
2. If you acquire a new dependent, in most cases you must enroll that dependent within 30 days to be assured of the right to enroll the dependent, unless special enrollment rules apply. See page 16 for more information. Contact the Plan Administration Office, BeneSys Administrators, whenever you acquire a new dependent, or when any of the following events occur:

- Change of name
- Change of address
- Change in marital or domestic partner status
- Change in beneficiary
- Change or addition of eligible dependents
- Member or dependent becoming eligible for Medicare

3. Only BeneSys Administrators may confirm your eligibility status or accept appeals to the Board of Trustees concerning the self-funded PPO Plan or your eligibility for benefits under Kaiser. Appeals on issues related to specific benefits and coverages provided by Kaiser, such as medical necessity, must be submitted to Kaiser.

4. This group health plan believes it is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the “Affordable Care Act”). Under the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on non-essential benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administration Office, P.O. Box 1607, San Ramon, CA 94583.

You may also contact the Employee Benefits Security Administration, U. S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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PLAN SERVICES PROVIDERS

Plan Administration Office

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

BAC Local 3 Trust Funds(888) 208-0250
c/o BeneSys Administrators or (925) 208-9995
P.O. Box 1607
San Ramon, CA 94583

General Trust Information

Website www.BAC3-brickbenefits.org
Email staff@BAC3-brickbenefits.org

Local Union

The Union also provides assistance on Plan benefits:

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

Other Providers

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

Anthem Blue Cross (Self-Funded PPO Plan)
For Utilization Review.....(800) 274-7767
For Preferred Providers..... www.anthem.com/ca/
For 24/7 NurseLine(866) 670-1565

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

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

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

Delta Dental(800) 765-6003
or www.deltadentalins.com

HIGHLIGHTS OF THE PLAN

Who is eligible to participate?

This Plan covers employees working under collective bargaining agreements in positions for which contributions are required to be made to this Plan. Eligibility is based on hours of covered employment, as reported and paid on your behalf to the Plan Administration Office. A month of coverage "costs" 120 Hours.

The following other people may also participate:

- Employees who are working outside the geographical jurisdiction of the Union, if they have authorized reciprocity from their work area trusts, and their contributions have been received by this Plan.
- Qualifying non-bargaining unit employees who are employed by an employer that was making contributions on behalf of its non-bargaining unit employees on November 22, 2005 and qualifying officers/shareholders of contributing employers.
- Retired employees who satisfy the appropriate eligibility rules for retiree coverage and who pay the required monthly charge which applies to their coverage.
- Eligible dependents of all of the above, including:
 - your lawful spouse;
 - your domestic partner, if your domestic partnership has been registered with a governmental agency pursuant to state or local law authorizing such registration, and the children of your domestic partner, subject to the age limitations below;
 - your natural children, adopted children, and stepchildren, until the last day of the calendar year they reach age 26 for medical benefits, or through any age with a qualifying disability.

What benefits are provided?

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

- The self-funded PPO Plan.
- Kaiser Foundation Health Plan (a health maintenance organization, or HMO).

The self-funded PPO Plan pays benefits to you, or directly to your provider, for health care which is medically necessary and prescribed by a licensed provider. The self-funded PPO Plan pays benefits for most types of care, regardless of whom you use as providers, but you will pay significantly less if you use PPO providers. The Plan's current PPO is Anthem Blue Cross.

Under Kaiser, you pay only a fixed fee for each covered visit, which may vary with the type of service. However, Kaiser requires that you use only their doctors and facilities, and have all your health care handled through a primary care physician.

The Plan provides a variety of other benefits:

- Dental benefits are provided by the self-funded PPO Plan for all plan participants.
- Prescription benefits are provided by the medical option in which you enroll: either the self-funded PPO Plan or Kaiser.
- Vision care benefits are provided through Vision Service Plan for Plan participants who are not enrolled in Kaiser. Participants enrolled in Kaiser receive vision benefits through the Kaiser program.
- Life insurance is provided through United of Omaha for active Plan participants only.

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

What if my claim for benefits is denied?

All claims for benefits must be submitted within 12 months of the date of service. If your claim for benefits is denied, you may appeal to the Board of Trustees by submitting a written appeal to the Administration Office within 180 days of receiving the denial of the original claim. If you do not submit a claim within 180 days of receiving a denial, you will be deemed to have waived any objection to the denial. **If your claim is denied by the Board of Trustees, you may file a civil action under ERISA § 502(a) within one year from the date on which the Board of Trustees provides notice that your appeal has been denied.** This is a summary of the Plan's claims and appeal procedures. See Appendix 3 for the Plan's complete Claims and Appeal Procedures.

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

ELIGIBILITY FOR BENEFITS

1. Employee Eligibility

Eligibility for benefits as a bargaining unit employee is determined by your hours of covered employment, as reported and paid to the Plan Administration Office.

Initial Eligibility

A new employee will become eligible for benefits for the first time when he or she has been credited with 360 hours in a period of no more than six consecutive months. This initial eligibility starts on the first day of the second month following the month in which you have completed 360 hours. For example, if you start working for a contributing Employer on January 1, and you complete 360 hours of work on March 31, you are eligible to participate on May 1. Once you are eligible for benefits, you will be sent an enrollment card to complete and return to the Plan Administration Office.

When you continue to work in covered employment and have hours reported and paid on your behalf to the Plan Administration Office, a Reserve Account is established for you. Each month, your Reserve Account is credited with the hours that you worked two months prior. For example, hours worked in February will be credited to your Reserve Account in April.

Continuing eligibility “costs” 120 hours. To maintain eligibility, you must have a Reserve Account balance of at least 120 hours at the beginning of each month.

Reserve Account

After you work more than 120 hours in a month, additional hours go into your Reserve Account. During periods when you cannot work enough hours, including labor disputes, you can use these reserve hours to maintain eligibility. You can accumulate up to 480 hours in your Reserve Account. If you die while eligible for coverage, your Reserve Account will continue to provide benefits to your Eligible Dependents until the account is run out.

You may be able to accumulate up to an additional 360 hours of eligibility, if your employer is delinquent in paying contributions for you during the 90 days before your Reserve Account runs out. If you think you are eligible for this extended eligibility, contact the Plan Administration Office for more information.

Self-Payments to Continue Eligibility

For coverage months beginning on or after July 1, 2012, if the combination of your credited work hours and reserve hours do not equal 120, you may continue your eligibility by making self-payments for a maximum of 3 months in any 12-month period. You can make self-payments only if you have at least 60 months of prior coverage under this Plan, and you are either available for work in the Industry (that is, registered on the Local’s out-of-work list and available for dispatch), or you are disabled and have exhausted your Reserve Account. The Board of Trustees will review the suitability of this provision on an annual basis.

Short Payments to Continue Eligibility

For coverage months beginning on or after July 1, 2012, if the combination of your credited work hours and reserve hours equal at least 80, you may continue your eligibility by making a short payment to bring your total hours up to the required minimum of 120 hours. If you are eligible to make a short payment and do not do so, your coverage will terminate. The Board of Trustees will review the suitability of this provision on an annual basis.

Reinstatement

If you lose coverage because your Reserve Account has run out, but you return to covered employment within six months of losing coverage (including the end of coverage maintained by self-payments or short payments), you do not have to work 360 hours to be covered again. Instead, your eligibility will be reinstated as of the second calendar month following the month in which you work at least 120 hours. If your coverage is not reinstated within six months of losing coverage, you will have to work 360 hours to be covered again.

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 will be reinstated when the combination of hours you work and your Reserve Account totals 120 hours. You will not have to meet the initial eligibility requirements again.

Disability Coverage

If you become disabled, you may receive coverage at no charge for up to six months. 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 6 months.

To be "disabled" and receive this coverage, you must meet one of the following requirements: 1) be receiving State Disability Insurance ("SDI") benefits; or 2) be awarded "Qualified Injured Worker" status, under California Workers' Compensation laws; or 3) prove that you would qualify for SDI benefits, except that you did not have enough credits under that program to qualify for benefits when your disability commenced. If your proof of disability is pending, you must maintain coverage by making full COBRA payments. Then if you provide the necessary proof of your disability, you will receive a refund of up to six months of premiums.

When this special disability coverage ends, and if you remain disabled, your Reserve Account can be used to continue your coverage. Once your Reserve Account falls below the 120 hours needed to maintain coverage, you may be qualified to continue your coverage by making self-payments or short payments, as explained above. If you do not qualify to make self-payments or short payments, you may apply for COBRA continuation coverage. See page 13 and Appendix 2.

Coverage During Military Service

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

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

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

Family and Medical Leave Act

If you work a qualifying number of hours for an employer who employs at least fifty employees, you may be eligible for a leave of absence under the Family and Medical Leave Act ("FMLA"). If the FMLA applies to your employer, your employer is responsible for making contributions for your coverage while you are on FMLA qualifying leave. FMLA leave may be taken because of the birth or placement of a son or daughter with you for adoption or foster care; to care for your spouse, son, daughter, or parent who has a qualifying "serious health condition"; because of your own qualifying "serious health condition"; because of a "qualifying exigency" related to service in the United States Armed Forces by your spouse, son, daughter, or parent; or if you are the spouse, son, daughter, parent or next of kin of a member of the United States Armed Forces who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness, to care for the service member. The definition of qualifying FMLA leave may change as the law is amended. Your Reserve Account, if you have one, will not be charged for coverage while you are on FMLA qualifying leave. If you believe this law applies to you, contact the Plan Administration Office for more information.

Self-Pay Eligibility for Participants Working Out of the Area Under a Lower Contribution Rate

If you are a traveling Participant working in an area that has a lower contribution rate than this Plan, your hours will be reciprocated back to this Plan on a pro-rata basis. For example, if you work in an area that has a contribution rate that is 10% lower than this Plan's contribution rate, you will receive credit for only 90% of the hours you work out of area. If your Reserve Account falls below 120 hours due exclusively to this pro-rata crediting, you will be permitted to self-pay the additional hours needed to maintain eligibility, if you meet the following requirements:

- (a) you begin self-paying hours for the first month your Reserve Account falls below 120 hours because of a lower reciprocal contribution rate, including retroactive payments, if necessary; and
- (b) you have had three consecutive years of coverage under this Plan; and
- (c) your coverage was earned through active hours of work in at least nine of the most recent twelve months; and

- (d) the combination of reciprocal hours reported and paid, and the hours in your hour bank is fewer than 120 hours, and, therefore, not sufficient to maintain coverage; and
- (e) your self-pay contributions are timely received within 30 days of the date the Plan Administration Office sends out the self-pay balance statement to you.

Self-Pay Eligibility for Apprentices

If you are eligible for coverage as an active employee, and are dispatched as an apprentice under Division of Apprentice Standards (DAS) rules, you may self-pay the hours needed to continue coverage during such employment.

2. Loss of Coverage for Cause

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

- (a) 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 or for 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; or
- (e) you continue to work for a signatory employer who is delinquent in its fringe benefit contributions, after you have been notified that you are required to quit working for that employer because of its delinquency.

If any of these occur, you lose coverage and your Reserve Account will be cancelled. If your coverage ends for cause: (a) you are not eligible to continue coverage by self-payments or short payments; and (b) you will not again be eligible for coverage until you complete 720 hours of covered work within a subsequent 12-month period.

3. Dependent Eligibility

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

- (a) your lawful spouse or domestic partner, if your domestic partnership has been registered with a governmental agency pursuant to state or local law authorizing such registration; and

- (b) your child(ren) until the last day of the calendar year they reach age 26, unless extended due to disability, as described below.

The term “child” means any of the following:

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

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

Your Eligible Dependent's coverage begins on the same date as your coverage, provided he or she has been properly enrolled as a dependent. After initial enrollment, whenever you acquire a new Eligible Dependent through marriage, registration of a Domestic Partner, birth or adoption, you need to advise the Plan Administration Office and properly enroll him or her in your medical plan no later than 30 days after the marriage, registration of Domestic Partnership, birth or placement for adoption. Failure to do this may mean a lapse in your Eligible Dependent's coverage. Newly-acquired dependents because of birth, adoption, or placement for adoption become eligible on the date of the birth, adoption, or placement for adoption. Newly-acquired dependents because of marriage or registration of a Domestic Partnership become eligible for benefits on the first day of the month after they are properly enrolled as dependents.

If you declined enrollment for yourself or your Eligible Dependents because you had other health insurance or other group health plan coverage, you may in the future enroll yourself and your Eligible Dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends.

If your Eligible Dependents lose eligibility under Medicaid or a State Sponsored Children's Health Insurance Plan, and/or become eligible for a special premium assistance subsidy under Medicaid or a State Sponsored Children's Health Insurance Plan, you may enroll them in this Plan, provided that you file your enrollment form with the Plan Administration Office within 60 days after losing coverage under Medicaid or a State Sponsored Children's Health Insurance Plan and/or becoming eligible for premium assistance under Medicaid or a State Sponsored Children's Health Insurance Plan.

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

- (a) he or she lives outside the United States;
- (b) he or she is on active duty in the Armed Forces of any country.

Your children are covered until the last day of the calendar year during which they attain age 26. Coverage for a child may be continued after that time if he or she has a physical or developmental disability which began before coverage would otherwise have ended, and which makes him or her incapable of self-sustaining employment. Proof of the disability must be provided within 31 days of the termination of regular coverage of the dependent, and from time to time as requested by the Plan Administration Office thereafter.

Opt-Out for Dependent Medical Coverage: If you are eligible for coverage under this Plan, and any of your covered dependents are eligible for coverage under an employer-provided “high deductible health plan,” you may opt not to enroll, or to terminate coverage of, those dependents in this Plan’s medical coverage. They will remain eligible for coverage under this Plan’s dental, vision, life insurance and accidental death and dismemberment benefits.

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

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

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

4. Non-Bargaining Unit Employees Eligibility

Effective November 22, 2005, the Plan was closed to new non-bargaining unit employees. Participants who were covered as non-bargaining unit Employees on November 22, 2005, and have remained continuously covered since that time, and meet the additional requirements below, are eligible to continue to receive coverage under Kaiser or the self-funded PPO Plan. Effective May 1, 2015, an employer may report on behalf of all its non-bargaining unit employees provided that the employer was reporting on behalf of its non-bargaining unit employees on November 22, 2005.

Effective July 1, 2014, to remain eligible, for each non-bargaining unit employee both of the following requirements must be met:

- (a) At least 1400 hours must be reported for each participating non-bargaining unit employee; and
- (b) At least 110 hours must be reported for at least one bargaining unit employee each month.

5. Officer/Shareholder Eligibility

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

- (a) the Board of Trustees approves your continued participation;
- (b) you are working with the tools of the trade;
- (c) 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;
- (d) your Employer signs a participation agreement;
- (e) your participation meets the requirements under applicable law; and
- (f) you apply for participation within 30 days of becoming eligible for participation as an officer/shareholder.

6. Retired Employee Eligibility

You will be eligible for retiree medical benefits if you meet all of the following conditions:

- (a) (i) you were covered as an active Employee for 5 of the 8 years immediately preceding your retirement; or
(ii) for retirements on February 1, 2013 or after, you were covered as an active Employee for 5 of the 12 years immediately preceding your retirement, and you can demonstrate that you would have met the requirement in (i) above, except for lack of work in the Industry; and
- (b) you are actually receiving benefits from a pension plan administered and established under any Trust to which the Union appoints Trustees, or to which the Plan has sent reciprocity payments on your behalf; and
- (c) you apply for coverage within 60 days of your retirement; and
- (d) If eligible for Medicare, you enroll in both Part A and Part B of Medicare; and

- (e) if eligible for Medicare and elect Kaiser coverage, you enroll on Kaiser Senior Advantage and reside in the Senior Advantage service area.

To receive retiree coverage, you must pay a monthly charge, as determined from time to time by the Board of Trustees, by the 20th of the month prior to the month of coverage, and you must continue to receive pension benefits.

Retiree medical coverage options are Kaiser and UHC HMO only, for retirees residing within the service areas of Kaiser or UHC.

Your eligible dependents for retiree coverage are the same as for active participants: your spouse, domestic partner or child. See Section 3 for details. You must enroll your dependents within 60 days of your retirement. If you acquire a new dependent after you begin retiree coverage, you can enroll your new dependent by giving notice within 30 days of the date you acquire the new dependent.

If your spouse or domestic partner has their own employer-based health coverage when you retire and later loses that coverage due to termination of employment or termination of employer-provided health coverage, you can enroll your spouse or domestic partner by giving notice within 63 days of the loss of that employer-based coverage. To be eligible to do so, you must show that your spouse or domestic partner: (a) had been so employed for at least 12 months when you retired, (b) had been continuously covered under that employer-provided coverage since the date of your retirement, and (c) lost that coverage due to termination of employment or termination by the employer of employer-provided health coverage.

7. Health Reimbursement Accounts ("HRAs")

Beginning January 1, 2017, active employees working in covered employment earn credit in a Health Reimbursement Account (HRA), based on contributions made for that purpose. HRA accounts may be used to pay certain Plan premiums and have qualified medical expenses reimbursed.

Contributions will be made to an active employee's HRA account for each month between January, 2017 and December, 2020 that (1) you work over 250 hours in covered employment and your employer makes the required contributions, and (2) you have the maximum allowable hours in your reserve account (480 hours). The amount of the contribution is the current hourly contribution rate made on your behalf to this Plan times the number of hours you work in excess of 250 hours. For example, if you work 260 hours in June, and the hourly contribution rate is \$9.85, your HRA account will be credited with \$98.50 in August (10 hours times \$9.85).

An Eligible Health Care Expense is an expense incurred by you or your eligible dependent(s) for medical care as defined in Internal Revenue Code section 213(d).

Examples of Eligible Health Care Expenses include:

- Premiums for medical insurance under the Plan (including retiree premiums and COBRA premiums)

- Over the Counter Medications or insulin
- Uninsured medical expenses (i.e., copayments, coinsurance, deductibles)
- Acupuncture
- Chiropractor expenses
- Eye exams
- Contact lenses or glasses used to correct a vision impairment
- Dental expenses
- Dermatology
- Hearing aids
- Laboratory fees
- Nursing services
- Physical therapy
- Smoking cessation programs
- Wheelchairs
- Menstrual care products

Examples of common items that are **not** Eligible Health Care Expenses include:

- Cosmetic surgery (unless necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease)
- Funeral or burial expenses
- Household and domestic help
- Massage therapy
- Custodial care
- Health club or fitness program dues
- Weight loss programs
- Vitamins or nutritional supplements

You may apply for reimbursement of an Eligible Health Care Expense by submitting a reimbursement form and supporting documentation to the Plan Administration Office. The expense must have been incurred on or after January 1, 2017, and you must submit your claim for reimbursement with one year of the date the expense was incurred.

Any unused amounts in your HRA account at the end of the Plan Year will be rolled over to the next Plan Year and will be available for reimbursement. In the event of your death, if you have a balance in your HRA account, your account can be used to pay for the Eligible Health Care Expenses of your dependents covered under the Plan. If there are no remaining eligible dependents under the Plan, the balance of your HRA Account will be forfeited to the general assets of the Plan.

If you lose eligibility for cause (see section 2 above), your HRA account will be terminated and forfeited to the general assets of the Plan.

You may permanently opt out of or waive future reimbursement from the HRA. If you elect to waive future reimbursement, your HRA Account will be forfeited to the general assets of the Plan, and will not be reinstated at a later time for any reason.

8. COBRA Continuation Coverage

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

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

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

- (a) your death;
- (b) your divorce or dissolution of your domestic partnership;
- (c) your child no longer qualifies as an eligible dependent; or
- (d) you have become eligible for Medicare.

You or your dependents must also return your COBRA election form within 60 days of receiving it. You are not required to submit a premium payment when you return your COBRA election form. Your first payment must be received within 45 days of your election of COBRA coverage, and you must make all subsequent payments for COBRA coverage by the 15th of each month for coverage for the next month.

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

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

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

If you elect COBRA coverage, you may select "core coverage" (that is, all Plan benefits except

dental care, vision benefits, life insurance, and accidental death or dismemberment insurance), or full COBRA coverage (all Plan benefits). If you elect one type of coverage, the election also applies to your dependents. However, if you do not elect COBRA coverage, your dependents may elect either form of coverage for themselves. If your dependents are covered for dental care and vision benefits only, they may elect COBRA for those benefits.

COBRA coverage is not available if an employee is terminated for working for a non-contributing employer, or for gross misconduct on the job.

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

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

You may be able to receive reimbursement for COBRA premiums you paid because your employer was delinquent in making contributions on your behalf and later paid those contributions. See Section 2.10 of the Formal Plan Rules for detailed rules regarding your eligibility and contact the Plan Administration Office if you think you may be eligible for reimbursement.

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

You may be able to receive reimbursement of medical and dental premiums you paid in a group health plan offered by your spouse's employer because your employer was delinquent in making contributions on your behalf and later paid those contributions. See Section 2.10(3) of the Formal Plan Rules for detailed rules regarding your eligibility and contact the Plan Administration Office if you think you may be eligible for reimbursement.

9. Continuity of Care

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

10. Third Party Reimbursement

If you or your dependent has an injury or sickness caused or allegedly caused by a third party's act or omission, the Plan will pay benefits for that injury or sickness, subject to its right to reimbursement from any amount recovered by reason of the third party's act or omission, on the following conditions: (1) that you or your dependent (or legal representative) will not take any action which would prejudice the Plan's reimbursement rights, and (2) that you or your dependent (or legal representative) will cooperate in doing what is reasonably necessary to assist the Plan in enforcing its

reimbursement rights, including taking the actions set forth in Section 9.04(3) of the Formal Plan Rules. The Plan's reimbursement right will be for 100% of benefits paid, regardless of whether or not you or your dependent has received full or any compensation, and will not be reduced because the recovery does not fully or partly compensate you or your dependent for all losses sustained or alleged, or the recovery is not described as being related to medical costs or loss of income.

The complete Plan rules regarding Third Party Reimbursement are found in Section 9.04 of the Formal Plan Rules, available from the Plan Administration Office.

11. Reservation of Powers

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

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

12. Assignment

Coverage and a participant or beneficiary's rights under this Plan may not be assigned. A direction to pay a provider is not an assignment of any right under this Plan or any legal or equitable right to instate any court proceeding.

BENEFIT SUMMARIES

The Plan offers two medical plan options to new enrollees:

- The self-funded PPO Plan (a preferred provider organization, or PPO), or
- Kaiser Foundation Health Plan (a health maintenance organization, or HMO).

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

How to Enroll Yourself and Your Dependents

When you first become eligible for health care benefits, you must choose from the currently available medical plan options, and enroll dependents, by filling out an Enrollment Form. The Plan maintains a "rolling" open enrollment. After initial enrollment, you may change your medical plan option at any time during the year, as long as you have not changed plans in the last consecutive 12 months. If you make a change, it will not be effective until the first day of the second calendar month following the date your Enrollment Form is received by the Plan Administration Office. You may enroll new dependents within 30 days of the birth, marriage, registration of a domestic partnership, adoption or placement for adoption which makes your new dependent eligible.

You must complete an Enrollment Form.

If you are a new participant, medical benefits will be paid only after you have completed an enrollment package for one of the medical plan options. If you do not return a timely enrollment form for an HMO option, you will automatically be enrolled in the self-funded PPO Plan. You may enroll your dependents within 30 days, or 60 days as applicable, of the event which makes your dependent eligible.

Special Enrollment Rules

If you fail to enroll your eligible dependents because they have health coverage elsewhere, and coverage under that other plan ends, you may enroll your eligible dependents in health care coverage under this Plan. You must submit your enrollment form within 30 days of loss of coverage under the other plan.

In addition, if your dependent(s) are eligible but not enrolled for coverage in this Plan, your dependent(s) can be enrolled if: 1) your dependent(s)' Medicaid or State Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, or 2) your dependent(s) become eligible for employment assistance under Medicaid or CHIP. In order to benefit from this option, you must submit your enrollment form within 60 days of the termination from, or eligibility for, such assistance.

Current Medical Plan Options

A complete description of all self-funded benefits provided by the Plan may be found in the Formal Plan Rules, available from the Plan Administration Office.

Kaiser prepares a separate detailed summary of its general benefit structure, limitations, and conditions for particular kinds of care. This detailed summary is available free of charge from BeneSys Administrators or Kaiser. Below is a brief comparison of the options available when this booklet was published. The summaries and tables below are not intended to supersede Kaiser's formal Evidence of Coverage document ("the EOC"), which is a binding contract. If there is any discrepancy between any table and an EOC, the EOC prevails.

Appeals of matters under the discretion of Kaiser are handled directly by Kaiser, and not through the Plan Administration Office or the Board of Trustees.

For more detailed information about Kaiser's benefits, the conditions of treatment and/or payment, and the claims review and adjudication procedures, please refer to Kaiser's Evidence of Coverage document or contact Kaiser directly.

The following options for medical coverage are currently available under the Plan:

SELF-FUNDED PPO PLAN

Under the self-funded PPO Plan, you pay annual deductibles before the Plan pays any benefits. You may see any doctor based on your medical need. However, if the doctor you choose is one of Anthem Blue Cross's preferred providers, you receive a higher level of coverage and pay a lower deductible. For office visits to a preferred provider, you pay a co-payment, which does not count toward your deductible: \$10 for a general office visit and \$20 for a specialist office visit. A list of participating medical providers in Anthem Blue Cross's network is available, free of charge, as a separate document from BeneSys Administrators. You can also look for a doctor or other providers online at www.anthem.com/ca/.

KAISER FOUNDATION HEALTH PLAN HMO

Except in cases of life-threatening emergency, Kaiser requires that all medical care and benefits be provided at Kaiser facilities and with Kaiser providers. Services and supplies must be provided, prescribed, authorized or directed by a Kaiser physician. Members must meet Kaiser's service area residence requirement and choose a personal Kaiser physician who will coordinate all medical care. After making a co-payment, most services are covered at 100% and there are no deductibles. There is a \$25 charge for office visits, a \$100 charge per admission for hospital stays, and a \$10 charge per prescription for generic drugs, and a \$15 charge per prescription for brand name drugs. Kaiser covers preventive services at 100% with no copayments.

Self-Funded PPO Plan - Benefit Summary - Active Employees

Under the Self-Funded PPO Plan, you must pay an annual deductible before any benefits are paid by the Plan, and you are responsible for certain percentages of expenses incurred for covered charges (typically 20% when you use a PPO Provider). For a complete list of covered services, including applicable exclusions and limitations, see the Formal Plan Rules.

Self-Funded PPO Plan - Benefit Feature	PPO Provider	Non-PPO Provider
Annual Deductible		
Per Person	\$250	\$500
Per Family	\$750	\$1,500
Annual Maximum Out-of-Pocket		
Per Person	\$1,250	\$8,500
Per Family	\$3,750	\$25,500
Office Visits		
Primary Care Visit	\$10 copay	\$20 copay
Specialist Visit	\$20 copay	\$40 copay
Podiatry Office Visit	\$20 copay	\$40 copay
Chiropractic Visit.....	80%	60%
(Up to \$1,000 per calendar year. Copayments do not count toward your deductible or out-of-pocket maximum.)		
Virtual office visits will be treated as in-person office visits under the Plan.		
Use of the Anthem Blue Cross telemedicine program, LiveHealth Online, will also be treated as an office visit. LiveHealth Online provides 24/7 access to medical care through video consultations for minor injuries and illnesses. LiveHealth Online visits require a co-payment equal to the PPO Provider office visit co-payment.		
Insured Percentages (After Deductible is Satisfied)		
Hospital Charges (including physician/surgeon fee)	80%	60%
(You must use in-network PPO ambulatory surgical centers for cataract and arthroscopic surgeries, and for colonoscopies. You must use Blue Distinction Centers for bariatric and transplant surgeries. There is a \$30,000 maximum per surgery on knee and hip surgeries.)		
Hospital Room and Board.....	80%	60%
(Up to the semiprivate room charge.)		
Ambulance and Air-Ambulance	80%	80%
Emergency Services.....	80%	80%
Anesthesia	80%	60%

Self-Funded PPO Plan - Benefit Feature	PPO Provider	Non-PPO Provider
Lab/Blood Work/X-ray/Imaging(CT/PET Scans/MRIs)	80%	60%
Prescription Drugs (Prescriptions must be filled at pharmacies that accept the Sav-Rx Card, or using the Sav-Rx Mail Order system.)		
Generic Drugs	No charge	N/A
Formulary Brand Name - Retail(up to a 30-day supply)	\$10	
Formulary Brand Name - Mail Order (31-90-day supply).....	\$20	
All Other Drugs - Retail.....	\$40	
All Other Drugs - Mail Order	\$80	
Home Health Care/Hospice - Outpatient	80%	60%
(Maximum of 100 visits per calendar year)		
Hospice Care Counseling and Bereavement.....	80%	60%
Hospice Care - Inpatient	80%	60%
Routine Physical (age 19 and older)	\$10 copay	Not Covered
(One routine physical every 2 years; must use a PPO provider.)		
Adult Immunizations (per CDC recommendations)	80%	60%
Well Child Care (under age 19)		
Primary Physician Office Visit	\$10 copay	
Pediatric Specialist Office Visit.....	\$20 copay	\$20 copay
Well Woman Care.....	80%	\$40 copay
(One pap smear per year; one baseline mammogram age 35-39; one mammogram every 2 years age 40-49; one mammogram per year age 50 and older.)		60%
Chiropractic Benefits	\$10 copay	N/A
(The maximum benefit is \$1000 per calendar year. Active employees enrolled in Kaiser are eligible for chiropractic benefits under the Self-Funded PPO Plan.)		
Podiatry Services (other than office visits)		
Inpatient	80%	60%
Outpatient.....	80%	60%
Mental Health Treatment - Inpatient		
Inpatient Services.....	80%	60%
Mental Health Treatment - Outpatient		
Outpatient Treatment	80%	60%
Outpatient Office Visits	\$10 copay	\$20 copay

Self-Funded PPO Plan - Benefit Feature	PPO Provider	Non-PPO Provider
Substance Abuse Treatment - Inpatient Inpatient Services.....	80%	60%
Substance Abuse Treatment - Outpatient Outpatient Treatment	80%	60%
Outpatient Office Visits	\$10 copay	\$20 copay
Hearing Aid Benefit	Up to \$1,000 toward one hearing aid device for each ear every 36 months as medically necessary	
Laser Eye Surgery (LASIK or PRK) Benefit	Up to a \$500 lifetime maximum for laser eye surgery for each eye as medically necessary	

Services Outside the Geographical Area of the Self-Funded PPO Plan

You and your eligible dependents are covered under the Self-Funded PPO Plan anywhere in the United States. While in California, your PPO is Anthem Blue Cross. When outside of California, your PPO providers are part of the First Health Travel Network. You may obtain a directory of providers online at www.firsthealth.com. When you use First Health providers in states outside of California, you will receive PPO Provider benefit levels.

Exclusions and Limitations

In general, the Plan does not pay for care, treatment, services or supplies for which a Covered Person is not required to pay, which are not prescribed by a Physician, which are not Medically Necessary, or which are in excess of Reasonable and Customary Charges. For a complete list of the Plan's exclusions and limitations, see the Formal Plan Rules, available from the Plan Administration Office.

Utilization Review

Certain procedures/services require review by the Anthem Blue Cross Utilization Review Program.

Services that require review include, but are not limited to:

- A nonemergency hospital admission,
- An emergency hospital admission,
- Childbirth,
- Inpatient mental and emotional illness treatments,
- Inpatient surgery,
- Preadmission/post-release testing,
- Skilled nursing facility/inpatient hospice services,
- Jaw joint disorder treatments in excess of \$300,
- Bariatric surgery.

The responsibility of notifying the Utilization Review Program lies with the covered person. Individuals are advised to contact the Utilization Review Program directly to verify that the admitting physician or hospital has made the notification. The telephone number for the Anthem Blue Cross Utilization Review Program is 1-800-274-7767. For more information about the Utilization Review Program, see Section 11 of the Formal Plan Rules. A copy of the Formal Plan Rules can be obtained from the Plan Administration Office.

24/7 NurseLine

You and your eligible dependents are eligible to use the Blue Cross 24/7 NurseLine when you have questions or need assistance in your medical care. You can use the NurseLine at no cost to you. You can reach the 24/7 NurseLine by calling (866) 670-1565.

Kaiser Foundation Health Plan - Benefit Summary - Active Employees

Benefit Feature	Amount You Pay
Lifetime Maximum	None
Annual Deductible Per Individual..... Per Family.....	None None
Annual Maximum Out-of-Pocket Per Person Per Family.....	\$1,500 in co-pays \$3,000 in co-pays
Hospital Charges (Inpatient)	\$100 copay per admission
Emergency Room	\$50 copay per visit (waived if admitted)
Outpatient Surgery (Ambulatory Surgery Center)	\$25 copay per procedure
Physician Charges - Office Visits	\$25 copay per visit
Routine Physical - One Per Year	No charge
Well Child Care	No charge
Well Woman Care	No charge
Lab/Blood Work/X-ray/Scanning and Imaging	No charge
Mental Health Treatment - Inpatient.....	\$100 copay per admission
Mental Health Treatment - Outpatient.....	\$25 copay for individual visit \$12 copay for group treatment
Substance Abuse Treatment - Inpatient.....	\$100 copay per admission
Substance Abuse Treatment - Outpatient.....	\$25 copay for individual visit \$5 copay for group visit
Home Health Care (up to 100 visits maximum per year)	No charge
Rehabilitation Services	Inpatient: \$100 per admission Outpatient: \$25 per visit
Habilitation Services	\$25 per visit
Skilled Nursing Care (up to 100 days maximum per benefit period)	No charge

Benefit Feature	Amount You Pay
Durable Medical Equipment	No charge
Hospice	No charge
Vision	\$25 co-pay for eye exam and \$175 eye wear allowance when medically necessary every 24 months
Prescription Drugs (Up to a 100 day supply)	\$10 generic \$15 brand name

Active employees enrolled in Kaiser are eligible for chiropractic benefits under the Self-Funded PPO Plan.

Kaiser Physician Authorization

Benefits provided by Kaiser 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, except where specifically noted to the contrary in your Evidence of Coverage for such items as drugs prescribed by dentists, Emergency Ambulance Services, Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, eyeglasses and contact lenses prescribed by Non-Plan Providers, and Visiting Member Services;
- (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 for such items as authorized referrals, Emergency Ambulance Services, Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, hospice care, and Visiting Member Services.

Out-of-Area Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and Emergency Ambulance Services

Out-of-Area Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and Emergency Ambulance Services are medically necessary services that you receive immediately from a non-Kaiser provider for a sudden, unforeseen injury or illness (including pregnancy).

How to File a Claim for Out-of-Area Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and Emergency Ambulance Services

If you receive Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non-Plan Provider or Emergency Ambulance Services, you are not responsible for any amounts beyond your Cost Share for covered Emergency Services. However, if the provider does not agree to bill Kaiser, you may have to pay for the Services and file a claim for reimbursement. Also, you may be required to pay and file a claim for any Services prescribed by a Non-Plan Provider as part of covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care even if you receive the Services from a Plan Provider, such as a Plan Pharmacy.

If you have received Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or Emergency Ambulance Services from a Non-Plan Provider, then as soon as possible after you received the Services, you must file your claim by mailing a completed claim form and supporting information to the following address:

Kaiser Permanente
Claims Administration - NCAL
P.O. Box 12923
Oakland, CA 94604-2923
Please call Member Service Contact Center if you need help filing your claim.

RETIREE MEDICAL COVERAGE OPTIONS

For Retirees Without Medicare

You must elect Kaiser if residing within the service area of Kaiser.

KAISER PERMANENTE TRADITIONAL PLAN

Service Area: covered zip codes in 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.

Benefit Feature	Amount You Pay
Annual Deductible	None
Annual Maximum Out-of-Pocket Per Person	\$1,500 in co-pays
Hospital Charges (Inpatient)	\$100 copay per admission
Emergency Room	\$50 copay per visit (waived if admitted)
Outpatient Surgery (Ambulatory Surgery Center)	\$25 copay per procedure
Physician Charges - Most Primary Care and Specialist Office Visits	\$25 copay per visit
Prescription Drug Coverage	
Most generic items (up to a 100 day supply)	\$10 copay
Most brand name items (up to a 100 day supply)	\$15 copay

BLUE CROSS PPO (only available if you reside outside the Kaiser service area)

For Retirees With Medicare*

You may choose either Kaiser Senior Advantage or UnitedHealthcare (UHC) Group Medicare Advantage.

* If eligible for Medicare, you must enroll in Part A and Part B of Medicare.

KAISER PERMANENTE SENIOR ADVANTAGE

Service Area: covered zip codes in 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.

Benefit Feature	Amount You Pay
Annual Deductible	None
Annual Maximum Out-of-Pocket Per Person	\$1,500 in co-pays
Hospital Charges (Inpatient)	\$100 copay per admission

Benefit Feature	Amount You Pay
Emergency Room	\$50 copay per visit (waived if admitted)
Outpatient Surgery (Ambulatory Surgery Center)	\$25 copay per procedure
Physician Charges - Most Primary Care and Specialist Office Visits	\$25 copay per visit
Prescription Drug Coverage Most generic items (up to a 100 day supply) Most brand name items (up to a 100 day supply)	\$10 copay \$15 copay

UHC GROUP MEDICARE ADVANTAGE

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

Benefit Feature	Amount You Pay
Annual Deductible	None
Annual Maximum Out-of-Pocket Per Person	\$6,700 in copays
Hospital Charges (Inpatient)	No charge
Emergency Room	\$50 copay per visit (waived if admitted)
Outpatient Surgery (Ambulatory Surgery Center)	No charge
Physician Charges - Most Primary Care and Specialist Office Visits	\$20 copay per visit
Prescription Drug Coverage Preferred generic (up to a 30 day supply) Preferred generic (mail order 90 day supply) Preferred brand name (up to a 30 day supply) Preferred brand name (mail order 90 day supply)	\$10 copay \$20 copay \$25 copay \$50 copay

UHC SENIOR SUPPLEMENT (Medicare Supplement Plan) (only available if you reside outside the Kaiser Senior Advantage or UHC Group Medicare Advantage service areas)

Service Area: those areas not covered under UHC Group Medicare Advantage.

The prescription drug benefits provided under the above coverage options are considered "creditable" with Medicare Part D. If you enroll in one of the above coverage options through the Bricklayers and Allied Craftworkers Local No. 3 Health and Welfare Plan, you should not enroll in an individual Medicare Part D plan.

INFORMATION ABOUT PARTICULAR MEDICAL BENEFITS

Maternity Benefits Under the Newborn and Mothers Health Protection Act

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

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

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

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

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

Knee and Hip Surgery

A maximum of \$30,000 is payable for services associated with a single hip joint replacement or a single knee joint replacement surgery. There are certain in-network providers, called Value Based Centers, which have agreed to provide the services for \$30,000. Before having a knee or hip surgery, contact the Administration Office to see if your provider is a Value Based Center. If you do not use a Value Based Center, benefits will be paid in accordance with the standard co-payment and co-insurance up to the maximum of \$30,000.

DENTAL BENEFITS

Dental benefits are provided to Active Employees under the Plan, to eligible dependents, to covered Retirees, and to COBRA participants who elect full coverage.

You may enroll in either the Delta Dental PPO or the DeltaCare USA HMO.

Delta Dental PPO

You may use any dentist when you need care. However, if the dentist you choose is part of the Delta Dental PPO network of preferred providers, you will receive a reduced fee for services. Allowed charges for diagnostic and preventive services, and for basic services, endodontics, periodontics and oral surgery, are covered at 100%, after payment of the required \$25 deductible, up to the calendar year \$2,000 maximum.

To file a Claim, get a claim form from the Union Office or the Plan Administration Office.

See the Formal Plan Rules for a complete description of current dental benefits, as well as conditions of coverage, limitations, and exclusions. A copy of the Formal Plan Rules can be requested from the Plan Administration Office.

Employees and Eligible Dependents	PPO Provider
Annual Deductible (per person).....	\$25
Annual Deductible (per family)	\$75
Percentage of Allowed Charges (after deductible):	
<u>For Diagnostic and Preventive Services</u>	100%
<u>For Basic Services, Endodontics (root canals), Periodontics (gum treatment) and Oral Surgery</u>	100%
<u>For Major Services</u> (crowns, inlays, onlays, and cast restorations) and Prosthodontics (bridges, dentures, and implants).....	80%
<u>Annual Maximum Benefits Paid</u>	\$2,000
(No annual maximum for dependents to age 19)	
Orthodontia Only:	
Percentage of Allowed Charges (after deductible)	50%
<u>Lifetime Maximum Benefits Paid</u>	\$1,500 through
(Only covered if begun before a Dependent's 17th birthday and limited to payments through completion of treatment or until the Dependent's 19th birthday, whichever occurs first.)	
	December 31, 2020

The Plan Administration Office can provide you with an up-to-date list of Delta Dental PPO providers, or you can go to deltadentalins.com.

If Delta Dental PPO refers you to a specialist, those services received from the specialist will be covered at 80% after the deductible is satisfied but not to exceed the \$2,000 maximum.

DeltaCare USA HMO

Under the DeltaCare USA HMO, you choose a participating contract dentist when you enroll and pay co-payments for some services. You must be referred to a specialist, if necessary, by the contract dentist. There is no deductible, maximum benefit per calendar year, or lifetime maximum. Out-of-network emergency services, with pre-authorization, are covered up to \$100 per emergency.

Most diagnostic and preventive services are covered at no cost to you. One prophylaxis cleaning is covered for each adult and child every six months at no cost. Additional cleanings within the six-month period have a \$45 copayment for an adult and a \$35 copayment for a child.

There are copayments (but no deductible, maximum benefit per year, or lifetime maximum) for crowns, root canals, periodontics treatment, dentures, retainers, surgery and orthodontics. Implants are not covered. Please see the Deltacare USA booklet for a complete list of covered services and copayments.

You must visit your selected DeltaCare USA primary care dentist to receive benefits under your plan. Please note the following when using your DeltaCare USA benefits:

1. If you do not have a primary care dentist, or wish to switch to a different one, go to deltadentalins.com and select DeltaCare USA as your network, where you can find or change your primary care dentist.
2. You do not need a DeltaCare USA ID card when you visit the dentist. Simply provide your name, birth date and enrollee ID or social security number.
3. There are no claims forms to complete — just pay your co-payment, if any, at the time of treatment.

If you are currently enrolled in the Delta Dental PPO Plan and switch to the DeltaCare USA HMO, the Plan pays a one-time \$300 benefit. This benefit is taxable to the Employee. Please contact the Plan Administration Office if you would like to switch your dental plan.

VISION CARE BENEFITS

Vision care benefits are provided on an insured basis through Vision Service Plan ("VSP") to active employees who are not enrolled in Kaiser, to all eligible dependents, to retirees, and to COBRA participants who elect full coverage. Employees enrolled in Kaiser receive vision benefits through the Kaiser program. A summary of the vision benefits available through Kaiser can be found on page 23.

Participating VSP Providers:

The Plan provides benefits when you go to an Ophthalmologist, Optician, or Optometrist who is on the Vision Service Plan panel of participating providers, for the following services and supplies:

- Co-pays: \$10 for exam and for prescription glasses.
No co-pay applies for contact lenses.
- Examination: One examination is covered in full every 12 months.
- Lenses: One pair of standard lenses is covered in full every 12 months
(Single vision, lined bifocal, and lined trifocal are covered; polycarbonate impact-resistant lenses for dependent children are covered.)
- Frames: One frame is covered every 24 consecutive months. Frame of your choice covered up to \$120 (\$140 for featured frame brands), plus 20% off any out-of-pocket costs.
- Contacts: One pair of contact lenses is covered, in lieu of a frame and lenses, every 12 months. Benefits are limited to \$120 per set of contact lenses and the contact lens exam (fitting and evaluation). If you choose contact lenses, you will be eligible for a frame 24 months from the date the contact lenses were obtained.

Non-Participating Providers:

If covered services and/or materials are provided by a non-participating Ophthalmologist, Optician, or Optometrist, charges will be paid, but not to exceed the following Amounts:

<u>Service</u>	<u>Out-of Network Reimbursement Amounts</u>
Exam	\$45.00
Single Vision Lenses.....	\$45.00
Lined Bifocal Lenses	\$65.00
Lined Trifocal Lenses	\$85.00
Frame	\$47.00
Contact Lenses	\$105.00

HOW TO USE VISION SERVICE PLAN

1. Find a participating doctor. If you want to confirm that your doctor participates in VSP, or you want to find a VSP doctor, call VSP at (800) 877-7195, or go to the VSP website, www.VSP.com.
2. Call the participating VSP doctor's office for an appointment. Be sure to tell them that you are a VSP member. You must provide the participating employee's Social Security number and the name of the group, which is the Bricklayers and Allied Craftworkers Local No. 3 Health and Welfare Plan. The doctor then obtains an authorization from VSP.
3. Go to your appointment. If eyewear is necessary, the doctor will order it from a VSP-contracted laboratory. You are responsible for deductibles, co-payments and any additional charges for cosmetic options or non-covered services or supplies. The doctor will bill you for these charges, and will submit the necessary claim forms to VSP for the covered charges.

If you use a non-participating provider, you must pay the provider in full and submit a claim to VSP within 6 months for partial reimbursement less co-pays. Send your claim for reimbursement of charges for a non-participating provider to Vision Service Plan, P.O. Box 997100, Sacramento, CA 95899.

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

LASER EYE SURGERY BENEFIT

The Self-Funded PPO Plan will pay a lifetime maximum of up to \$500 towards laser eye surgery (e.g., LASIK or PRK) for each eye as medically necessary. You will be responsible for any balance beyond this specified allowance. Deductibles, coinsurance or copays do not apply.

Reimbursement of the \$500 allowance for each eye may be obtained by submitting a reimbursement form with supporting documentation to the Plan Administration Office. Payment of claims will be subject to the regular claim time limits under the Plan.

PRESCRIPTION DRUG BENEFITS

If you are enrolled in Kaiser, you and your dependents will receive your prescription drug benefits from Kaiser.

Kaiser

All prescriptions must be filled at Kaiser pharmacies. There is a \$10 co-payment per prescription for generic drugs at Kaiser and a \$15 co-payment for brand name drugs.

Self-Funded PPO Plan

If you are enrolled in the self-funded PPO Plan, prescription drug benefit payments for you and your dependents are administered through Sav-Rx. To receive these benefits, you must use your Sav-Rx card at a participating pharmacy and pay the required co-payment as advised by the pharmacy. All prescription benefits under the PPO Plan are for generic drugs, unless a physician specifies the use of a formulary brand name or other non-generic drug.

The Plan utilizes Sav-Rx's Step Therapy Program for new prescriptions. The Step Therapy Program identifies certain prescribed drugs for which there is a less expensive therapeutically equivalent drug. Under the Step Therapy Program, the less expensive drug must be tried before the more expensive drug can be authorized.

Retail pharmacy

The following co-payments apply at the retail level:

- No charge generic drug
- \$10 for formulary brand drug
- \$40 for all other drugs

Mail Order

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

- No charge for generic drug
- \$20 for formulary brand drug
- \$80 for all other drugs

Specialty Drugs Subject to Sav-Rx High Impact Advocacy (“HIA”) Program

Specialty drugs identified by Sav-Rx as being eligible for a manufacturer-sponsored coupon program are subject to the HIA program. If you are taking or have been prescribed a specialty drug that is a part of this program Sav-Rx will notify you to facilitate your enrollment in the manufacturer sponsored coupon program. You are required to cooperate with Sav-Rx and enroll in a manufacturer sponsored coupon program subject to the HIA program. Specialty drugs listed in the HIA program are subject to different copayment amounts. Copayment amounts are set at the level determined by the Sav-Rx HIA program and are subject to change. The copayment may be as high as 25%. However your actual out-of-pocket expense under the HIA program will never be greater than the out-of-pocket expense under the Plan's Retail Pharmacy copayment structure. Specialty drugs subject to the HIA program must be processed through a Sav-Rx Specialty Pharmacy.

Prescription drug expenses are not counted toward any out-of-pocket limit, and prescription drug copayments are never payable at 100%, even after a covered person has satisfied an otherwise applicable out-of-pocket limit. If your doctor has not specified a brand name drug and you request a brand name drug, you must pay the difference between the cost of the available generic drug and the brand name drug.

See the Formal Plan Rules for a complete description of current prescription drug benefits under the self-funded PPO Plan, as well as conditions of coverage, limitations, and exclusions.

LIFE INSURANCE SUMMARY

The Plan provides life insurance for active employees through United of Omaha, regardless of the option you elect for medical coverage. Dependents, COBRA participants and retirees are not eligible for life insurance benefits. The amount of life insurance is reduced by 50% at your age 70.

The following is a summary of the benefits currently in effect. The complete terms and conditions are stated in the insurance policy issued by United of Omaha. Please note, however, that the terms of the United of Omaha policy may change from time to time, and the actual benefits are determined by the policy in effect at the time of a covered person's death. This summary is not intended to supersede that policy, and any changes to the policy supersede this booklet.

Benefit Amounts: The following amounts of benefits are payable:

Employee	\$10,000
Employee age 70 or over	\$5,000

These benefits are payable to your designated beneficiary if you die while eligible for benefits under the Plan. These benefits are subject to the exclusions described in the separate life insurance booklet. Benefits are also payable under "Continuation of Insurance" provisions for thirty-one days after termination of eligibility, or beyond that if you exercise the Conversion Privilege, or if you qualify for, and comply with the requirements for Waiver of Premium Benefit in the Event of Total Disability.

Waiver of Premium If You Are Disabled

If you become totally disabled, and your life insurance coverage will end because you are retired, on COBRA, or your extended disability coverage has run out, your life insurance will be continued without payment of any premium if 1) your disability began while you were covered for life insurance, 2) your disability began before you reached age 60, and 3) you provide proof of disability as described below.

You must notify United of Omaha of your total disability not later than the 9th through the 12th month of your disability. You and your physician will then be required to submit proof of your disability. If accepted, your life insurance will be continued for a period of one year. Thereafter, you and your physician must submit proof again each year that you are totally disabled. Your proof of disability must be submitted annually during the 3-month period before each anniversary of receipt of your initial proof, in order for your life insurance to be continued for another year.

Conversion Privilege

If your employment ends, you may apply for an individual life insurance policy (called a conversion policy) without giving information about your health, provided you apply within 31 days of the date your group life insurance coverage ends. You may apply for any available individual life insurance policy except term insurance; the amount of the conversion policy may not exceed the amount of the terminated group insurance policy; and the premium for the policy will be at the standard rate for such policies based upon your class of risk and your age when the policy takes effect.

Beneficiary for Life Insurance

You may designate anyone, or any number of people, to be your beneficiary for your life insurance benefit. If you do not designate a beneficiary, or if no beneficiary survives you, your benefits will be paid:

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

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

How to File a Claim for Life Insurance

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

CLAIMS AND APPEALS PROCEDURES SUMMARY

How to Submit Claim Forms for Benefits

Medical: No claims forms are required for medical, hospital, and surgical benefits if you are covered under Kaiser. Simply present your Kaiser card whenever you receive services, and make the applicable co-payment.

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

by mail: BAC Local 3 Trust Funds
c/o BeneSys Administrators
P.O. Box 1607
San Ramon, CA 94583

electronically*: EDI #47198

*Your provider may also submit claims electronically through BeneSys's secure electronic data interchange (EDI) system. BeneSys's EDI number is 47198. If your provider is able to submit claims electronically, simply give this number to your provider.

Dental: Your dentist should submit claims directly to BeneSys Administrators. Your dentist may also submit claims electronically through BeneSys's secure electronic data interchange (EDI) system. BeneSys's EDI number is 47198. If your dentist is able to submit claims electronically, simply give this number to your dentist.

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

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

Claims and Appeals

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

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

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

You or your health care provider may file a claim for benefits within 12 months of the date of service by contacting the Plan Administration Office, BeneSys Administrators. BeneSys will notify you of its determination within the following deadlines, unless BeneSys notifies you that it needs more information or an extension:

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

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

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

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

These procedures are the only procedures you may use to appeal an adverse action taken by the Board of Trustees or other Plan fiduciary or agent. For full claims and appeal procedures and rules, see Appendix 3.

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

ADMINISTRATIVE INFORMATION REQUIRED BY ERISA

This Plan is known as the Bricklayers and Allied Craftworkers Local No. 3 Health and Welfare Plan. The Internal Revenue Service Employer Identification Number (EIN) of the Trust Fund is 23-7034407 and the Plan Number is 501. The Plan Year runs from July 1 to June 30 of each calendar year.

PLAN ADMINISTRATOR:

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

Board of Trustees
Bricklayers and Allied Craftworkers Local No. 3 Health and Welfare Plan
c/o BeneSys Administrators
P.O. Box 1607
San Ramon, CA 94583
Telephone: (888) 208-0250 or (925) 208-9995

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

The Benefit Consultant is Rael & Letson, 2929 Campus Drive, Suite 400, San Mateo, CA 94403.

TYPE OF ADMINISTRATION:

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

The Plan's life insurance and vision benefits are insured by the plan carriers.

The Bricklayers and Allied Craftworkers Local No. 3 Health and Welfare Plan offers a self-funded PPO medical and dental plan. It contracts with ULLICO for Stop Loss Coverage. The Board of Trustees has also hired health maintenance organizations and other providers to provide benefits or claims services under insurance contracts or service agreements. Their names and phone numbers appear on page 1 above.

AMENDMENT AND TERMINATION OF PLAN AND/OR TRUST FUND:

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

AGENT FOR SERVICE OF LEGAL PROCESS:

Raphael Shannon Kraw
Kraw Law Group
605 Ellis Street, Suite 200
Mountain View, CA 94043
(650) 314-7815

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

FUNDING AND PLAN SPONSORSHIP:

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

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

Labor Organizations

Bricklayers and Allied Crafts Local Union No. 3, I.U. of B.A.C.
10806 Bigge Street
San Leandro, CA 94577

Employer Associations

Northern California Masonry Contractors Multi-Employer Bargaining Association
2882 Grove Way
Castro Valley, CA 94621

Tile, Terrazzo, Marble & Restoration Contractors Association of Northern California
c/o De Anza Tile
45755 Northport Loop West
Fremont, CA 94538

Terrazzo and Mosaic Association of Northern California
36 Wood Street
San Francisco, CA 94118

Marble Dealers of Northern California
c/o Carrara Marble Company
15939 Phoenix Drive
City of Industry, CA 91745

Northern California PCC/Restoration Contractors Association, Inc.
1482 67th Street
Emeryville, CA 94608

YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administration Office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

Continue Group Health Plan Coverage

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

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called fiduciaries of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a health and welfare or vacation benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administration Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, which is the San Francisco Regional Office, EBSA, San Francisco Regional Office, 90 Seventh Street, Suite 11-300, San Francisco, CA 94103, Telephone: (415) 625-2481, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

APPENDIX 1: BOARD OF TRUSTEES

Employee Trustees

Troy Garland
BAC Local 3
10806 Bigge Street
San Leandro, CA 94577

Dave Jackson
BAC Local 3
10806 Bigge Street
San Leandro, CA 94577

Steve Kantoniemi
BAC Local 3
10806 Bigge Street
San Leandro, CA 94577

Gary Peifer
BAC Local 3
2840 El Centro Road, Suite 105
Sacramento, CA 95833

Randy Smith
BAC Local 3
10806 Bigge Street
San Leandro, CA 94577

Employer Trustees

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

David Filippi
American Terrazzo
36 Wood Street
San Francisco, CA 94118

Robert Filippi
American Terrazzo
36 Wood St.
San Francisco, CA 94118

Randy Statham
P.T.S. Masonry, Inc.
7117 Tokay Avenue
Sacramento, CA 95838

APPENDIX 2: GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

This section contains important information for participants in the Bricklayers and Allied Craftworkers Local No. 3 Health and Welfare Plan about the right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law you can contact the Plan's Administration Office.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

This notice explains, in general:

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

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

1. What is COBRA Continuation Coverage?

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

After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "**Qualified Beneficiary.**" You, your spouse or domestic partner, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for the

coverage on their own. COBRA coverage is also coordinated with other forms of extended coverage, so that your period of COBRA coverage is reduced by any period of other extended coverage. [See Section 4, C.]

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

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

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

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

- The employee dies;
- The employee's hours of employment are reduced;
- The employee's employment ends for any reason other than his/her gross misconduct;
- The employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You divorce, or dissolve your domestic partnership with, the employee.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both); or
- The child stops being eligible for coverage under the Plan as a dependent child, which means the child has attained age 26 or is no longer disabled.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Bricklayers and Allied Craftworkers Local No. 3 Health and Welfare Plan, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

3. When is COBRA Coverage Available?

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

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

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

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

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

IMPORTANT:

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

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

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

Your notice must include the following information:

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

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

4. How is COBRA Coverage Provided?

Once the Plan Administration Office receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered

employees may elect COBRA continuation coverage on behalf of their spouses or domestic partners, and parents may elect COBRA continuation coverage on behalf of their children. Please inform the Plan Administration Office immediately if you acquire any new dependents through marriage, registration of a domestic partnership, having children born, adopted or placed with you for adoption.

Qualified Beneficiaries who elect COBRA coverage may elect "core coverage" (that is, all Plan benefits except dental care, vision benefits, life insurance, and accidental death or dismemberment insurance), or full COBRA coverage (all Plan benefits). If the employee elects one type of coverage, the election also applies to his/her dependents. However, if the employee does not elect COBRA coverage, the employee's dependents may elect either form of coverage for themselves. If the employee's dependents are covered for dental care and vision benefits only, they may elect COBRA for those benefits.

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

Generally, when the Qualifying Event is (1) the end of employment or (2) reduction of the employee's hours of employment, COBRA continuation coverage lasts up to a total of **18 months** at 102% of Plan cost. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

a) **Disability extension.**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administration Office in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage at 150% of Plan cost, for a total **maximum of 29 months**. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

b) **Second Qualifying Event.**

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

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

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

When the Qualifying Event is (1) the death of the employee, (2) the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), (3) divorce from, or dissolution of a domestic

partnership with, the employee, or (4) a dependent child's loss of dependent status, the Qualified Beneficiary may elect COBRA continuation coverage for up to a total of **36 months**.

C. Coordination with Other Coverage

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

D. Other Coverage Options Besides COBRA Continuation Coverage

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

5. Where Can You Get More Information?

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the person identified in Section 6. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, you may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area at:

EBSA, San Francisco Regional Office
90 Seventh Street, Suite 11-300
San Francisco, CA 94103
Telephone: (415) 625-2481
Or visit the EBSA website at www.dol.gov/ebsa.

6. Plan Administration Office Contact Information

Bricklayers and Allied Craftworkers Local No. 3 Health and Welfare Plan
c/o BeneSys Administrators
P.O. Box 1607
San Ramon, CA 94583
Telephone: (888) 208-0250 or (925) 208-9995
Fax: (925) 362-8564

IMPORTANT: Keep Your Plan Informed of Address Changes

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

APPENDIX 3: CLAIMS AND APPEAL PROCEDURES

(The Claims and Appeal Procedures are also contained in Section 7 of the Formal Plan Rules)

Applicability

(1) The following claims and appeals procedures shall apply to all matters within the discretion of the Board of Trustees, including:

- claims and appeals regarding eligibility under this 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 other provider has denied the claim on the grounds that the claimant or family member is not eligible for the benefit under the terms of this Plan;
- claims and appeals regarding self-funded PPO Plan benefits.

(2) 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.
- 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.
- 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.

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

Filing a Claim

Participants, family members and assignees (hereinafter "claimants") may initiate a claim for benefits within 12 months of the date of service 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.

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.

Notification of Claim Decision

(1) Time Limits and Requests for Additional Information.

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

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

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

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

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

The 30-day time period may be extended for one additional 15-day period, but only due to matters beyond the Administration Office's control. If the Administration Office needs a 15-

day extension, it will, before the end of the first 30-day period, notify the claimant of the following: the reason for the delay; the expected date of decision; and any additional information the Administration Office needs to make the decision. If the Administration Office requires additional information, the claimant will have up to 45 days to provide the specified information. Once the specified information is provided, the Administration Office will notify the claimant of its decision within 15 days.

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

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

Appeal Procedures

(1) GROUNDS FOR APPEAL: The claimant may appeal any adverse action within the discretion of the Board of Trustees to the Board of Trustees. The Board of Trustees hears all appeals regarding self-funded PPO Plan benefits, all appeals regarding eligibility under this Plan for any type of benefit, 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 other provider has denied the claim on the grounds that the claimant or family member is not eligible for the benefit under the terms of this Plan.

(2) 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.

(3) 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.

(4) **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.

(5) NOTIFICATION

(a) TIME LIMITS FOR NOTIFICATION

(i) **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.

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

(iii) **Post-Service Claims:** The Board of Trustees will render a decision on the appeal at the regularly scheduled meeting immediately following the filing of the appeal, unless the appeal is filed within 30 days of the meeting, in which case the decision may be made at the second meeting following the appeal. The claimant shall be notified of the time and place of the meeting. The Board of Trustees does not need to make a verbatim record, but the Administration Office shall keep 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:

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

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

(iii) 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;

(iv) if the decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the Plan's terms to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(v) 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

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

(6) TIME LIMIT FOR CIVIL ACTION: A civil action arising from the denial of benefits must be filed within one year from the date on which the Board of Trustees provides notice that the claimant's appeal has been denied, regardless of any state or federal statutes establishing provisions relating to limitations of actions.

Appeals to Medical Plan Carriers

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

Waiver of Class, Collective and Representative Actions

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