NORTHERN CALIFORNIA PLASTERERS HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION
AND FORMAL PLAN RULES

September 1, 2018

Summary Plan Description

INTRODUCTION

The Northern California Plasterers Health and Welfare Plan covers active employees working in all types of employment under the collective bargaining agreements of Operative Plasterers' and Cement Masons' Local Union No. 300 and Plasterers' and Shophands' Local Union No. 66, as well as qualified retired employees, signatory employers and their non-bargaining unit employees, and eligible dependents of all of the above. Regular coverage for active employees is entirely funded through employer contributions.

What does this booklet cover?

This booklet is the Summary Plan Description of the Health and Welfare Plan as in effect on September 1, 2018. It includes a Summary of Eligibility Rules and a Summary of Benefits, describing the benefits available under the Plan. This booklet also includes the Formal Plan Rules, administrative information, and general information about your rights as a Plan participant.

No difference is intended between these summaries and the Formal Plan Rules, or with the contracts and evidence of coverage documents of the Plan service providers. However, if any differences exist, the terms of the Formal Plan Rules, contracts, or evidence of coverage documents, govern.

The summaries and the Formal Plan Rules contained in this booklet supersede and replace all prior versions. In addition, if any of the formal rules or provider contracts are changed after the date of this booklet, the new rules and/or contracts will supersede and replace the information in this booklet.

Your Obligations under the Plan

Your eligibility for benefits, and the eligibility of your dependents, depends on timely enrollment of, and current information about, you and your dependents. Contact the Trust Office, HS&BA, whenever you acquire a new dependent, or when any of the following events occur:

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

PLAN SERVICE PROVIDERS INFORMATION

If you need further information about your eligibility status or your rights and duties under the Plan, or to request copies of certificates of creditable coverage, privacy notices, COBRA notices, Summaries of Benefits and Coverage, or other documents, contact the Trust Office:

Northern California Plasterers Health and Welfare Trust Fund
c/o HS&BA
4160 Dublin Blvd., Suite 400
Dublin, CA 94568
(844) 663-8121

Website: www.plasterersbenefits.com

Privacy Officer and Security Officer:
HS&BA
4160 Dublin Blvd., Suite 400
Dublin, CA 94568
(925) 833-7300

Your Local Union may also provide assistance with Plan benefits.

If you need information or assistance concerning a particular Plan service provider, you may contact the provider directly, at the following addresses, phone numbers, or web sites:

Kaiser Permanente
Northern California Region
1800 Harrison Street, 9th Floor
Oakland, CA 94612
(800) 464-4000
www.kaiserpermanente.org

Vision Service Plan
Customer Service Dept.
333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195
www.vsp.com

PhysMetrics
P.O. Box 25220
Fresno, CA 93729-5220
(877) 519-8839

Blue Shield of California
P.O. Box 272540
Chico, CA 95927
(888) 256-1915
www.blueshieldca.com

Premier Access Insurance Company
P.O. Box 659010
Sacramento, CA 95865–9010
(888) 715-0760
www.premierlife.com

Lincoln National Life Insurance
8801 Indian Hills Drive
Omaha, NE 68114
(800) 927-4357

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HIGHLIGHTS OF THE PLAN

1. Benefits Available. The Plan provides the following types of benefits, through the Plan service providers listed below:

" Medical, hospital, surgical and prescription drug benefits are currently provided on an insured basis through one of two health maintenance organizations ("HMOs"): Kaiser Permanente Health Plan or Blue Shield. For members who live outside the service areas of the Plan HMOs, coverage is provided by the Blue Shield PPO Plan.

" Dental benefits are provided on an insured basis through the Premier Access DHMO and a self-funded basis through the Premier Access PPO.

" Vision benefits are provided on a self-funded basis through Vision Service Plan.

" Life and Accidental Death & Dismemberment Insurance benefits are provided on an insured basis through Lincoln Life Insurance.

2. Enrollment Requirements. You must enroll in a Plan HMO, and comply with the HMO's rules, to be eligible for any medical, hospital, surgical or prescription drug benefits.

Be sure to enroll all of your dependents, or they will not be covered. Once you have enrolled in an HMO, you are automatically covered for the other benefits applicable to you.

> New dependents must request enrollment within 30 days, or 60 days as applicable, to guarantee their right to immediate enrollment. For example, you must request enrollment of a new spouse within 30 days of your marriage, and of a new child within 30 days of his or her birth or adoption. If you fail to enroll a dependent in a timely manner when you or the dependent is first eligible for benefits, your dependent may not be able to receive medical benefits until the next open enrollment. See pages 8 and 12 for more information about enrollment rights and requirements.

3. Authority to Act on Behalf of the Board of Trustees. Only the Trust Office is authorized to provide information about eligibility for benefits under the Plan, and about the benefits for which you qualify. Information from any other source, including a Local Union, a Trustee, or an employer, is not binding on the Plan. As a convenience, the Trust Office may respond to oral requests, and a Local Union may provide assistance in utilizing your Plan benefits. However, only written

responses from the Trust Office or the Plan's Legal Counsel are the authorized responses of the Board of Trustees.

4. Right of Appeal. If you are dissatisfied with an action or decision of the Trust Office or other agent of the Board of Trustees, you may appeal that action to the Board of Trustees within 180 days of receiving notification of the unfavorable action or decision. You must submit a written request for appeal of the unfavorable action or decision to the Trust Office, or you will be deemed to have waived your objections to it. See the section entitled Summary of Claims and Appeals Rules for more details regarding how to file an appeal. The Board of Trustees' decision with regard to an appeal is final and binding on all parties. A lawsuit based on the Board of Trustees' denial of benefits must be filed within one year from the date the Board gives you notice of its decision.

Important Note Concerning Appeals: The Board of Trustees hears appeals only about eligibility issues and self-administered benefits, and not about determinations by Plan HMOs or other Plan service providers. Each of the Plan's HMOs and other Plan service providers has its own appeal procedures, which are described in its evidence of coverage documents. Representatives of the Trust Office or Local Union may help you with an appeal to an HMO or other Plan service provider, but such appeals are ultimately your own responsibility.

5. Reservation of Rights. The Board of Trustees has exclusive discretion, under the Trust Agreement, to establish and amend the Plan. The Board of Trustees reserves the right to amend, modify, or discontinue all or part of the Plan, and/or the contracts or policies under which benefits are provided, whenever, in its exclusive discretion, conditions so warrant. In no event shall any benefits provided under this Plan be deemed vested. Any amendments to the Formal Plan Rules, or changes to the contracts with Plan service providers, which are adopted by the Trustees after the publication of this booklet, supersede the summaries in this booklet.

6. Distribution on Termination. If this Plan is ever terminated, its remaining assets shall be used to continue to provide benefits for so long as Plan assets permit, or the Trustees may provide for the transfer to a successor plan providing similar benefits to employees in the Plastering Industry. In no event shall any assets of the Plan or Trust Fund revert to a contributing employer.

I. SUMMARY OF ELIGIBILITY RULES

A. Eligibility Rules for Active Employees

Eligibility for benefits as a bargaining-unit employee is determined by your hours of covered employment. When you work in covered employment and have hours reported and paid on your behalf to the Trust Office, a reserve of hours or Hour Bank is established for you. Your employer will report the hours you work each month in the following month, and they can be used to pay for coverage two months after that. For example, your hours worked in January are reported and paid in February, and are used to provide coverage in April. This may cause a delay in your initial eligibility or create a gap in coverage even after a month in which you worked the number of hours required to maintain coverage.

1. Initial Eligibility. A new employee will become eligible for benefits under this Plan on the first day of the third month following the month in which he or she has completed a minimum of 210 hours of covered employment for participating employers, within a period of 12 months. The first 105 hours worked to establish initial eligibility are not credited to your Hour Bank.

2. Initial Eligibility for Newly Organized Employees. A new member enrolled as part of an organizing drive sponsored by a Local Union may be granted an Hour Bank credit of 210 hours, effective for coverage in the month after the Trust Office receives notification from the Local Union. However, this grant is conditioned on the employee's continuing to be employed in covered employment. If a newly organized member leaves covered employment within 8 months of enrollment in the Plan, then his or her Hour Bank will be revoked immediately.

3. Continuing Eligibility. Once you have qualified for benefits, your Hour Bank is charged a fixed amount each month for that month's coverage. The Plan charge is currently 105 hours per month in order to continue coverage. If you work more than 105 hours of covered employment in any month, the excess hours are added to your Hour Bank, and will be used when necessary to continue coverage in months when you work less than 105 hours. You may accumulate a maximum Hour Bank of 420 hours, after the deduction for each month's coverage.

4. Termination of Eligibility Due to Depletion of Hour Bank. Your coverage will terminate at the end of any month following the month in which the combination of your newly reported hours and Hour Bank credits falls below 105 hours.

5. Reinstatement. If your coverage terminates due to the depletion of your Hour Bank, your coverage will be reinstated on the first day of the third month following the month in which you have been credited with 105 hours within 12 months after termination of your coverage. If you do not qualify for reinstatement within 12 months, you must re-qualify for Initial Eligibility as explained above.

6. Special Coverage While Disabled. If you become disabled from working in the Plastering Industry while you are eligible for benefits, you will be entitled to 9 months of coverage at no cost, after depletion of your Hour Bank. Such coverage will consist of medical, dental, vision and hearing aid benefits.

To qualify, you must have been continuously covered as a participant for 36 months prior to your qualifying disability, and you must have been covered through your Hour Bank for a minimum of 6 months since your last 9 months of coverage.

You must also provide proof of your disability in order to qualify for this special coverage. "Disabled" and "disability" for purposes of this special coverage means that you are unable to perform work in the Plastering Industry or in any other job which demands a level of physical capacity similar to work in the Plastering Industry.

After receiving 9 months of no-cost coverage, you may continue coverage using your reserve hours until they are exhausted, and thereafter for up to 20 additional months by paying the applicable COBRA contribution rate.

If you remain disabled after receiving these 29 months of coverage, and you are receiving a pension from the Northern California Plastering Industry Pension Plan, you may apply to the Board of Trustees to extend your coverage for an additional 12 months at the applicable COBRA contribution rate.

For additional information regarding coverage while disabled, see the Formal Plan Rules, Article I, Section H.

7. Special Coverage While Unemployed. If you lose coverage due to termination of employment, and you remain on a Local Union's out-of-work list and are available for dispatch, you may elect continuation core coverage (medical coverage only) by paying a subsidized reduced rate for up to 6 months of continuation coverage in any 12-month period.

8. Coverage While Working for a Delinquent Employer. You will receive credit for hours worked for a delinquent employer for a maximum of 3 months, or up until the time you are advised to stop working for the delinquent employer and return to the Hiring Hall for dispatch, if earlier. After that, if you continue to work for a delinquent employer, your Hour Bank will be canceled.

9. 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) have your Hour Bank frozen, and terminate coverage of your dependents, on the first day of the month following your entry into active military service. (Under this option, you may choose to continue coverage for your dependents for up to 24 months under COBRA.); or

(b) continue coverage of your dependents at the normal monthly charge against your Hour Bank until it is exhausted. (Thereafter, you may choose to continue coverage for your dependents for up to 24 months under COBRA.)

To make your election, you must notify the Trust Office of your call to active duty. If you do not give proper notice, you will be deemed to have elected option b. above.

For additional information regarding reemployment after military service, see the Formal Plan Rules, Article I, Section L.

10. 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 Hour Bank, 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 Trust Office for more information.

11. Pregnancy Disability Leave**.** If you are a female employee who is disabled by pregnancy, childbirth, or a related medical condition, you may be eligible for leave under the Pregnancy Disability Leave ("PDL") rules of the California Fair Employment and Housing Act. While you are on PDL qualifying leave, your

employer is responsible for making the appropriate contribution for your coverage under rules determined by the Board of Trustees. The definition of PDL qualifying leave may change as the law is amended. Your Hour Bank, if you have one, will not be charged for coverage while you are on PDL qualifying leave. If you believe this law applies to you, contact the Trust Office for more information.

12. Termination of Coverage Due to Misconduct. You will lose coverage, and your Hour Bank will be forfeited, if you:

(a) work for an employer in the Plastering Industry who is not signatory to a collective bargaining agreement of one of the Local Unions;

(b) work as a sole proprietor or owner-operator in the Plastering Industry without being signatory to a collective bargaining agreement of one of the Local Unions;

(c) continue to work for an employer that has been delinquent in paying contributions to this Trust Fund after being notified to cease working for that delinquent employer; or

(d) knowingly comply with your employer paying less than the full hourly contribution rate for every hour you work.

If your coverage is terminated for any of these reasons, your coverage may not be reinstated until the misconduct has ended and you have re-qualified under the rules for Initial Eligibility above.

13. COBRA Continuation Coverage. In addition to other forms of extended coverage discussed above, the Plan provides COBRA continuation coverage to any covered person who loses coverage due to a qualifying event. COBRA qualifying events include termination of employment or reduction of hours, death, divorce, loss of dependent status, or loss of coverage due to the member's entitlement to Medicare. If any of these events occur, contact the Trust Office. See the section entitled Your Rights Under COBRA and Article VII of the Formal Plan Rules for more detailed rules of COBRA coverage.

14. Health Conversion Privilege.

(a) Whether or not you and/or your eligible dependent(s) elect COBRA continuation coverage, you will retain the right to elect individual conversion coverage offered by the HMO or PPO in which you are enrolled. If you decide not to elect COBRA continuation coverage, you and/or your eligible dependent(s) have thirty-one (31) days from the date coverage would have otherwise terminated to request conversion coverage from your HMO or PPO.

(b) Conversion to individual coverage is also available to you and/or your eligible dependent(s) at the end of the COBRA continuation period, provided that all required payments have been made. You and/or your eligible dependent(s) will be notified of this conversion privilege within 180 days before your COBRA continuation coverage terminates.

B. Eligibility Rules for Dependents

1. Eligible Dependents. Your Eligible Dependents are generally covered whenever you are covered, if they have been properly enrolled.

Your "eligible dependents" include:

(a) your lawful spouse.

(b) each child, as defined below, up until the end of the calendar month that he/she attains the age of 26. Dependent children are covered for life insurance until their 21st birthday, unless they are full-time students and primarily supported by you, in which case they are covered until their 25th birthday.

(c) each grandchild, as defined below, until his/her 19th birthday, or until age 23 while he/she remains a full-time student at a school or college, is unmarried, and is dependent on you for support and maintenance. If your covered grandchild takes a "medically necessary leave of absence" from a postsecondary educational institution, he/she will continue to be covered until the earlier of: 1) one year from the date the leave of absence began; or 2) when his/her coverage would otherwise end under the terms of the Plan (currently at his/her 23rd birthday). In order for your dependent grandchild to qualify for this continuation of coverage, his or her treating physician must certify in writing that the leave of absence is medically necessary. "Medically necessary leave of absence" shall have the meaning defined in 29 U.S.C. §1185(c)(a).

(d) your domestic partner as defined by California law, and children of such domestic partner, if entirely supported by you, but only for coverage under the Plan's insured benefit plans. Such domestic partners and children are not eligible dependents for coverage under any of the Plan's self-funded benefits, nor are they eligible for COBRA.

(e) each disabled child, whose coverage would terminate solely due to reaching his/her 26th birthday, if he/she is incapable of self-sustaining employment due to mental or physical disability, and chiefly dependent on you for support and maintenance, but only for coverage under the Plan's insured benefit plans. For your disabled child to be eligible for this extension, written proof of incapacity must be submitted within thirty-one (31) days of the date that the

dependent's coverage would otherwise terminate, and from time to time as requested by the Trust Office or the life insurance carrier.

"Child" means your son or daughter, stepchild, adopted child and foster child. "Child" also includes a minor child placed with you for the purpose of legal adoption for whom you have assumed and retained a legal obligation to provide total or partial support in anticipation of adopting that child, whether or not the adoption becomes final. "Grandchild" means any dependent grandchild for whom you have assumed sole custody and liability for maintenance and support, subject to the approval of the Trustees.

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

2. Enrollment of Dependents. New participants may enroll dependents when they first become eligible for benefits. After initial enrollment, if you acquire a new dependent, you must request enrollment of the dependent within 30 days of the birth, marriage, or other event which makes the dependent eligible. For example, if you get married, you must request enrollment of your new spouse within 30 days of your marriage. If you have a newborn child, you must request enrollment of the child within 30 days of his or her birth.

Failure to enroll a new dependent in a timely manner may result in your dependent not being eligible for medical benefits until the next open enrollment held in June for a July 1 effective date. The decision whether or not to allow late enrollment is up to your chosen medical plan, not the Board of Trustees.

3. Special Enrollment Rules for Dependents.

(a) If you have failed to enroll your spouse, and you have a newborn baby or adopted child, the mother of the child may request enrollment within 30 days of the child's birth (or adoption), along with the child.

(b) 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 request enrollment for your dependent within 30 days of loss of coverage under the other plan.

(c) 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 request enrollment for your dependent within 60 days of the termination from, or eligibility for, such assistance.

4. Termination of Dependent Coverage. Coverage for your dependent(s) will end when your coverage ends, when you die, or when your dependent ceases to qualify as an Eligible Dependent.

C. Eligibility Rules for Retirees

1. Eligible Retirees. When you retire, you are eligible for retiree coverage under the Plan if you are retired from covered employment in the Plastering Industry and are currently receiving a pension from the Northern California Plastering Industry Pension Plan, and you satisfy the requirements of one of the following three paragraphs:

(a) you were covered as an active employee, and/or you were continuously registered on the out-of-work list of a participating Local Union, and/or you were covered as a disabled participant, for 24 of the 36 months immediately preceding your application for retiree benefits under this Plan, and for 7 of the 10 years immediately preceding your application for retiree benefits under this Plan; or

(b) you were covered as an Individual Employer or as a non-bargaining unit employee under this Plan for the twelve (12) months immediately preceding retirement, and were continuously covered under the Plan for the five (5) years immediately preceding your retirement; or

(c) you were covered under the Retiree Eligibility Rules of this Plan and/or the Plastering Industry Welfare Plan as of December 31, 2012.

2. Retiree Coverage. Retirees may waive their COBRA rights and instead opt to receive retiree coverage under the Plan, which consists of core medical benefits (not including dental and vision coverage), a reduced life insurance benefit, and the Plan hearing aid benefit only. In order to receive retiree coverage, you must pay a monthly premium determined from time to time by the Board of Trustees. Your dependents are eligible for medical benefits under the same eligibility rules as apply to active employees. Surviving dependents of deceased retired employees may elect survivor coverage, subject to payment of the monthly premium for such coverage.

(a) Early (Non-Medicare Eligible) Retirees. Retirees under the age of 65 may elect retiree coverage for an indefinite period of time by paying the required

monthly premium. You may elect to be covered under Kaiser or Blue Shield, if you reside in the service areas of those medical providers. If you reside outside those service areas, you may receive coverage under the Blue Shield PPO.

In lieu of the standard retiree coverage, early retirees, after run-out of their Hour Bank, if any, may elect full COBRA coverage, including dental and vision coverage, for 18 months by paying the required premium. However, all coverage will end at the end of 18 months, and you will not be eligible for any additional retiree coverage under the Plan.

(b) Age 65 and Older (and Other Medicare-Eligible) Retirees. Medicare-eligible retirees age 65 and older, and other retirees with a Social Security Disability Award who are covered under Parts A and B of Medicare, may elect retiree coverage for an indefinite period of time by paying the required monthly premium. You may elect to be covered under the Kaiser Senior Advantage or Blue Shield 65 Plus plans, if you reside in the service areas of those medical providers. If you reside outside those service areas, you may receive coverage under the Blue Shield Custom PPO COB 100/50 plan.

In lieu of the standard retiree coverage, retirees age 65 and older, after run-out of their Hour Bank, if any, may elect full COBRA coverage, including dental and vision coverage, for 18 months by paying the required premium. However, all coverage will end at the end of 18 months, and you will not be eligible for any additional retiree coverage under the Plan.

Medicare-eligible retirees and dependents must be enrolled in Medicare Parts A and B, and, if required by their HMO plan rules, enroll in their HMO's Medicare-Risk program as well.

D. Eligibility Rules for Individual Employers and Non-Bargaining Unit Employees.

Individual Employers and their Eligible Dependents are eligible to receive flat-rate coverage under the Plan, if certain conditions are satisfied. Eligible Individual Employers may also obtain coverage for their non-bargaining unit employees who work at least 20 hours per week and are not covered under another health plan. In order to participate, the Individual Employer must apply in writing to the Trust Office with 90 days of signing a collective bargaining agreement with a Local Union and pre-pay four months of the required premium. See Article IV of the Formal Plan Rules for complete rules regarding Individual Employer coverage.

E. Points Accounts

Employees working in covered employment under certain collective bargaining agreements earn credit towards a "Points Account," based on contributions made for that purpose. Covered active and retired employees may

use those accounts to pay certain Plan premiums, and to have qualified medical expenses reimbursed. Qualified medical expenses must have been incurred within 60 months of your last participation. See the Formal Plan Rules, Article VI, Section B.3., for an explanation of reimbursable expenses.

Points Accounts may be used for premiums due for coverage under this Plan under the following circumstances:

1. If you are retired and eligible for Retiree Coverage, you may use your Points Account to pay your retiree premium.

2. If you become eligible for COBRA Continuation Coverage under the Plan, including subsidized self-pay coverage, you may use your Points Account to pay the COBRA premium.

3. If you become disabled while covered under the Plan, and you qualify for Special Disability Coverage, you may use your Points Account to pay the premium for that form of coverage, or to pay the premium for COBRA Continuation Coverage. If you remain disabled, you may continue to purchase coverage through your Points Account until it is exhausted.

4. If you die, your eligible dependents may use your Points Account to pay their Plan COBRA premium, and may continue to purchase coverage through your Points Account until it is exhausted.

For contributions made to your Points Account starting January 1, 2014 only, your Points Account may not be used to purchase individual health insurance policies.

Your Points Account may be forfeited if you work for a non-union-signatory employer in any capacity, or if you are not covered under this Health and Welfare Plan, for three consecutive calendar years.

You may elect to permanently opt out of, and waive all future reimbursements from, your Points Account annually and upon loss of coverage, in which case your account will be forfeited under Plan rules.

II. SUMMARY OF MEDICAL BENEFITS

The Plan provides coverage for medically necessary hospital, medical, and surgical care, prescription drugs and related services and supplies through Kaiser Permanente Health Plan and Blue Shield, the Plan's designated health maintenance organizations ("HMOs"). However, if you live outside the service area of the Plan HMOs, you will be enrolled in the Blue Shield PPO Plan.

Kaiser and Blue Shield have their own rules for coverage and co-payments. For the complete rules of each provider, see its Evidence of Coverage ("EOC") booklet. A summary of the medical benefits currently provided for active employees and early (non-Medicare eligible) retirees begins on the next page. A summary of the medical benefits currently provided for retirees age 65 and older begins on page 20. The summaries which follow are not intended to supersede the formal EOCs of Kaiser or Blue Shield. If there is any discrepancy between these summaries and the EOCs of Kaiser or Blue Shield, the EOCs govern.

At open enrollment held in June for a July 1 effective date, members will receive summaries of each provider's benefits. A full set of enrollment documents is also available at any time from the Trust Office on request. Read your enrollment packages carefully, because once your enrollment period passes, you may not change your choice of medical benefits provider until the next open enrollment period.

The benefits provided by the Plan's medical benefit providers may change from time to time, at the discretion of the Board of Trustees. You will receive revised schedules of benefits each June at open enrollment, and whenever changes are adopted between open enrollments. Any schedules of benefits that you receive are considered part of this Summary Plan Description.

Once you have enrolled, you and your family will receive only the medical benefits available to members covered through that provider. You are required to make all co-payments, and to comply with all of your HMO's (or PPO's) rules, to remain eligible for benefits through the rest of the enrollment year.

Note re Kaiser coverage: If you enroll in the Kaiser DHMO plan, the Northern California Plasterers Health and Welfare Plan will self-fund up to a maximum of $2,000 per participant, or $4,000 per family, each calendar year to pay for out-of-pocket expenses (including deductible amounts and co-pays). You will be provided with a debit card which can be used at Kaiser facilities for this purpose. Your debit card will be automatically cancelled if used at a non-Kaiser facility.

A. MEDICAL COVERAGE OPTIONS FOR ACTIVE EMPLOYEES AND EARLY RETIREES

1. Kaiser Permanente Deductible Plan (DHMO) - Benefit Summary

The Services described below are covered only if all of the following conditions are satisfied:

- the Services are determined by Kaiser to be Medically Necessary;
- the Services are provided, prescribed, authorized, or directed by a Kaiser Plan Physician and you receive the Services from Kaiser Plan Providers inside Kaiser's Northern California Region Service Area (your Home Region), except where specifically noted to the contrary in the Evidence of Coverage (EOC) for authorized referrals, hospice care, Emergency Care, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services.

Annual Out-of-Pocket Maximum for Certain Services

You will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:

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

Annual Deductible for Most Services

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

For self-only enrollment (a Family of one Member) ..... $2,000 per calendar year
For any one Member within a Family enrollment ..... $2,600 per calendar year
For an entire Family of two or more Members ..... $4,000 per calendar year

Note: The Northern California Plasterers Health & Welfare Plan will self-fund up to a maximum of $2,000 per participant, or $4,000 per family, each calendar year to pay for out-of-pocket expenses (including deductible amounts and co-pays) under this Kaiser plan. You will be provided with a debit card which can be used at Kaiser facilities for this purpose.

Lifetime Maximum ..... None

Professional Services	**You Pay**
Most primary and specialty care consultations, exams and treatment	$30 per visit after Deductible
Routine physical maintenance exams	No charge*
Well-child preventive exams (through age 23 months)	No charge*
Family planning counseling	No charge*
Scheduled prenatal care exams	No charge*
Eye exams for refraction	$30 per visit after Deductible
Hearing exams	No charge*
Urgent care consultations, exams and treatment	$30 per visit after Deductible
Physical, occupational and speech therapy	$30 per visit after Deductible

Kaiser DHMO - Active Employees & Early Retirees (continued)

Outpatient Services	**You Pay**
Outpatient surgery & certain other outpatient procedures	$150 after Deductible
Allergy injection (including allergy serum) per visit	$5 after Deductible
Most immunizations (including the vaccine)	No charge*
Most X-rays and lab tests per encounter	$10 after Deductible
MRIs, most CT, Pet scans per procedure	$50 after Deductible
Health education (covered individual health education counseling and covered health education programs)	No charge
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, lab tests and drugs (per admission)	$250 after Deductible
Emergency Health Coverage	**You Pay**
Emergency department visits (per visit) (After Deductible, charge does not apply if admitted directly to the hospital as an inpatient; see Hospitalization Services)	$100 after Deductible
Ambulance Services	**You Pay**
Ambulance services (per trip)	$100 after Deductible
Prescription Services Covered outpatient items under Kaiser's drug formulary guidelines. (Deductible applies to all drug benefits.)	**You Pay**
Most generic items from a Kaiser pharmacy	$10 for a 30-day supply; $20 for a 31-60-day supply; or $30 for a 61-100-day supply
Most generic refills for Kaiser's mail order service	$10 for a 30-day supply or $20 for a 31-100-day supply
Most brand-name items from a Kaiser pharmacy	$30 for a 30-day supply; $60 for a 31-60-day supply; or $90 for a 61-100-day supply
Most brand name refills from Kaiser's mail order service	$30 for a 30-day supply or $60 for a 31-100-day supply
Specialty drugs	20% coinsurance; prescription up to $150 maximum for 1-30 days
Smoking cessation drugs (prescription only)	No charge*
Durable Medical Equipment (DME)	**You Pay**
Covered DME for home use in accord with Kaiser's DME formulary guidelines	20% coinsurance after Deductible
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization per admission	$250 after Deductible
Individual outpatient mental health evaluation and treatment	$30 per visit after Deductible
Group outpatient mental health treatment	$5 per visit after Deductible
Chemical Dependency Services	**You Pay**
Inpatient detoxification per admission	$250 after Deductible
Individual outpatient chemical dependency evaluation and treatment	$30 per visit after Deductible
Group outpatient chemical dependency treatment	$5 per visit after Deductible

Kaiser DHMO - Active Employees & Early Retirees (continued)

Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge after Deductible
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	No charge after Deductible
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies	No charge after Deductible
Hospice care	No charge after Deductible

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to Kaiser's EOC. Please note that Kaiser provides all benefits required by law (for example, diabetes testing supplies).

* The Deductible does not apply to these Services.

MEDICAL COVERAGE FOR ACTIVE EMPLOYEES AND EARLY RETIREES (continued)

2. Blue Shield of California Access+ HMO - Benefit Summary

The services below are covered as indicated, when authorized through your Primary Care Provider, and when you use a Network Provider.

General Features	You Pay
Calendar Year Deductible	None
Maximum Benefits	Unlimited
Annual Copayment Maximum (2 individual maximum per family.)	$3,500 per individual $7,000 per family
Office Visits - Primary care	$40 office visit copayment
Office Visits - Specialist and non-physician health care practitioner (Written approval required except for OB/GYN and pediatrician serving as primary care physician)	$40 office visit copayment ($50 copayment for Access+ specialist self-referral)
Hospital Benefits	Facility fee: $100 copayment + 40% coinsurance Physician/Surgeon: No charge
Outpatient Surgery	Facility fee: 40% coinsurance Physician/Surgeon: No charge
Emergency Services (Copayment waived if admitted.)	$100 copayment
Urgently Needed Services	$40 copayment
Ambulance	$100 copayment
Preventive Care/Screening/Immunizations	No charge

Other Services	You Pay
Diagnostic Tests & Imaging (Laboratory, pathology, blood work, x-ray, CT/PET scans, MRIs)	No charge
Pregnancy - prenatal and postnatal care	No charge
Pregnancy - delivery and all inpatient services	$100 copayment + 40% coinsurance
Mental/Behavioral Health Services & Substance Use Disorder Services (Routine outpatient services: professional/physician office visits)	$40 copayment
Mental/Behavioral Health Services & Substance Use Disorder Services (Non-routine outpatient services)	40% coinsurance
Mental/Behavioral Health Services & Substance Use Disorder Services (Inpatient/Residential Services)	$100 copayment + 40% coinsurance Physician: No charge
Home health care (Coverage limited to 100 visits)	$40 copayment
Skilled nursing care (Coverage limited to 100 days)	40% coinsurance

Rehabilitation Services	$40 copayment for office visit; 40% coinsurance for outpatient hospital
Habilitation Services	$40 copayment for office visit; 40% coinsurance for outpatient hospital
Durable Medical Equipment	50% coinsurance
Hospice services	No charge

Pharmacy Benefits	**You Pay**
Retail Pharmacy (Up to 30-day supply)	$15 generic $30 formulary brand name
Mail Service Pharmacy (Up to 90-day supply)	$30 generic $60 formulary brand name
Brand Name Non-Formulary Drugs	Not covered
Specialty Drugs	20% coinsurance up to $200 copayment maximum per prescription
Smoking Cessation Drugs (Prescription Only)	No charge. Deductible does not apply.
This is a summary of the most frequently asked-about benefits. This chart does not explain all benefits, coinsurance, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and coinsurance. For a complete explanation, please refer to Blue Shield's EOC.	

Not covered: Acupuncture, Chiropractic Care, Cosmetic Surgery, Long-Term Care, Non-Emergency Care When Traveling Outside the U.S., Private-Duty Nursing (unless enrolled in a participating hospice program), Routine Eye Care (Adult), Routine Foot Care (unless for treatment of diabetes), Weight Loss Programs.

3. Blue Shield PPO - Out-of-Area Only - Benefit Summary

Type of Coverage	Your Cost When You Use a Network Provider	Your Cost When You Use a Non-Network Provider
Annual Deductible		
Individual	$750	$1,500
Family	$1,500	$3,000
Out-of-Pocket Maximum		
Individual	$4,750	$9,500
Family	$9,500	$19,000
Physician's Office Services for Sickness and Injury		
Primary Care Physician	$25 copay	40% coinsurance
Specialist	$25 copay	40% coinsurance
Other Practitioners		
Chiropractic treatment	$25 copayment	50% coinsurance
Acupuncture	$25 copayment	40% coinsurance
Preventive Services		
Preventive care/ Screening/Immunizations	No charge	Not covered
Urgent Care and Emergency Services		
Urgent Care services	$25 copayment	40% coinsurance
Emergency care services	$100 copayment plus 20% coinsurance	$100 copayment plus 20% coinsurance
Ambulance	20% coinsurance	20% coinsurance
Hospital - Inpatient		
Facility fee	$100 copayment plus 20% coinsurance	40% coinsurance
Physician/Surgeon	20% coinsurance	40% coinsurance
Outpatient Surgery		
Facility fee	20% coinsurance	40% coinsurance
Physician/Surgeon	20% coinsurance	40% coinsurance
Tests		
Diagnostic tests (x-ray, blood work)	Lab, pathology, x-ray, imaging & other exams at free standing location: $25 copayment At outpatient hospital: $50 copayment	40% coinsurance
Imaging (CT/PET scans, MRI)	20% coinsurance	40% coinsurance
Prescriptions		
Generic	Retail: $10 copayment Mail Order: $20 copayment	Retail: $10 copayment + 25% coinsurance Mail Order: Not covered
Brand formulary	Retail: $30 copayment Mail Order: $60 copayment	Retail: $30 copayment + 25% coinsurance Mail Order: Not covered
Brand Non-formulary	Retail: $50 copayment Mail Order: $100 copayment	Retail: $50 copayment + 25% coinsurance Mail Order: Not covered
Specialty Drugs	30% coinsurance up to $200 copayment maximum	Not covered
Smoking Cessation Drugs (prescription only)	No charge. Deductible does not apply.	Not covered

Blue Shield PPO – Out-of-Area (continued)

Type of Coverage	Your Cost When You Use a Network Provider	Your Cost When You Use a Non-Network Provider
Pregnancy		
Prenatal and postnatal care	20% coinsurance	40% coinsurance
Delivery and all inpatient services	$100 copayment plus 20% coinsurance	40% coinsurance
Mental/Behavioral Health		
Routine outpatient services: professional/physician office visits	$25 copayment	40% coinsurance
Non-routine outpatient services	20% coinsurance	40% coinsurance
Inpatient/Residential Services	$100 copayment + 20% coinsurance	40% coinsurance
Substance Use Disorder Services		
Routine outpatient services: professional/physician office visits	$25 copayment	40% coinsurance
Non-routine outpatient services	20% coinsurance	40% coinsurance
Inpatient/Residential Services	$100 copayment + 20% coinsurance	40% coinsurance
Other Services		
Home health care (Limited to 100 visits per year)	20% coinsurance	Not covered
Skilled Nursing care (Limited to 100 days)	20% coinsurance	20% coinsurance
Rehabilitation services	$25 copayment for office visit	40% coinsurance for office visit; 40% coinsurance for outpatient hospital
Habilitation services	$25 copayment for office visit	40% coinsurance for office visit; 40% coinsurance for outpatient hospital
Durable medical equipment	20% coinsurance	40% coinsurance
Hospice	No charge	Not covered
This is a summary of the most frequently asked-about benefits. This chart does not explain all benefits, coinsurance, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and coinsurance. For a complete explanation, please refer to Blue Shield's EOC.		

B. MEDICAL COVERAGE OPTIONS FOR AGE 65 AND OLDER RETIREES

1. Kaiser Permanente Senior Advantage (HMO) with Part D - Benefit Summary

The Services described below are covered only if all of the following conditions are satisfied:

- the Services are determined by Kaiser to be Medically Necessary and in accord with Medicare guidelines;
- the Services are provided, prescribed, authorized, or directed by a Kaiser Plan Physician and you receive the Services from Kaiser Plan Providers inside Kaiser's Northern California Region Service Area, except where specifically noted to the contrary in the Evidence of Coverage (EOC).

Annual Out-of-Pocket Maximum for Certain Services

You will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:

For self-only enrollment (a Family of one Member) ..... $1,500 per calendar year
For any one Member in a Family of two or more Members..... $1,500 per calendar year
For an entire Family of two or more Members..... $3,000 per calendar year

Annual Deductible.....None

Lifetime Maximum .....None

Professional Services	**You pay**
Most primary and specialty care consultations, exams and treatment…	$15 per visit
Annual wellness visit and Welcome to Medicare preventive visit…….	No charge
Routine physical exam	No charge
Eye exams for refraction	$15 per visit
Hearing exams.....	$15 per visit
Urgent care consultations, exams and treatment	$15 per visit
Physical, occupational and speech therapy	$15 per visit
Outpatient Services	**You pay**
Outpatient surgery & certain other outpatient procedures.....	$15 per procedure
Allergy injection (including allergy serum) per visit	$3 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays, annual mammograms and lab tests	No charge
Manual manipulation of the spine……	$15 per visit
Hospitalization Services	**You pay**
Room and board, surgery, anesthesia, X-rays, lab tests and drugs ……	$250 per admission

Kaiser Senior Advantage - Medicare-Eligible Retirees (continued)

Emergency Health Coverage	**You pay**
Emergency department visits …… (Charge does not apply if admitted directly to the hospital as an inpatient or within 24 hours for the same condition - see Hospitalization Services for inpatient Cost Sharing).	$50 per visit
Ambulance Services	**You pay**
Ambulance services	No charge
Prescription Services	**You pay**
Covered outpatient items in accord with Kaiser's formulary guidelines: Most generic items ..... Most brand-name items ..... Smoking cessation drugs are covered at the applicable copay.	 $10 for up to a 100-day supply $15 for up to a 100-day supply
Durable Medical Equipment (DME)	**You pay**
Covered DME for home use in accord with Kaiser's DME formulary guidelines.....	No charge
Mental Health Services	**You pay**
Inpatient psychiatric care …… Individual outpatient mental health evaluation and treatment …… Group outpatient mental health treatment	$250 per admission $15 per visit $7 per visit
Chemical Dependency Services	**You pay**
Inpatient detoxification per admission …… Individual outpatient chemical dependency evaluation and treatment… Group outpatient chemical dependency treatment.....	$250 per admission $30 per visit $5 per visit
Home Health Services	**You pay**
Home health care (part-time, intermittent).....	No charge

Other	**You pay**
Eyewear purchased at Kaiser plan medical offices or plan optical sales Offices every 24 months	Amount in excess of $150 allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
External prosthetic devices, orthotic devices, and ostomy and urological supplies	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to Kaiser's EOC. Please note that Kaiser provides all benefits required by law (for example, diabetes testing supplies).

MEDICAL COVERAGE OPTIONS FOR AGE 65 AND OLDER RETIREES (continued)

2. Blue Shield 65 Plus HMO - Benefit Summary

Annual Out-of-Pocket Maximum: $6,700 per calendar year

Medical Benefits (Medicare-Covered)	**Your In-Network Cost**
Doctor Office Visits	
Primary care physician	$10 copay
Specialist	$10 copay
Preventive Care Services Approved by Medicare, including:	
Annual wellness visit	No charge
Prostate cancer screening	No charge
Breast cancer screening	No charge
Immunizations	No charge
Inpatient Care	
Inpatient hospital care	No charge
Skilled nursing facility care (up to 100 days)	No charge
Outpatient Services	
Radiation therapy	No charge
Outpatient surgery and hospital services	No charge
Outpatient rehabilitation services	$10 copay
Lab Services	
Laboratory tests	No charge
X-rays	No charge
Diagnostic radiology services	No charge
Emergency Services	
Ambulance services	No charge
Emergency care (waived if admitted)	$50 copay
Urgently needed care	$10 copay
Other Medicare-Covered Benefits	
Chiropractic services (up to 12 visits per year)	$10 copay
Podiatry services (for Medicare-covered visit)	$10 copay
Eye exam (every 12 months)	$10 copay
Hearing exam (diagnostic)	$10 copay

Blue Shield 65 Plus HMO - Medicare-Eligible Retirees (continued)

Prescription Drugs	**Your Cost**	
	Network Pharmacy (31-day supply)	Mail Order (90-day supply)
Tier 1: Preferred generic	$10 copay	$20 copay
Tier 2: Preferred brand	$20 copay	$40 copay
Tier 3: Non-preferred brand	$35 copay	$70 copay
Tier 4: Injectable	$35 copay	$70 copay
Tier 5: Specialty	$35 copay	$35 copay for 30-day supply
Coverage gap stage (after prescription costs reach $3,750)	The Plan continues to pay its share of the cost of your drugs and you pay your share of the cost.	
Catastrophic coverage stage (after you have paid $5,000 out-of-pocket)	The applicable drug tier copay, or 5% coinsurance, whichever is lower	
This is a summary of the most frequently asked-about benefits. This chart does not explain all benefits, coinsurance, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and coinsurance. For a complete explanation, please refer to Blue Shield's EOC.		

MEDICAL COVERAGE OPTIONS FOR AGE 65 AND OLDER RETIREES (continued)

3. Blue Shield Custom PPO COB 100/50 - Out-of-Area Only - Benefit Summary

Covered Service	Your Cost When Using a Participating Provider	Your Cost When Using a Non-Participating Provider
Deductible	No deductible	Individual coverage: $500 Family coverage: $500 for individual; $1,000 for family
Out-of-Pocket Maximum	Individual coverage: $500 Family coverage: $500 for individual; $1,000 for family	Individual coverage: $2,000 Family coverage: $2,000 for individual; $4,000 for family
Physician services		
Primary care office visit	$0	50%
Specialist care office visit	$0	50%
Physician home visit	$0	50%
Physician or surgeon in outpatient or inpatient facility	$0	50%
Other professional services		
Acupuncture services (up to 20 visits per member per year)	$0	50%
Chiropractic services (up to 12 visits per member per year)	$0	50%
Family planning	$0	Not covered
Podiatric services	$0	50%
Emergency services and urgent care		
Emergency room services	$0	$0
Emergency room physician	$0	$0
Urgent care physician	$0	50%
Ambulance services	$0	$0
Outpatient facility services		
Ambulatory surgery services	$0	50% up to $350/day plus 100% of additional charges
Outpatient department of hospital	$0	50% up to $350/day plus 100% of additional charges
Inpatient facility services		
Hospital services and stay	$0	50% up to $600/day plus 100% of additional charges
Transplant services	$0	Not covered

Diagnostic x-ray, imaging, pathology and laboratory services		
Laboratory services at lab center	$0	50%
Laboratory services at hospital outpatient dept.	$0	50% up to $350/day plus 100% of additional charges
X-ray and imaging services at outpatient radiology center	$0	50%
X-ray and imaging services at hospital outpatient dept.	$0	50% up to $350/day plus 100% of additional charges
Radiological and nuclear imaging services at outpatient radiology center	$0	50%
Radiological and nuclear imaging services at hospital outpatient dept.	$0	50% up to $350/day plus 100% of additional charges
Skilled nursing facility services (up to 100 days per member per benefit period)		
Freestanding skilled nursing facility	$0	$0
Hospital-based skilled nursing facility	$0	50% up to $600/day plus 100% of additional charges
Other services		
Home health services (up to 100 visits per member per year)	$0	Not covered
Hospice program services	$0	Not covered
Diabetes care services	$0	50%
Rehabilitation and habilitative services at office location	$0	50%
Rehabilitation services and habilitative at hospital outpatient dept.	$0	50% up to $350/day plus 100% of additional charges
Durable medical equipment	$0	50%
Orthotic equipment/devices	$0	50%
Prosthetic equipment/devices	$0	50%
Dialysis services	$0	50% up to $350/day plus 100% of additional charges
Allergy serum	$0	50%
Mental health and substance abuse disorder benefits (outpatient)		
Office visit	$0	50%
Other outpatient services	$0	50%
Partial hospitalization	$0	50% up to $350/day plus 100% of additional charges
Psychological testing	$0	50%

Mental health and substance abuse disorder benefits (inpatient)		
Physician inpatient services	$0	50%
Hospital services	$0	50% up to $600/day plus 100% of additional charges
Residential care	$0	50% up to $600/day plus 100% of additional charges
This is a summary of the most frequently asked-about benefits. This chart does not explain all benefits, coinsurance, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and coinsurance. For a complete explanation, please refer to Blue Shield's EOC.		

C. INFORMATION ABOUT CERTAIN BENEFITS

1. 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 hours, 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).

2. 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, provided in a manner determined in consultation with the attending Physician and the patient, for:

(a) all stages of reconstruction of the breast on which the mastectomy was performed; and

(b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(c) prostheses; and

(d) 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.

III. SUMMARY OF DENTAL BENEFITS

The Plan provides coverage for dental care through Premier Access for covered active employees and their Eligible Dependents, and for COBRA participants who elect full coverage.

You have a choice of enrolling in the Premier Access PPO or the Premier Access DHMO. The benefits under each option are summarized below. If you do not elect to enroll in the DHMO option, you will automatically be enrolled in the PPO option.

Participants may elect to opt out of the Plan's dental coverage annually at open enrollment.

Benefit	**Your Cost under the PPO Option**	**Your Cost under the DHMO Option**
Annual Deductible	None	None
Annual Maximum	$1,750	None
Preventive Services	No charge	No charge
Basic Services	15% coinsurance for Premier Choice network; 25% coinsurance in- and out-of-network	Subject to co-pays. See the DHMO Description of Benefits and Copays for details.
Major Services	20% coinsurance for Premier Choice network; 30% coinsurance in- and out-of-network	Subject to co-pays. See the DHMO Description of Benefits and Copays for details.
Orthodontic services for eligible dependent children	50% coinsurance up to $1,500 maximum	Subject to co-pays. See the DHMO Description of Benefits and Copays for details.
TMJ Services	25% coinsurance up to a $2,000 lifetime maximum	Not covered
This is a summary of the most frequently asked-about benefits. This chart does not explain all benefits, copays, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and copays. For a complete explanation, please refer to the Premier Access EOC.		

IV. SUMMARY OF VISION CARE BENEFITS

Vision Care Benefits are provided to covered active employees and their Eligible Dependents, and to COBRA participants who elect full coverage. Vision Care Benefits are provided on a self-funded basis and administered by Vision Service Plan (VSP). VSP has a network of participating providers. Benefits are greater if you visit a VSP network provider. Participants may elect to opt out of the Plan's vision coverage annually at open enrollment.

Benefit	**When Using a VSP Provider**
Exam (1 per year)	$5 co-pay.
Lenses (every 12 months)	No charge, if combined with exam.
Frames (every 24 months)	No charge, up to a $150 allowance ($170 allowance for featured brand frames). 20% savings on the amount over the allowance.
Contact lenses (every 12 months)	No charge for exam up to $60 maximum; no charge for lenses up to $150 allowance.
This is a summary of the most frequently asked-about benefits. This chart does not explain all benefits, copays, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and copays. For a complete explanation, please refer to VSP's EOC.	

V. SUMMARY OF INSURANCE BENEFITS

The Plan provides life insurance and accidental death and dismemberment insurance through Lincoln Life. **The summary and chart below does not explain all benefits, exclusions, or limitations. For a complete explanation, please refer to Lincoln Life's Certificate of Group Insurance**.

LIFE INSURANCE - SCHEDULE OF BENEFITS

EMPLOYEE LIFE INSURANCE

Active employees $10,000
Retired employees $2,000

DEPENDENT LIFE INSURANCE

Spouse or domestic partner of an active employee
(through spouse's or domestic partner's age 70 only) $5,000

Spouse or domestic partner of a retired employee
(through spouse's or domestic partner's age 99 only) $1,000

Dependent child of an active employee, age:

14 days to 6 months $500
6 months to 21 years $5,000
21 years to 25 years, if a full-time student $5,000
21 years & older, if physically or mentally disabled..... $5,000

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE - SCHEDULE OF BENEFITS

Active Employees

Loss	**Common Carrier Accident**	**Other Covered Accident**
Loss of Life	$20,000	$10,000
Loss of One Member (Hand, Foot or Eye)	$10,000	$5,000
Loss of 2 or More Members	$20,000	$10,000

Retirees

Loss	**Common Carrier Accident**	**Other Covered Accident**
Loss of Life	$4,000	$2,000
Loss of One Member (Hand, Foot or Eye)	$2,000	$1,000
Loss of 2 or More Members	$4,000	$2,000

VI. SUMMARY OF SELF-FUNDED BENEFITS

1. Hearing Aid Benefit**.** The Plan pays 80% of the cost of a hearing aid device prescribed for you or your dependent(s) by a qualified professional, up to a maximum amount of $1,200.00. Only one hearing aid device per person is covered, unless proof is provided that devices are medically necessary in both ears. The Plan will cover one hearing aid device per ear every three years.

2. Smoking Cessation Benefit. The Plan will reimburse you and your dependent(s) for the cost of up to three boxes of Nicoderm patches in each calendar year. Proof of payment must be provided to the Trust Office to receive reimbursement.

VII. SUMMARY OF CLAIMS AND APPEALS RULES

The Health and Welfare Plan provides for claims and appeals for all matters under the discretion of the Board of Trustees.

APPEALS TO YOUR HMO OR PLAN PROVIDER
If you are denied benefits by an HMO or plan provider on any grounds under the HMO or provider's sole discretion, such as whether a particular medical treatment is medically necessary, your only appeal is directly to the HMO or provider under the HMO's or provider's own appeal rules, and not to the Plan's Board of Trustees. The Trust Office or your Local Union may be able to assist you with an appeal to an HMO provider, but the final responsibility for such appeals is yours.

GENERAL RULES ABOUT APPEALS TO THE BOARD OF TRUSTEES:

- The Plan's appeals procedures are the only recourse for matters under the discretion of the Board of Trustees.
- For matters under the Board of Trustees' discretion, failure to appeal an adverse action about your Plan benefits is deemed a waiver of all objections to the action.
- The decision of the Board of Trustees on any matter within its discretion is final and binding on all parties affected by the action in question.

Claims and Appeals Procedures for Specific Treatments or Benefits, or for Self-Administered Benefits

These procedures apply to all decisions under the discretion of the Board of Trustees, concerning specific treatments or benefits, based on your eligibility under the Plan.

For example, the Plan's appeal procedures do apply if you are denied preauthorization for a medical treatment, or are denied medical treatment, or you have been sent a bill by a Plan provider, on the grounds that you are ineligible for Plan benefits. If you believe that you were wrongly denied medical, dental, vision or other benefits on eligibility grounds, you may submit a claim for eligibility for benefits by contacting the Trust Office. Your authorized representative or, if the situation is urgent, your doctor, may also contact the Trust Office to submit a claim.

The Plan's claims and appeals procedures also apply if you are requesting a benefit that is administered by the Trust Office.

The Trust Office will notify you of its action on your claim within the following times, unless they notify you that they need more information or more time:

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

You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim. If your claim is denied, you will receive a notice which includes the specific reasons for the denial; the specific Plan provisions on which the denial was based; any internal rule, guideline, protocol or standard applied in making the denial; a description of any additional information or documents needed if you want your claim to be reconsidered; a description of the Plan's appeal procedures; an explanation of your right to file a civil action under ERISA section 502(a) within one year of the denial of your claim; and an explanation of the scientific or clinical judgment which was the basis for the denial of your claim if that adverse benefit determination was based on medical necessity or other similar exclusion or limitation.

If you need a notice or explanation to be provided in a language other than English, contact the Trust Office.

If you disagree with the action of the Trust Office on a claim, you may appeal to the Board of Trustees by sending a letter to the Trust Office, within 180 days of receiving the denial of benefits. Be sure to provide any information or documents that you want the Trustees to consider. The Board of Trustees will conduct an independent review of your appeal. If you file an appeal, you may contact the Trust Office for more information about the procedure for your appeal.

The Trustees will notify you in writing of their decision on your appeal 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 meeting of the Board of Trustees, unless you submit the appeal less than 30 days before the meeting, in which case you will be notified within 5 days after the meeting after the next meeting.

Appeals Procedures Regarding Eligibility and Other Matters

If you disagree with the decision of the Trust Office or other Plan representative on an eligibility determination not related to specific care, or on any other Plan question, the appeal procedure starts when you send a letter of appeal to the Trust Office. When you submit your appeal, you should submit any other information or documents that you want the Trustees to consider. Your appeal

must be submitted within 180 days from when you received notification of the action or decision you are appealing. Otherwise, you will be deemed to have waived all objections to the prior decision. After you submit your appeal, the Trustees will determine whether additional information is needed. For further information about the procedures for your appeal, refer to the Formal Plan Rules or contact the Trust Office.

The Board will decide your appeal at their next regular meeting, unless it is not received in time to have your appeal reviewed. The Trust Office will notify you of the Board's action.

You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your appeal. If your appeal is denied, you will receive a notice which includes the specific reasons for the denial; the specific Plan provisions on which the denial was based; any internal rule, guideline, protocol or standard applied in making the denial; an explanation of your right to file a civil action under ERISA section 502(a) within one year of the denial of your claim; and an explanation of the scientific or clinical judgment which was the basis for the denial if that adverse benefit determination was based on medical necessity or other similar exclusion or limitation.

If you need a notice or explanation to be provided in a language other than English, contact the Trust Office.

Please note that the Board's final action on an appeal is binding on all parties affected by the appeal. No lawsuit may be filed without first exhausting these appeals procedures. Any lawsuit based on the Board of Trustees' denial of benefits must be filed within one year from the date the Board gives you notice of its decision.

For full claims and appeal procedures and rules, see Article VIII of the Formal Plan Rules.

VIII. GENERAL INFORMATION ABOUT THE PLAN

This Plan is the Northern California Plasterers Health and Welfare Plan, a group health plan. The Plan is sponsored and administered by the Board of Trustees of the Northern California Plasterers Health and Welfare Trust Fund. The Plan Year ends on June 30. The federal EIN of the Trust Fund is 94-6251593, and the Plan Number is 501.

The Board of Trustees is assisted in the administration of the Plan by a contract administrator, HS&BA (the "Trust Office"). The mailing address and contact information for the Board of Trustees are as follows:

Northern California Plasterers Health and Welfare Trust Fund
c/o HS&BA
4160 Dublin Blvd., Suite 400
Dublin, CA 94568
Phone: (844) 663-8121

Website: www.plasterersbenefits.com

The Board of Trustees is also assisted in the administration of the Plan by the Local Unions: Operative Plasterers' and Cement Masons' Local Union No. 300 and Plasterers' and Shophands' Local Union No. 66.

The Board of Trustees has 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 ii.

The Board of Trustees consists of four representatives of employees, from the Local Unions, and four representatives of signatory employers. The current members of the Board of Trustees are:

LABOR TRUSTEES	EMPLOYER TRUSTEES
Mr. Emilio Aldana Operative Plasterers' and Cement Masons' Local Union No. 300, Area 429	Ms. Nancy Brinkerhoff Ironwood Commercial Builders, Inc.
Mr. Jeff Crothers Plasterers' Local Union No. 66	Mr. Roger Henley Henley & Company
Mr. Robert Noto Plasterers' Local Union No. 66	Mr. Chet O'Donnell O'Donnell Plastering
Mr. Marshall Vasquez Operative Plasterers' and Cement Masons' Local Union No. 300, Area 224	Mr. James Ruane Patrick J. Ruane, Inc.

The Plan's legal counsel and agent for service of process is:

Patricia A. McCormick, Esq.
Katherine A. McDonough. Esq.
Kraw Law Group
605 Ellis Street, Suite 200
Mountain View, CA 94043
650 314-7800

Legal process may also be served on the Plan or Trust Fund by service on any of the Trustees or at the Trust Office.

The Plan Consultant is:

Jeff Kao
The Segal Company
100 Montgomery Street, Suite 500
San Francisco, CA 94104-8290
(415) 263-8288

The Plan is funded by contributions from employers who are signatory to, or members of an employer association which is signatory to, a collective bargaining agreement with Operative Plasterers' and Cement Masons' Local No. 300 or Plasterers' and Shophands' Local Union No. 66. The Plan is also funded in some cases by monthly payments by participants and dependents. The Plan is maintained pursuant to, and the amount of contributions required of signatory employers is determined by, the collective bargaining agreements. The amount of monthly payments of participants and dependents for whom such payments are required is determined by the Board of Trustees.

A complete list of employers and employee organizations sponsoring the Plan, and copies of any document governing the Plan, including the Trust Agreement, insurance and HMO contracts, and collective bargaining agreements calling for contributions to the Plan, may be obtained by participants and beneficiaries upon written request to the Trust Office, or may be inspected by participants and beneficiaries at the Trust Office, or the Local Unions, during normal business hours. A participant or beneficiary may also request in writing information as to whether a particular employer, employer association, or labor organization is a plan sponsor, and if so, the sponsor's address. There may be a charge for copies of Plan documents.

The Board of Trustees has hired an investment consultant, SEI Investment Management Corporation, to advise the Board with regard to the investment of the Plan's reserve assets.

IX. YOUR RIGHTS UNDER FEDERAL LAW

As a participant in the Northern California Plasterers 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 shall be entitled to:

Receive Information About Your Plan and Benefits

" Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, 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 administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

" Continue health care coverage for yourself, spouse or 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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 medical child support order (QMCSO), you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. 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 administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, which is 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.

X. YOUR RIGHTS UNDER COBRA

The Northern California Plasterers Health and Welfare Plan provides for continuation of coverage for a limited period, for qualified employees, retirees, and dependents, subject to payment of a monthly premium ("COBRA continuation coverage"). Your rights to elect COBRA continuation coverage are briefly summarized below, and appear in the Formal Plan Rules under the Section entitled "COBRA Continuation Coverage." A more complete explanation is also available from the Trust Office on request, and is provided whenever a person receives a COBRA election.

Other Health Coverage Alternatives to COBRA

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the Health Insurance Marketplace. The Marketplace helps people without health coverage find and enroll in a health plan; for California residents see: www.coveredca.com. For non-California residents see your state Health Insurance Marketplace or www.healthcare.gov.

Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that other plan within 30 days of losing coverage under this Plan, even if that other plan generally does not accept late enrollees.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

This section contains important information about your rights to COBRA continuation coverage, which is a temporary extension of health coverage you may elect when you lose your regular coverage under the Northern California Plasterers Health and Welfare Plan ("the Plan") due to a qualifying event. The following pages, along with the COBRA information contained in the Formal Plan Rules, will serve as an initial notice to you regarding your rights under COBRA.

This notice explains, in general:

- what COBRA continuation coverage is;
- what Qualifying Events trigger the eligibility for COBRA continuation coverage;

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

1. What is COBRA Continuation Coverage?

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

After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of a 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 your period of COBRA coverage may or may not be reduced by periods 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:

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

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

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

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- The child stops being eligible for coverage under the Plan as a "dependent child," after reaching the Plan's limiting age for dependents.

3. When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator 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 Administrator within 30 days of the Qualifying Event. The Employer Report Form submitted to the Trust 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 Administrator.

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.

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

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

(a) a divorce or a child's loss of dependent status under the Plan;

(b) occurrence of a second Qualifying Event entitling certain Qualified Beneficiaries to an extension of the COBRA maximum coverage period to up to 36 months (see Section 4, A (b)); and

(c) when a Qualified Beneficiary who is entitled to 18 months of COBRA has been determined by the SSA to be disabled at any time during the first 60 days of COBRA coverage (see Section 4, A (a)).

You must include the following information in your notice to the Plan Administrator:

(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 address provided in Section 6.

4. How is COBRA Coverage Provided?

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

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

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

(a) Disability extension of 18-month period of continuation coverage

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 Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and

must last at least until the end of the 18-month period of continuation coverage.

(b) Second Qualifying Event extension of 18-month period of continuation coverage

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

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

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

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

C. Coordination with Other Coverage

The period of time for which an employee or his/her dependent is eligible for COBRA coverage is not reduced by any period of time in which the employee or his/her dependent was covered under his/her Hour Bank, but will be reduced for any period of coverage provided at less cost than COBRA coverage, including Special Disability Coverage or Unemployment ("Self-Pay") Coverage.

5. Where Can You Get More Information?

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the office 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: 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 Administrator's Contact Information

Northern California Plasterers Health and Welfare Trust Fund
c/o HS&BA
4160 Dublin Blvd., Suite 400
Dublin, CA 94568
(844) 663-8121

Website: www.plasterersbenefits.com

IMPORTANT: Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator 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 Administrator.

Health Coverage Tax Credit (HCTC)

The Trade Act of 2002 created a tax credit (called the Health Coverage Tax Credit or HCTC) for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance including COBRA. While the HCTC expired on January 1, 2014, it was reinstated to be effective for coverage periods through 2019. For more information, visit, www.irs.gov/HCTC.

CalCOBRA Coverage for Medical Benefits Only

In certain circumstances a COBRA Qualified Beneficiary may continue coverage under CalCOBRA after federal COBRA coverage is exhausted. You are not eligible for CalCOBRA if you have Medicare, you have or get coverage under another group health plan, or you are eligible for or covered under federal COBRA. If you are entitled to elect CalCOBRA coverage, you will be notified by the insurance company. You can add eligible family members to your CalCOBRA. You may have to pay the whole cost of the CalCOBRA coverage you elect. For more information on CalCOBRA, contact your medical insurance company.

APPENDIX 1
FORMAL PLAN RULES
(As revised through September 1, 2018)

I. ELIGIBILITY RULES FOR BARGAINING UNIT EMPLOYEES

A. Who May Participate in the Plan?

All active employees employed by Individual Employers under Collective Bargaining Agreements with Operative Plasterers' and Cement Masons' Local No. 300 or Plasterers' Local Union No. 66 requiring contributions to the Northern California Plasterers Health and Welfare Trust Fund ("Trust Fund") shall be eligible for coverage for themselves and their dependents in accordance with these Rules.

B. Crediting of Hours.

1. Eligibility for employees working in covered employment, or for the Local Union or a related entity, is determined by the employee's reserve of hours or "Hour Bank" credits. An employee receives one Hour Bank credit for each hour of covered employment. Provided that an employee's hours are properly reported and paid in a timely manner by his or her employer, credits are available for coverage on the first day of the third month following each month in which the employee worked in covered employment. Failure of an employer to report hours in a timely manner and pay the required contributions may result in lapses in an employee's eligibility under the Hour Bank, except as set forth in Article I, Section J.

2. Hours of covered employment under a reciprocal agreement are recognized upon receipt of contributions from the work trust fund, and will be credited in the same proportion that the hourly contribution rate reciprocated from the work trust fund is to the lower of the hourly contribution rates then in effect under the participating Local Unions' collective bargaining agreements.

C. Initial Eligibility.

An employee who has not previously been eligible for coverage will become eligible for initial coverage on the first day of the third month following the month in which he or she has completed a minimum of 210 hours of work for one or more Individual Employers, within a period of 12 months. The first 105 hours worked in establishing initial eligibility shall not be included in the employee's reserve of hours.

D. Initial Coverage for Newly Organized Employees.

1. A new employee who becomes enrolled in the Plan as a result of organizing by a participating Local Union shall be granted an "advance" of Hour Bank credit equivalent to 210 hours of covered employment. This Hour Bank advance will be effective for coverage in the month after the Trust Office is notified by the Union that the employee has been working for an employer signed to a collective bargaining agreement as part of an organizing drive. In all other regards, the employee's "advance" Hour Bank will be subject to the same rules as a regular Hour Bank.

2. Notwithstanding any other provision of this Plan, such employee's entire Hour Bank shall be revoked immediately if the employee ceases to work in, or be available for, covered employment within 8 months of enrollment in the Plan. The employee shall not thereafter be eligible for any form of coverage other than COBRA, unless he or she has again met the conditions for Initial Eligibility.

E. Continuation of Eligibility.

In order to continue coverage once it has become effective, an employee must work a minimum of 105 hours per month. If an employee performs more than 105 hours of covered employment in any month, any excess hours are retained in his or her Hour Bank, and will be used to continue coverage during any month or months in which he or she works less than 105 hours. An employee may accumulate a maximum of 420 hours in his or her Hour Bank, following the deduction for each month's coverage.

F. Termination of Eligibility.

1. Termination When Hour Bank Falls Below Minimum. For employees working under the jurisdiction of a participating Local Union, coverage will terminate as of the end of the month following the month in which his or her total credited hours, including the Hour Bank, is less than 105.

2. Termination of Hour Bank for Misconduct. The Hour Bank of any covered employee will be canceled if he or she does any of the following:

(a) accepts employment in any capacity and of any duration from any contractor in the Plastering Industry who is not signatory to the collective bargaining agreement of a participating Local Union;

(b) engages in the Plastering Industry as a sole proprietor or owner-operator without being signatory to the collective bargaining agreement of a participating Local Union;

(c) continues to work for an employer that has been delinquent in paying contributions owed to this Trust Fund, when his or her Local Union has notified the employee to cease working for the delinquent employer; or

(d) knowingly complies with his or her employer paying less than the full hourly contract rate of contribution for every hour worked by him or her.

The employee and his or her dependents shall not be eligible again for coverage under the Plan until the misconduct has ended and the employee has requalified under the requirements for Initial Eligibility in Article I, Section C, counting only covered employment performed after the misconduct ended.

3. Rescission. After an employee is covered under the Plan, his or her coverage will not be rescinded, unless he or she has performed an act, practice or omission that constitutes fraud, or unless he or she makes an intentional misrepresentation of material fact. For purposes of this section, a rescission is a retroactive cancellation or discontinuance of coverage, other than for a failure to timely pay required premiums or contributions toward the cost of coverage.

G. Reinstatement of Eligibility.

1. If an employee's coverage terminates on the grounds of the run-out of his or her Hour Bank, his or her coverage will be reinstated as of the first day of the third month following the month in which he or she has been credited with 105 hours within 12 months after the termination of coverage.

2. If an employee fails to be credited with 105 hours of covered employment in the 12 months following the termination of coverage, he or she shall only be eligible for coverage upon again satisfying the requirements for Initial Eligibility in Article I, Section C.

H. Special Continuation of Eligibility During Period of Total Disability.

1. (a) If, after qualifying for coverage, an employee becomes disabled by sickness or accident and is unable to perform work covered by the applicable Collective Bargaining Agreement or any other work requiring similar physical capacities, he or she will be entitled to nine (9) months of coverage at no cost. Such coverage will consist of medical, dental, vision and hearing aid benefits. Thereafter, an employee may continue coverage using his or her reserve hours until they have been exhausted, and thereafter for twenty (20) months by paying the applicable COBRA contribution rate.

(b) In order to qualify for coverage under Paragraph 1(a), an employee must meet both of the following requirements:

(1) he or she must have been continuously covered as a participant under this Plan for 36 months immediately prior to his or her disability; and

(2) he or she must have been covered through the Hour Bank for a minimum of 6 months since his or her last 9 months of coverage under Paragraph 1(a).

2. If, after qualifying for coverage, and being continuously covered under the Plan for fifteen (15) years immediately prior to his or her disability, an employee becomes disabled by sickness or accident and is unable to perform work covered by the applicable Collective Bargaining Agreement or any other work requiring similar physical capabilities, he or she will be entitled to six (6) months of COBRA coverage, by paying a monthly premium at a rate set by the Board of Trustees. Such coverage will consist of medical, dental, vision and hearing aid benefits, and is in addition to the initial nine (9) months of subsidized coverage provided under Paragraph 1 above and/or any coverage based on his or her reserve hours. Thereafter, an employee may continue coverage for fourteen (14) months by paying the applicable COBRA contribution rate.

3. For purposes of this section, "disabled" and "disability" means that the employee is physically unable to perform work in the Plastering Industry or in any other job which requires a level of physical capacity which is similar to that required for work as a plasterer. To qualify for disability coverage under this section, an employee must apply to the Board of Trustees and submit proof of disability. Proof of disability may include a Social Security Disability Award, medical records, doctors' opinions and/or such other proof as the Board of Trustees may deem appropriate. Proof of continued disability must be submitted to the Board of Trustees at the end of each six (6) month period of disability coverage in order to receive further coverage.

4. When the twenty-nine (29) month period of disability coverage under Paragraphs 1 or 2 above ends, an employee who remains disabled and is receiving pension benefits from the Northern California Plastering Industry Pension Trust Fund may apply to the Board of Trustees to extend his or her coverage for twelve (12) months at the applicable COBRA contribution rate. At the end of each such twelve (12) month period, a qualifying employee may petition the Board of Trustees to extend his or her coverage for another twelve (12) months. Coverage provided by the Plan after the twenty-nine (29) months of extended coverage ends is exclusive of any benefits provided by Medicare and will be provided only so long as the Board of Trustees can afford to provide such extended coverage.

5. Notwithstanding any other provision in this section, coverage under this section will terminate when:

(a) the employee is no longer disabled; or

(b) the employee does not make a required monthly payment on or before the 20th of the month.

I. Special Continuation of Eligibility During Unemployment.

If an employee loses coverage due to termination of employment, and remains on a participating Local Union's out-of-work list and is available for dispatch, he or she may elect continuation core coverage (medical coverage only) and pay a subsidized contribution rate for up to 6 months of continuation coverage in any 12-month period. The subsidized contribution rate may be changed from time to time by the Board of Trustees. An employee who is eligible for and elects this coverage will continue to be eligible to receive and pay for additional months of core coverage at the full COBRA rate, such that his or her total months of subsidized coverage and COBRA coverage equals eighteen (18).

J. Crediting of Hours and Subsidized Coverage for Employees of a Delinquent Employer.

1. The Plan will credit hours worked for a delinquent employer up to a maximum of three consecutive months, or until the employee has been advised to cease working for the delinquent employer and return to the Hiring Hall for dispatch, whichever is earlier. Thereafter, if the employee continues to work for a delinquent employer, his or her Hour Bank will be canceled.

2. If an employee loses coverage due to his or her employer's failure to pay fringe benefits and has exhausted the three (3) months of coverage described in Paragraph 1 above, he or she may elect continuation core coverage (medical coverage only) and pay a subsidized contribution rate for the first four (4) months of continuation coverage. The subsidized contribution rate for this coverage may be changed from time to time by the Board of Trustees. If the employer has not submitted reports of contributions for the months for which fringe benefits were not paid, the employee must provide check stubs or other evidence that he or she worked for the employer for the sufficient number of hours to qualify for each month's coverage. After the initial four months of coverage expire, the employee may pay for additional months of core coverage at the full COBRA rate such that the total months of subsidized coverage and COBRA coverage equals eighteen (18). Eligibility for coverage under this section will be revoked immediately if an employee continues to work for a delinquent employer after being sent a notice to cease working for that employer. If the delinquent fringe benefit amounts are later paid by the employer, the employee will be reimbursed for the amounts he or she paid for coverage under this section.

K. Coverage under the Family & Medical Leave Act (FMLA).

1. If an employee works a qualifying number of hours for an employer who employs at least fifty employees, he or she may be eligible for FMLA leave for the following reasons: the birth or placement of a son or daughter for adoption or foster care; to care for his or her spouse, son, daughter or parent who has a serious health condition; because of his or her own serious health condition; because of a qualifying exigency arising from the fact that his or her spouse, son, daughter, or parent is on active duty (or been notified of an impending call or order to active duty) in the United States Armed Forces in support of a contingency operation; or if he or she is the spouse, son, daughter, parent or next of kin of a member of the United States Armed Forces, including the National Guard or Reserves, 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. Information about each employee's eligibility for FMLA leave is available from his or her employer.

2. If the employee qualifies for and takes an FMLA qualifying leave, the employee's medical benefits will be continued by the Plan. The employer is legally obligated to make the required contribution for the employee's coverage during an FMLA qualifying leave. The required contribution amount will be established under rules determined by the Board of Trustees. An employee's Hour Bank will not be used to provide coverage until the qualified FMLA leave ends.

L. Coverage Rules While in Military Service.

1. If a covered employee enters full-time military service, his or her eligibility for coverage is terminated immediately. If the military service is in the Armed Forces of the United States, and the employee gives notice to the Trust Office of his or her entry into military service, the employee's Hour Bank will be automatically preserved until his or her return to covered employment after termination of that military service, provided that the return to covered employment is within the applicable time period provided in the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). An employee whose coverage is terminated under this rule may purchase coverage for his or her dependents for a maximum of 24 months of Continuation Coverage under the rules included in the section regarding COBRA coverage, which satisfies USERRA.

2. However, an employee may elect to waive his or her rights under USERRA. In that case, the employee's Hour Bank will be applied to provide coverage for his or her dependents at the applicable rate for active employees. The Hour Bank credits so applied shall no longer be available to provide coverage upon the employee's return to covered employment. When the Hour Bank credits

so applied are exhausted, the employee may purchase coverage for his or her dependents for a maximum of 24 months of COBRA Continuation Coverage under the rules included in the section regarding COBRA coverage. If the employee returns to work for a contributing employer within the applicable time period provided under USERRA, the Plan will waive the minimum Hour Bank credits required for eligibility for coverage in the month that the employee returns to covered employment and the month following the month when the employee returns to covered employment. Thereafter, the current monthly deduction for continuing eligibility will be applied to the employee's Hour Bank credits.

II. DEPENDENT ELIGIBILITY

A. Eligible dependents.

"Eligible dependents" of an employee include:

1. his or her lawful spouse.

2. each child, as defined in Paragraph C below, up until the end of the calendar month that he/she attains the age of 26.

3. each grandchild, as defined in Paragraph C below, until his or her 19th birthday, or until age 23 while he or she remains a full-time student at a school or college, is unmarried, and is dependent on the employee for support and maintenance. If a covered grandchild takes a "medically necessary leave of absence" from a postsecondary educational institution, he or she will continue to be covered until the earlier of: 1) one year from the date the leave of absence began; or 2) when his or her coverage would otherwise end under the terms of the Plan (currently at his or her 23rd birthday). In order for a dependent grandchild to qualify for this continuation of coverage, his or her treating physician must certify in writing that the leave of absence is medically necessary. "Medically necessary leave of absence" shall have the meaning defined in 29 U.S.C. §1185(c)(a).

4. domestic partners as defined in Paragraph D below, and children of such domestic partner, if entirely supported by the employee, but only for coverage under the insured benefit plans, which are the Plan's HMOs and PPO (currently Kaiser Foundation Health Plan and Blue Shield of California), the DHMO dental benefit, and life insurance. Such domestic partners and children of domestic partners are not eligible dependents for coverage under any of the Plan's self-funded benefits (currently vision, the PPO dental benefit, and hearing aid), nor are they eligible for COBRA.

5. each disabled child, whose coverage would terminate solely due to reaching his or her 26th birthday, will continue to be covered if he or she is, and

continues to be, incapable of self-sustaining employment due to mental or physical disability, and chiefly dependent on the employee for support and maintenance, but only for coverage under the insured benefit plans, which are the Plan's HMOs and PPO (currently Kaiser Foundation Health Plan and Blue Shield of California), the DHMO dental benefit, and life insurance. For a disabled child to be eligible for this extension, written proof of incapacity satisfactory to the Board of Trustees must be submitted to the Trust Office within thirty-one (31) days of the date that the dependent's coverage would otherwise terminate. Proof of ongoing incapacity may also be required by the Board of Trustees in order to maintain such coverage, at the Board's discretion.

B. Enrollment of, and Effective Date for Coverage of, Dependents.

1. An employee's dependents become eligible for coverage on the same day as the employee, provided that the employee included them on the enrollment form. If an employee acquires an eligible dependent after the employee's coverage is effective, immediate coverage of the dependent is assured only if the employee requests enrollment for that dependent within 30 days of the dependent's birth, marriage to the employee, or other occurrence making the person an eligible dependent under the Plan. Coverage of a newborn is effective retroactive to birth if enrollment is requested within 30 days after the date of birth; the spouse of the employee, if not previously enrolled, may also enroll at that time. If enrollment of a new dependent is not requested within 30 days of acquiring that dependent, medical coverage of the dependent commences the first day of the month following submission of an enrollment form, contingent on the chosen medical benefits provider's acceptance of the dependent. If a medical benefits provider declines to accept a late-enrolled dependent, the dependent's coverage will be effective following the next open enrollment.

2. Special Enrollment Rules: If an employee fails to enroll his or her eligible dependent because they have health coverage elsewhere, and coverage under that other plan ends, the eligible dependent may enroll in this Plan. Enrollment for such dependent must be requested within 30 days of loss of coverage under the other plan. If an employee's dependent becomes eligible or loses eligibility for a premium assistance program under Medicaid or a State Children's Health Insurance Program, enrollment for that dependent must be requested within 60 days of such event, or else must wait until the next open enrollment.

3. An employee may be required to submit supporting documents, such as a Marriage Certificate, Declaration of Domestic Partnership, or Birth Certificate, for all claimed dependents.

C. Child Defined.

"Child" means a son or daughter, stepchild, adopted child and foster child of the employee. "Child" also includes a minor child placed with the employee for the purpose of legal adoption for whom the employee has assumed and retained a legal obligation to provide total or partial support in anticipation of adopting that child, irrespective of whether the adoption becomes final. "Grandchild" means any dependent grandchild for whom the employee has assumed sole custody and liability for maintenance and support, subject to the approval of the Board of Trustees.

D. Domestic Partner Defined.

1. The Plan covers domestic partners as set forth under section 297 of the California Family Code. Such domestic partners are two adults who have established a domestic partnership in California by filing a Declaration of Domestic Partnership with the Secretary of the State. At the time of the filing, all of the following requirements must be met:

(a) Both persons have a common residence;

(b) Neither person is married to someone else or is a member of another domestic partnership;

(c) The two persons are not related by blood in a way that would prevent them from being married to each other in this state;

(d) Both persons are at least 18 years of age;

(e) Both persons are capable of consenting to the domestic partnership; and

(f) Either of the following must be true:

(1) both persons are members of the same sex, or

(2) both persons are of the opposite sex, if at least one of the persons is over the age of 62 and qualifies for certain Medicare or Social Security entitlement.

2. As part of this coverage, this Plan pays the incidental federal employment payroll taxes, in accordance with governing IRS and U.S. Department of Labor rulings.

E. Dual Coverage.

If a person has dual coverage under this Plan both as an employee and a dependent, the maximum amount payable may not exceed 100% of the actual allowable benefits.

F. Termination of Dependent's Coverage.

A dependent's coverage will terminate at the earliest of:

1. termination of the employee's coverage;

2. termination of the Plan or modification of the Plan to terminate dependent's benefits;

3. when the person ceases to qualify as an "eligible dependent;"

4. the end of the period for which contributions have been made; or

5. the employee's death.

G. Qualified Medical Child Support Orders.

The Plan will comply with any Medical Child Support Order ("MCSO") or National Medical Support Notice with which it is properly served and which is a Qualified Medical Child Support Order ("QMCSO") or National Medical Support Notice under applicable federal law. Upon service with an MCSO, the Trust Office will review the MCSO under procedures adopted by the Board of Trustees, and determine within a reasonable time whether or not the MCSO is a QMCSO. The determination that an MCSO is not a QMCSO is subject to the Appeals Procedure provided elsewhere in this Plan.

III. RETIREE ELIGIBILITY

A. The only benefits which shall be provided to retirees or their eligible dependents under this Plan, except under COBRA, are the medical benefits provided by the Plan's health maintenance organizations (HMOs), medical benefits provided by the Plan's preferred provider organizations (PPOs), the reduced life insurance provided under the Plan, and the hearing aid benefit provided by the Plan. Effective January 1, 1995, a Medicare-eligible retiree or his/her dependents may elect to receive benefits through the Medicare-risk program of the HMO in which he/she is enrolled.

B. No employee retiring on or after January 1, 2013, shall be eligible for benefits under this Plan, except under COBRA, unless he or she satisfies Paragraph 1 below and satisfies either Paragraph 2 (a), (b) or (c) below:

1. He or she is retired from Industry Service and is currently receiving a pension from the Northern California Plastering Industry Pension Plan; and

2. either:

(a) he or she was covered as an active employee, and/or maintained availability for employment by continuous registration on the out-of-work list of a participating Local Union, and/or was covered under the disability coverage rules of Article I, Section H, for 24 of the 36 months immediately preceding application for retiree benefits under this Plan, and for 7 of the 10 years immediately preceding application for retiree benefits under this Plan; or

(b) he or she was covered as an Individual Employer or as a non-bargaining unit employee under this Plan for twelve (12) months immediately preceding his or her retirement and remained continuously covered under this Plan for five (5) continuous years immediately preceding his or her retirement; or

(c) he or she was covered under the Retiree Eligibility Rules of this Plan and/or the Plastering Industry Welfare Plan as of December 31, 2012.

C. 1. COBRA coverage for retirees: Employees retiring on or after January 1, 1988, shall have the right upon the run-out of their Hour Bank, if any, to extend coverage for medical, dental, and vision under COBRA for eighteen (18) months in addition to any other extension hereinbefore provided, by making monthly payments at 102% of premium cost. The Trust Office shall have the duty to notify said retired employees when the right becomes available. The retired employees shall then have sixty (60) days from date of receipt of notice to notify the Trust Office of their exercise of the right, but must commence the monthly self-payments on or before the 20th day of the next month and each month thereafter, failing which the right to extend coverage shall be lost for the remainder of the eighteen (18) months. Retired employees desiring coverage for the months prior to receipt of the notice must make payment for those months within forty-five (45) days of receipt of said notice. Election of COBRA coverage pursuant to this Paragraph 1 constitutes a waiver of the right to retiree coverage described in Paragraph 2 below. If the retired employee elects COBRA coverage at 102% of the premium cost under this Paragraph 1, his or her coverage shall terminate at the end of the eighteen (18) months and he or she shall not then be eligible to receive any further benefits from the Plan.

2. Plan retiree coverage: Employees who retire may waive their COBRA rights described in Paragraph 1 above, and may instead opt to receive core medical coverage, reduced life insurance and the hearing aid benefit only, by making monthly payments in such amounts as the Board of Trustees shall from time to time fix for the cost of their coverage.

D. No retired employee who is eligible for Medicare, although otherwise meeting the requirements of these rules, shall be eligible for coverage under this Plan unless at all times he or she is covered under both Part A and Part B of Medicare.

E. No retired employee, although otherwise meeting the requirements of these rules, shall be eligible for coverage under this Plan while covered or entitled to be covered under any other group welfare plan, except as required under COBRA and the regulations issued thereunder.

F. Coverage of eligible dependents of a retired employee shall commence upon qualification of the retired employee and shall continue as long as the retiree is eligible for benefits. Surviving spouses and surviving eligible dependents of deceased retired employees may elect, at the time of the retiree's death, to obtain survivor coverage from the Plan for each month he or she pays the contribution in the amount and at the time and place established by the Board of Trustees for such coverage.

G. The eligibility for benefits of a retired employee and his or her dependents shall be suspended during any period of time the employee has suffered a suspension of benefits under the Northern California Plastering Industry Pension Plan, by reason of the employee's return to covered employment in the Plastering Industry.

H. The eligibility of any retired employee and his or her dependents who accepts employment of any duration from any employer in the Plastering Industry who is not party to a Collective Bargaining Agreement with any participating Local Union shall be terminated forthwith and may not again be restored under any circumstances.

I. The coverage of a dependent of a retired employee shall terminate when he or she is no longer an "eligible dependent" as defined under Article II, Section A. Retired employees are required to inform the Trust Office when a dependent is no longer an eligible dependent under the Plan.

J. No retired employee or his or her dependents shall become eligible for coverage unless and until the retired employee has filed an application for eligibility upon a form supplied by the Trust Office and such application has been approved by the Board of Trustees. Once the application has been approved, coverage will be retroactive to the date upon which the retired employee and dependents first became eligible under Plan rules.

K. Effective for retirees whose applications are received prior to July 1, 2014, for each eligible retiree age 60 or older, or disabled with a Social Security Disability Award and covered under both Part A and Part B of Medicare, the Plan shall pay

a portion of the premium paid by the Plan for that retiree and any covered dependent in an amount to be determined by the Board of Trustees, and that retiree shall pay the balance, if any, of the premium paid by the Plan. The amount charged the retirees, the age at which retirees are subsidized, and/or whether any subsidy is provided at all, may change from time to time at the discretion of the Board of Trustees and the retirees will be notified of any such change. In order to be eligible for this retiree subsidy, a retiree must remain a member in good standing of one of the participating Local Unions. The monthly payment must be received by the Trust Office by no later than the 20th day of the month prior to the coverage month. Each monthly payment must be received on time in order for coverage to continue.

L. The benefits herein provided for retirees and their dependents depend upon the financial condition of the Fund, and cannot be guaranteed for any period in excess of one (1) year, but may at any time be altered, amended, reduced or eliminated in their entirety, or conditioned upon self-payments in such amounts and at such times as the Board of Trustees, in its sole discretion, may determine.

IV. ELIGIBILITY RULES FOR INDIVIDUAL EMPLOYERS AND NON-BARGAINING UNIT EMPLOYEES

A. Who is Eligible?

1. An employer, including sole proprietors, members of unincorporated firms and managerial officers of corporate employers, who or which is signatory to a Collective Bargaining Agreement with a Local Union requiring contributions on behalf of his/her bargaining unit employees, may obtain flat-rate coverage for himself/herself and his/her eligible dependents by making application in writing to the Trust Office. Except as provided in Paragraph 3 below, such application must be made within ninety (90) days of the execution of the Agreement. Coverage shall be available only to such employers who work primarily within the geographic area covered by this Plan. Coverage shall not be available to any employer who is in any way, directly or indirectly, associated with any individual or entity who is performing plastering work and is not party to a Collective Bargaining Agreement with a participating Plasterers Local Union.

2. An eligible employer may also obtain coverage for his/her office clerical and/or non-bargaining unit employees (who work at least twenty (20) hours per week and are not covered by any other plan) and their eligible dependents, by making application in writing to the Trust Office. Except as provided in Paragraph 3 below, such application must be made within ninety (90) days of the date of execution of the Collective Bargaining Agreement or, in the case of new employees, date of hire, whichever is later.

3. An employer may defer an application for coverage, or may temporarily discontinue coverage, under these rules for himself or herself or for any eligible employee if that person has other group health coverage. A person whose coverage is deferred or discontinued may enroll thereafter only within thirty (30) days of termination of such other group health coverage, or at open enrollment.

B. Commencement of Flat Rate Coverage.

In order to obtain coverage for an individual under this rule, the employer must pre-pay four (4) months of premiums at the applicable flat rate for that individual. Coverage shall become effective on the first day of the second month following pre-payment of the required flat rate, and once coverage is obtained, it shall remain in effect during the ensuing period of employment and for a period of three (3) months from and after date of termination, subject to the other provisions of this Plan concerning flat-rate coverage for individual employers and office clerical and non-bargaining unit employees.

C. Termination of Coverage.

1. Coverage of an employer shall terminate immediately upon the earliest of the following:

(a) the failure of the employer to make the monthly contributions for his/her bargaining unit employees as required by his/her Collective Bargaining Agreement(s);

(b) the failure of the employer to remit the monthly flat rate promptly and in full on or before the 20th day of the month prior to the month for which coverage is being paid;

(c) the failure of the employer to employ any Participant plasterers for ninety (90) days;

(d) when the employer no longer works primarily within the geographic area covered by this Plan; or

(e) when an employer, in any way, directly or indirectly becomes associated with any individual or entity who is performing plastering work and is not party to a Collective Bargaining Agreement with a participating Plasterers Local Union.

2. Coverage of any office clerical or non-bargaining unit employees shall terminate when their employer is no longer eligible for coverage under this Plan.

3. After termination, coverage may not be reinstated, except upon full payment of all contributions and monthly flat rates, satisfaction of all eligibility rules, and approval of the Board of Trustees.

D. Retiree Coverage.

Any employer who has been continuously covered under this Plan for a period of at least five (5) years without default in payment of the monthly flat rates, may continue to maintain coverage for himself or herself and his/her eligible dependents, if any, on or after attainment of age 60, or date of cessation of business as an active employer, whichever is later, by making application in writing to the Trust Office within thirty (30) days thereafter and making payment of such monthly flat rate as shall be fixed by the Board of Trustees commencing with the application and continuing each month to make such payment thereafter. The flat rate shall take into account eligibility for Medicare and shall be adjusted accordingly if the dependent spouse is ineligible.

E. COBRA.

An individual who is eligible for benefits as an employer under this Plan shall qualify to continue coverage under the COBRA termination of employment rules only if the termination is caused by the complete cessation of the operation of the employer's business or the individual's complete separation from the business.

V. ENROLLMENT REQUIREMENTS AND MEDICAL BENEFITS

1. Enrollment Requirements.

Notwithstanding any other provision of these rules, no person shall be eligible for medical benefits until he or she has been properly enrolled in writing in one of the medical plan options then available for his or her class of participant. For new participants, this means completing an enrollment package for the medical plan option he or she has elected. For dependents, this means being enrolled by the participant when the participant enrolls, or for new dependents, being enrolled within 30 days of birth, marriage, or other event causing that person to become an eligible dependent under the terms of this Plan. If a participant fails to complete an enrollment package in a timely fashion, then his or her eligibility for medical benefits for himself or herself, and/or for his or her dependents, shall be at the discretion of the provider of the medical plan he or she has selected, pending the next open enrollment. Changes of medical plan option shall be made only at open enrollment elections at such time, and in such manner, as are approved by the Board of Trustees.

2. Medical Benefit Options. Medical benefits are currently provided by the following three medical benefit providers:

(a) Kaiser HMO: For all active and retired employees and their eligible dependents residing in the service area of the Kaiser HMO, who elect such coverage. The Northern California Plasterers Health and Welfare Plan will reimburse active employees for out-of-pocket expenses up to a maximum of $2,000 per participant, or $4,000 per family, during each calendar year.

(b) Blue Shield Access+ HMO Plan: For all active and retired employees and their eligible dependents residing in the service area of the Blue Shield Access+ HMO, who elect such coverage.

(c) Blue Shield PPO Plan: For all active and retired employees and their eligible dependents who do not reside in the geographic area covered by Kaiser and/or the Blue Shield Access+ HMO.

3. Other Benefits.

(a) Dental Benefits. For all active employees and their eligible dependents, and for COBRA participants who elect full coverage. Dental benefits are provided by Premier Access. Participants shall have the opportunity to opt out of the Plan's dental coverage on behalf of themselves and their eligible dependents, on an annual basis.

(b) Vision Benefits. For all active employees and their eligible dependents, and for COBRA participants who elect full coverage. Vision benefits are self-funded by the Northern California Plasterers Health and Welfare Plan and administered by Vision Service Plan (VSP). Participants shall have the opportunity to opt out of the Plan's vision coverage on behalf of themselves and their eligible dependents, on an annual basis.

(c) Hearing Aid Benefits. For all employees and their eligible dependents. Hearing Aid benefits are self-funded by the Northern California Plasterers Health and Welfare Plan and administered by the Trust Office.

(d) Smoking Cessation Benefit. For all employees and their eligible dependents. Smoking cessation benefits are self-funded by the Northern California Plasterers Health and Welfare Plan and administered by the Trust Office.

(e) Life Insurance and Accidental Death and Dismemberment Benefits. For all active employees and their eligible dependents, and retirees and their eligible dependents up to the limiting age. Life insurance and accidental death and dismemberment benefits are currently provided through The Lincoln Financial Group.

4. Losses Not Covered by the Plan. No benefits are payable for losses resulting from:

(a) Injury or disease covered by workers' compensation insurance, the Federal Employers Liability Act, or any other state or federal law, whether or not the claim is processed through the agency responsible for administering the same.

(b) Confinement or treatment not recommended and approved by a physician or other licensed practitioner.

(c) Care, treatment, services or supplies which are paid for or reimbursed by or through a government or instrumentality of a nation, province, state, county, municipality or other political subdivision, except as provided in the section of the Plan entitled "Rights of States."

(d) An act of war or injury sustained or sickness contracted while in the service of any military, naval or air force of any country, where such country is engaged in a war, whether declared or not, or while performing police duty as a member of any military, naval or air organization.

VI. POINTS ACCOUNTS

A. Establishment of Points Accounts.

1. Each active employee working under a collective bargaining agreement that provides for Points Account contributions will receive points-denominated credits for each hour of covered employment, in an amount provided for by the relevant collective bargaining agreement. These points credits will be in addition to the hours credited to each active employee for the purposes of determining current coverage and accruing a reserve Hour Bank. Points credits will accrue in a "Points Account," and can be used for any of the purposes allowed under the Plan rules stated below.

2. Points Accounts that have a year-end balance will be credited with an amount reflecting the actual net rate of return of all the Plan's Points Accounts for the Plan year minus operating expenses, applied to the average balance of each Points Account for the year. In addition, each Points Account may be credited with a bonus amount from time to time, subject to the Board of Trustees' sole discretion, in an amount to be determined by the Board of Trustees.

3. An employee or retiree may permanently opt out of and waive all future reimbursements from his or her Points Account annually and upon loss of eligibility for coverage. The account balance of any employee or retiree who

elects to permanently opt out of and waive all future reimbursements from his or her Points Account will be forfeited in accordance with the section entitled "Forfeiture of Points Accounts" below.

B. Use of Points Accounts.

1. Retiree Welfare Premiums. Points Accounts are intended primarily to be used to pay retiree premiums under this Plan. Once an employee has retired and is receiving a pension benefit from the Northern California Plastering Industry Pension Plan, the points credits accrued in his or her Points Account may be used to pay the monthly charge set by the Board of Trustees for retiree coverage for employees and eligible dependents of retired employees, if all the other conditions for coverage have been met.

2. COBRA Coverage. Points Accounts may be used to pay for COBRA coverage under the Plan, including subsidized Unemployment ("Self-Pay") Coverage.

In addition, if the employee dies, or the employee becomes disabled from the trade as defined under the rules for Special Disability Coverage, Points Accounts may be used as follows, when all other coverage is exhausted:

(a) If the employee and/or his or her surviving eligible dependents are eligible to elect COBRA continuation coverage, and do so, the employee's Points Account may then be used to pay the COBRA continuation coverage premium.

(b) If the employee's Points Account is exhausted before their COBRA continuation coverage period ends, the employee and/or his or her surviving dependent(s) may self-pay the premiums for the remaining months of COBRA coverage.

(c) If the COBRA continuation coverage period ends before the employee's Points Account is exhausted, the Points Account may be used to pay for Extended Points Account Coverage for the employee and/or his or her eligible dependents, at the COBRA continuation coverage rate, until the earlier of the following times:

(1) the Points Account is exhausted; or

(2) other coverage becomes available (including, but not limited to, coverage through Medicare or through another group health plan).

3. Qualified Expenses.

(a) Any employee may be reimbursed from his or her Points Accounts for qualified expenses that are not otherwise covered under the Plan, provided that he or she:

(1) is eligible for benefits under the Plan, or

(2) was eligible for benefits under the Plan within the prior sixty (60) months, including through COBRA coverage, and who has maintained his or her enrollment continuously on the out-of-work list of a participating Local Union and been available for dispatch since his last period of Plan coverage, or

(3) has retired, and has deferred retiree coverage under the Plan due to coverage under another group welfare plan in place since the time of retirement.

(b) In order to qualify for payment through an employee's Points Account, an expense must satisfy all of the following requirements:

(1) The expense must have been for medical care as defined in Internal Revenue Code § 213(d), except as follows: An expense for premiums for medical care shall be reimbursable only if the premium is for (i) medical coverage of an eligible dependent under insurance or a group health plan other than this Plan, or (ii) medical coverage of an employee and/or his or her spouse or eligible dependents provided through the spouse's COBRA coverage. Notwithstanding any provision of this plan to the contrary, pursuant to Internal Revenue Service Notice 2013-54 and U.S. Department of Labor Frequently Asked Question Guidance (Part XXII) issued on November 16, 2014, points account contributions made on or after January 1, 2014 cannot be used to reimburse the premiums of individual health insurance policies.

(2) The expense must have been incurred by the employee or retired participant, or by a person who was then a covered eligible dependent of the employee or retired participant.

(3) The reimbursement request must be for expense(s) totaling at least $300.00, unless the employee is retired and his or her Points Account consists of less than $300.00, in which case the reimbursement request may be for the amount in his or her Account.

(4) Regardless of when the claim is made, the expense must have been incurred while the employee was:

(i) covered by the Plan, or

(ii) within sixty (60) months of the last date the employee was covered by the Plan, including COBRA coverage, provided that the employee has

maintained his or her enrollment continuously on the out-of-work list of a participating Local Union and been available for dispatch during that time, or

(iii) retired, and deferring retiree coverage under the Plan due to coverage under another group welfare plan in place since the time of retirement.

(5) The claim for use of the Points Accounts must be made within one year of the time the expense is actually incurred. Extensions of this time limit will be granted only for good cause shown, at the sole discretion of the Board of Trustees.

(6) The expense must have been incurred on or after January 1, 2004.

(7) The employee must provide proof, satisfactory to the Board of Trustees, that the claim satisfies the requirements of this Section 3.

C. Forfeiture of Points Accounts.

1. Effective January 1, 2000, the Points Account of any employee who has not been covered under this Plan and/or the Plastering Industry Welfare Plan for three (3) consecutive calendar years shall be forfeited, unless:

(a) the employee is retired, and is deferring retiree coverage under the Plan due to coverage under another group welfare plan in place since the time of retirement, or,

(b) at the time the employee last performed covered employment, all of the following applied to him or her:

(1) he or she had just become disabled from the trade; and

(2) his or her work history would then satisfy the current activity test for Disability Retirement under Article V, Section 5.01 of the Northern California Plastering Industry Pension Plan.

2. The Points Account of any covered employee who accepts employment in any capacity and of any duration from any contractor in the Building and Construction Industry who is not signatory to the collective bargaining agreement of the union having jurisdiction of the work, or who engages in the Building and Construction Industry as a sole proprietor or owner-operator without being signatory to the collective bargaining agreement of the craft union having jurisdiction of the work, shall be terminated immediately and permanently forfeited.

3. (a) Any remaining balance in an employee's Points Account shall be forfeited under the following circumstances:

(1) if the Points Account is not exhausted when the employee is retired, and neither the employee nor the employee's dependents are eligible any longer to maintain coverage under any form of self-payment permitted under the Plan's rules;

(2) if the employee dies without any dependents eligible for any form of extended benefits under this Plan; or

(3) if the employee dies with surviving eligible dependents, but they elect not to maintain COBRA coverage.

(b) For purposes of this rule, the Points Account of a retired employee will not be forfeited if the retired employee has deferred retiree coverage under the Plan due to coverage under another group welfare plan in place since the time of retirement.

4. The Points Account of an employee or a retiree shall be immediately and permanently forfeited if he or she elects to permanently opt out of and waive all future reimbursements from his or her Points Account.

5. Once a Points Account has been forfeited, it cannot be used by the employee for any purpose, even for expenses that were incurred before the forfeiture occurred. Any employee who regains eligibility for coverage under the Plan after forfeiture of his or her Points Account shall be allowed to accrue new points credits to their Points Accounts, but they will not regain the points credits that were previously forfeited. A forfeited Points Account shall be paid to, and become part of the general reserves of, the Northern California Plasterers Health and Welfare Fund.

6. If an employee's Points Account was forfeited under this section, and the employee demonstrates that his account should be reinstated because of a mistake of fact or other extenuating circumstances, then the Trustees in their sole and absolute discretion may reinstate the employee's Points Account.

VII. COBRA CONTINUATION COVERAGE

In lieu of any other option to continue coverage, an employee or eligible dependent may elect continued coverage under COBRA as follows, whenever his or her coverage would otherwise terminate under the Plan as a result of a qualifying event defined below, unless all medical plan contracts of this Fund are terminated before the person's qualifying event. An election of special continuation coverage under Article I, Sections H, I, or J, shall be deemed to include an election of COBRA coverage when the period of special continuation coverage ends, for the remaining months of the original COBRA Continuation

Coverage period measured from the initial qualifying event. Domestic partners and their children are not eligible for federal COBRA coverage when they cease to qualify as dependents of an employee under this Plan.

A. Eligibility for COBRA.

1. An employee or dependent, other than a domestic partner or their child, is eligible for continued coverage for up to 18 months, at 102% of Plan cost, if and when the employee's coverage has terminated because his or her Hour Bank has been exhausted, unless the employee was fired for gross misconduct. A veteran who returns to covered employment after less than 31 days of military service shall only be charged 100% of Plan cost.

2. An employee and/or dependent, other than a domestic partner or their child, is eligible for an additional 11 months of coverage, for up to a total of 29 months, at 102% of Plan cost, if within the original 18-month period, the employee or dependent is totally and permanently disabled, and has obtained a Social Security Disability Award which finds that he or she was so disabled within 60 days of the original loss of coverage due to termination of employment or reduction of hours.

3. A dependent, other than a domestic partner or their child, is eligible for continued coverage, for up to 36 months, at 102% of Plan cost, if and when the dependent's coverage has terminated because of one of the following qualifying events:

(a) the death of the employee;

(b) divorce of the employee and spouse;

(c) a child loses eligibility as a dependent; or

(d) the employee becomes entitled to Medicare.

4. If an employee is eligible for and elects one of the Plan's special continuation coverage options, the period for which the employee and his or her dependent(s) are covered under COBRA Continuation Coverage is reduced by the period in which the employee or dependent was covered under any of those options.

5. If a second qualifying event occurs for a dependent, the dependent may then make a new election to receive COBRA coverage. However, the period in which the dependent shall be eligible for COBRA coverage shall not exceed 36 months from the original qualifying event.

6. Notwithstanding any other provision of this section, no one is eligible for coverage on the grounds of termination of employment if, at the time of the termination of his or her Plan coverage, he or she was still employed by the Individual Employer who formerly made contributions to this Trust Fund on behalf of that person, and the person's coverage has terminated for reasons other than a qualifying event. The following guidelines shall apply in interpreting this rule:

(a) An individual covered as an Individual Employer shall be eligible to elect COBRA coverage on the grounds of termination of employment if, and only if, there is a complete cessation of the operations of the individual's business, or complete separation of the individual from the business.

(b) A non-bargaining unit employee shall not be considered to have a COBRA qualifying event on the grounds of termination of employment if he or she loses coverage because the employer's coverage is terminated, or because the non-bargaining unit employee is disqualified from participating for a reason other than his or her own low hours, and at the time of the event leading to the termination of coverage, the employee was still employed by the employer.

7. Any child born, adopted or placed for adoption after a participant's COBRA effective date shall be covered from the date of birth or placement for adoption and will be covered as long as the participant remains eligible and pays for COBRA coverage.

B. Procedures of COBRA Coverage.

1. If an employee is about to lose coverage because his or her Hour Bank ran out, the Trust Office will notify the employee of the qualifying event, and of the right to elect this coverage.

2. A dependent who is about to lose coverage because of divorce, death of the participant, termination of dependent status, or entitlement of the employee for Medicare, must notify the Trust Office within 60 days of the qualifying event. The Trust Office will then notify the dependent of his or her COBRA rights.

3. An employee or a dependent who is eligible for COBRA coverage may elect "core coverage" (that is, all Plan benefits except dental care, vision benefits and life insurance and accidental death or dismemberment insurance), or full COBRA coverage (all Plan benefits except life insurance and accidental death and dismemberment insurance). The election of one type of coverage by an employee with dependents applies to his or her dependents as well. However, if an employee does not elect COBRA coverage, his or her dependent(s) may elect either form of coverage for themselves.

4. After a person receives notification from the Plan of the right to elect COBRA continuation coverage, he or she has 60 days to submit a written election of such coverage. If an eligible person elects COBRA coverage during this 60-day election period, the coverage shall be made retroactive to the initial termination date of coverage. A person who originally rejects COBRA coverage may rescind that election and elect COBRA coverage within the original 60 days, but in that case coverage will not be retroactive to the initial termination date of coverage.

5. A person who elects COBRA coverage must make the first payment within 45 days of the election of COBRA coverage, and must also make subsequent payments for COBRA coverage by the 15th of each month for coverage for the next month.

C. Termination of COBRA Coverage.

1. COBRA coverage will be terminated for all persons if all medical benefits of this Fund are terminated.

2. COBRA Coverage for any individual is terminated if any of the following occur:

(a) a payment for that individual is not made in full by the 15th of each month;

(b) the individual becomes covered under another group health plan either as an employee or dependent;

(c) the individual becomes entitled to Medicare AFTER electing COBRA;

(d) during a disability extension, the individual is determined by the Social Security Administration to no longer be disabled;

(e) the employee's coverage is terminated for misconduct; or

(f) this Health and Welfare Plan is terminated.

VIII. CLAIMS AND APPEALS PROCEDURE

A. Scope of These Procedures.

The following claims and appeals procedures shall apply to matters within the discretion of the Board of Trustees of the Northern California Plasterers Health and Welfare Plan, including the following:

1. any claim or appeal regarding eligibility under the Northern California Plasterers Health and Welfare Plan for any type of benefit;

2. any claim or appeal regarding medical benefits when the claimant has made a specific claim for medical care and the HMO or insurance carrier has denied the claim on the grounds that the claimant or family member is not eligible for the benefit under the terms of the Northern California Plasterers Health and Welfare Plan; and

3. any claim or appeal regarding self-funded benefits, including but not limited to self-funded vision, dental and hearing aid benefits.

B. Authority of the Board of Trustees.

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 Board of Trustees, the Trust Office or any other Plan fiduciary. The Board of Trustees reserves full discretionary authority to interpret Plan language and to decide all claims or disputes regarding right, type, amount or duration of benefits, or claim to any payment from this Plan. The decision of the Board of Trustees on any matter within its discretion shall be final and binding on all parties. A claimant must exhaust the Plan's internal claims and appeals procedures before initiating any civil action arising from a denial of benefits. 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.

C. Claims Procedures.

1. FILING A CLAIM.

Participants and family members (hereinafter "claimants") may initiate a claim for benefits by contacting the Trust Office and following the instructions given to access the benefit.

(a) For life insurance, disability coverage and accidental death and dismemberment claims, claim forms may be obtained from the Trust Office.

(b) For self-funded benefits (including but not limited to vision, dental or hearing aid claims), claim forms may be obtained from the Trust Office, the employee's employer or a participating Local Union office. A separate claim form must be submitted for each individual for whom a claim is made and for each new service.

(c) For medical claims, the medical plan in which the employee or retiree is enrolled should be contacted.

(d) 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.

2. NOTIFICATION OF FAILURE TO FOLLOW PLAN PROCEDURES.

If the claimant fails to follow the Plan's procedures for filing a claim for benefits, the Trust Office will notify the claimant as soon as possible, but within 5 days following the failure, or if the claim is for urgent care, as soon as possible but no later than within 24 hours of the failure. This notification may be oral, unless the claimant or authorized representative requests it in writing.

3. NOTIFICATION OF CLAIM DECISION

(a) Time Limits and Requests for Additional Information.

(1) Urgent Care Claims: If a claim is for urgent care, the Trust 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 Trust Office.

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

(2) 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 Trust Office will notify the claimant of its decision as soon as reasonably possible, but no later than 15 days after the Trust 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 Trust Office's control. If the Trust 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 Trust Office needs to make the decision. If the Trust Office requires additional information, the claimant will have up to 45 days to provide the specified information. Once the specified information is provided, the Trust Office will notify the claimant of its decision within 15 days.

(3) Post-service claims: If a claimant makes a claim after care has been provided, the Trust Office will notify the claimant of its decision as soon as reasonably possible, but no later than 30 days after the Trust 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 Trust Office's control. If the Trust 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 Trust Office needs to make the decision. If the Trust Office requires additional information, the claimant will have up to 45 days to provide the specified information. Once the specified information is provided, the Trust Office will notify the claimant of its decision within 15 days.

(b) Contents of Claim Denial Notice. The Trust 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:

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

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

(3) the internal rule, guideline, protocol, standard, or other similar criterion, applied in making the determination, including the basis for disagreeing with the view of health care professionals, vocational professionals, or with the disability determinations by the Social Security Administration (if no such criterion was used, then an affirmative statement to that effect must be provided);

(4) 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;

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

(6) a statement of the claimant's right to bring a civil action under ERISA section 502(a), within one (1) year after the claim has been denied;

(7) a statement that the claimant is entitled to receive upon request and free of charge, reasonable access to and copies of, all documents, records and other information relevant to claimant's claim; and

(8) an explanation of the scientific or clinical judgment for the determination if the adverse benefit determination was based on medical necessity or other similar exclusion or limitation.

D. Appeal Procedures.

1. SCOPE OF APPEALS TO THE BOARD OF TRUSTEES.

(a) The claimant may appeal any adverse action within the discretion of the Board of Trustees to the Board of Trustees. The Board of Trustees hears appeals on medical benefits only in instances when the denial was on the grounds of eligibility under the Plan.

(b) The Board of Trustees is not authorized to hear or decide appeals concerning unfavorable determinations made by Plan providers, other than eligibility under the Plan. Any dispute as to type or amount of benefits provided pursuant to an insurance policy, HMO contract, or service contract which includes a schedule of benefits administered by the provider shall be resolved under the terms of such policy or contract, including any appeals provisions of such policy or contract. Employees should refer to the provider's Evidence of Coverage for details of its appeals procedure. A covered person may call the Trust Office for assistance, but the responsibility for the appeal remains with the covered person.

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 of Trustees to consider, to the Trust Office. All claims and appeals under this section shall be adjudicated in a manner designed to ensure independence and impartiality of the persons involved in making the determination.

Decisions covered by the authority of the Plan regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) making determinations with respect to disability benefits of the Plan will not be made based upon the likelihood that the individual will support the denial of benefits. The claimant shall have the right to review and respond to any new evidence or rationales developed by the Plan during the pendency of any appeal. The Trust Office shall automatically provide to the claimant, free of charge, any new evidence or rationales (if any) as soon as possible and sufficiently in advance of the date on which the appeal determination is to be made in order to give the Claimant a reasonable opportunity to address the new evidence or rationale prior to the appeal date. The claimant or the claimant's duly authorized representative shall have the right to review and respond to new

evidence or rationales considered, relied upon or generated by the Plan in connection with the claimant's claim during the pendency of any appeal.

(a) TIME LIMITS. Claimants must submit an appeal within 180 days of receiving the denial of the original claim by the Trust 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.

(b) 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 or other person with respect to Plan benefits. In deciding appeals, the Board of Trustees shall consider 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.

(c) NOTIFICATION.

(1) TIME LIMITS FOR NOTIFICATION

(i) Urgent Care Claims: The Trust 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 Trust Office will notify the claimant of Board of Trustees' determination as soon as possible, but not more than 30 days after receiving claimant's request for an appeal.

(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 Board will authorize a hearing only in post-service appeals and only if the claimant or authorized representative submits a written request for a hearing, and the Board determines that a hearing would be of assistance in its deliberation.

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 Trust 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 Trust 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.

(2) CONTENTS OF NOTICE. The Trust 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) the internal rule, guideline, protocol, standard, or other similar criterion, applied in making the determination, including the basis for disagreeing with the view of health care professionals, vocational professionals, or with the disability determinations by the Social Security Administration (if no such criterion was used, then an affirmative statement to that effect must be provided);

(iv) 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;

(v) a statement of the claimant's right to bring a civil action under ERISA section 502(a), within one (1) year after the claim has been denied;

(vi) an explanation of the scientific or clinical judgment for the determination if the adverse benefit determination was based on medical necessity or other similar exclusion or limitation; and

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

(3) All notices and disclosures under this subsection shall be provided in a culturally and linguistically appropriate manner. The Trust Office will also provide customer service with oral language services in the non-English language and provide written notices in the non-English language upon request.

E. No employee, dependent, beneficiary, or other person shall have any right or claim to benefits under the Plan, except as specified in the rules and regulations of the Trust or Plan or in policies or contracts approved by the Board of Trustees.

F. The denial of an application or claim after the right to review has been waived or the decision of the Board of Trustees on petition for review has been

issued shall be final and binding upon all parties, including the claimant. No lawsuit may be filed without first exhausting the above appeals procedure or a showing that the Plan was not compliant with the above rules (unless the Plan's actions qualify as (i) de minimis; (ii) non-prejudicial; (iii) attributable to good cause or matters beyond the Plan's control; (iv) in context of an ongoing good faith exchange of information; and (v) not reflective of a pattern or practice of non-compliance). In any such lawsuit, the determinations of the Board of Trustees are subject to judicial review only for abuse of discretion. No legal action may be commenced or maintained against the Plan more than one (1) year after a claim has been denied.

IX. DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE BOARD OF TRUSTEES AND "MINIMUM NECESSARY" POLICY

1. Definitions. Whenever used in this Article, the following terms shall have the respective meanings set forth below.

(a) Plan means the Northern California Plasterers Health and Welfare Plan.

(b) Board means the Board of Trustees of the Northern California Plasterers Health and Welfare Trust Fund, which is the plan sponsor as defined in ERISA § 3(16)(B).

(c) Health Information means information (whether oral or recorded in any form or medium) that is created or received by a health care provider, health plan (as defined in 45 CFR § 160.103), employer, life insurer, school or university, or health care clearinghouse (as defined in 45 CFR § 160.103) that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

(d) Summary Health Information means information that summarizes the claims history, expenses, or types of claims by individuals for whom the Plan provides benefits, and from which the following information has been removed:

(1) names;

(2) geographic information more specific than state;

(3) all elements of dates relating to the individual(s) involved (e.g., birth date) or their medical treatment (e.g., admission date) except the year; all ages for those over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older);

(4) other identifying numbers, such as Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers;

(5) facial photographs or biometric identifiers (e.g., fingerprints); and

(6) any information the Board does not have knowledge of that could be used alone or in combination with other information to identify an individual.

(e) Protected Health Information ("PHI") means Health Information, including demographic information, that is (1) transmitted or maintained in any form or medium, (2) collected from an individual and created or received by a health care provider, health plan, employer, or health care clearinghouse, and (3) identifies the individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the individual involved.

2. Disclosure of Summary Health Information. Except as prohibited by 45 CFR § 164.502(a)(5)(I), the Plan may disclose Summary Health Information to the Board if the Board requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending, or terminating the Plan.

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

4. Disclosure of PHI. The Plan will disclose PHI to the Board only in accordance with 45 CFR § 164.504(f) and the provisions of this section.

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

6. Certification. The adoption of this section shall constitute certification by the Board that this Plan has been amended to include the provisions required under 45 CFR § 164.504(f).

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

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

(b) ensure that any of its agents to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Board with respect to such PHI;

(c) not use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan;

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

(e) make PHI available to individuals in accordance with 45 CFR § 164.524;

(f) make PHI available for individuals' amendment and incorporate any amendments in accordance with 45 CFR § 164.526;

(g) make the information available that will provide individuals with an accounting of disclosures in accordance with 45 CFR § 164.528;

(h) make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services for purposes of determining the Plan's compliance with 45 CFR Part 164;

(i) if feasible, return or destroy all PHI received from the Plan that the Board maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Board will limit further its uses and disclosures of the PHI to those purposes that make the return or destruction of the information infeasible; and

(j) ensure that adequate separation between the Plan and the Board, as required by this section and by 45 CFR § 164.504(f)(2)(iii), is established and maintained.

8. Disclosure Only to Designated Parties. Pursuant to this section, the Plan will disclose PHI only to the Board and/or to individual Trustees, and to Business Associates of the Plan.

9. Disclosure Only for Designated Purposes. Access to and use of PHI by the parties described in Paragraph 8 shall be restricted to Plan administration functions that the Board performs for the Plan. Such access or use shall be permitted only to the extent necessary for these individuals to perform their respective duties for the Plan.

10. Non-Compliance. If any person described in Paragraph 8 does not comply with the provisions of this section or the provisions of 45 CFR § 164.504(f), the Board shall provide a mechanism for resolving the issue of non-compliance, which may include disciplinary sanctions.

11. Statement Required in Privacy Notice. The Plan may not disclose, and may not permit a health insurance issuer or HMO providing services to the

Plan to disclose, PHI to the Board except as would be permitted by the Plan in this section, and only if the appropriate statement is included in the privacy notice of the Plan, the insurance issuer, or the HMO, as required by 45 CFR § 164.520.

12. Disclosure of ePHI. The Board will reasonably and appropriately safeguard electronic PHI (ePHI) created, received, maintained or transmitted to or by the Board on behalf of the Plan. Specifically, the Board will:

(a) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the Plan,

(b) ensure that adequate separation between the Plan and Board, as required by this Article and by 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures,

(c) ensure that any agent to whom the Board provides this information agrees to implement reasonable and appropriate security measures to protect the information, and

(d) report to the Plan any security incident of which it becomes aware.

13. "Minimum Necessary" Standard. In accordance with 45 CFR § 164.502(b), as amended from time to time, reasonable efforts will be made to limit any use or disclosure by the Plan of PHI, including ePHI, or request for PHI, to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

X. MISCELLANEOUS RULES

A. Reservation of Powers.

1. 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, and the scope and application of the Plan's right to reimbursement.

2. 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 these Rules, or in any summary of these rules, should be construed to make any benefits hereunder

vested, or as a waiver of any discretion or power conferred upon the Board of Trustees under the Trust Agreement.

B. Coordination of Benefits.

1. If a person is covered by a medical carrier under this Plan and also under another group plan (for example, the person's spouse's employer provides coverage), then benefits are subject to coordination.

2. How Coordination of Benefits Works.

(a) If an employee or his or her dependents are also covered under another group plan, the total amount received from all plans will never be more than 100% of "allowable expenses." Benefits are reduced only to the extent necessary to prevent any person from making a profit from his or her insurance.

(b) "Allowable Expenses" are any necessary and reasonable expenses for medical or dental services, treatment or supplies, covered by one of the plans under which an employee or his or her dependents are insured.

(c) A "plan" is considered to be any group insurance policy providing coverage for medical treatments or services on an insured or uninsured basis. This includes group blanket or franchise insurance, group Blue Cross, group Blue Shield, group practice and any other group prepayment coverage, labor-management trusteed plans, union welfare plans, employer organization plans, any coverage under governmental programs and any coverage required or provided by law, including Mandatory State No-Fault Auto Insurance.

(d) This Coordination of Benefits provision shall not apply to any other health coverage for which the participant pays the entire premium.

3. Which Plan Pays First.

(a) If both plans have a Coordination of Benefits provision, the plan that covers the participant as a non-dependent (for example, as an employee, retiree, member or subscriber) pays first, and the plan that covers the same person as a dependent pays second.

(b) If the participant is covered as an employee under two (2) plans, the plan which has covered the employee longer is primary. However, if the participant is covered as an active employee under one plan and as a laid-off or retired employee under another plan, the plan that covers him or her as an active employee will pay its benefits first. This does not apply if either plan does not have a provision regarding laid-off or retired employees.

(c) If one plan does not have a Coordination of Benefits provision, that plan is always primary.

(d) If a dependent child is covered under two (2) plans, the plan of the parent whose birthday occurs earliest in the calendar year pays its benefits first. If both parents have the same birthday, the plan which has covered the dependent child for the longer period pays its benefits first. If the parents of a dependent child are divorced or separated, the plan of the parent with custody pays its benefits first. If the parent with custody remarries, the "order of payment" is as follows:

(1) Natural parent with whom the child resides;

(2) Stepparent with whom the child resides; and

(3) Natural parent not having custody of the child.

This order of payment can change if the divorce decree directs one of the parents to be financially responsible for the health care expenses of the child.

For a person covered as a dependent under more than one plan of individuals who are not both the parents of the child (e.g., child is covered on spouse's plan), the order of benefits shall be determined by the longer/shorter length of coverage of the dependent child, and if length of coverage is the same, then the birthday rule applies between the dependent child's parent with coverage and the dependent child's spouse with coverage.

4. Medicare.

(a) Unless the employee elects otherwise, this Plan will provide primary coverage for the employee and spouse if he or she is an active employee age 65 or over and eligible for Medicare. The employee may select Medicare as his or her primary coverage. In that case, benefits under this Plan will cease.

(b) If the employee becomes eligible for Medicare because of total and permanent disability and continues to be eligible for benefits under this Plan as an active employee, this Plan will continue to provide primary coverage until he or she reaches age 65. At age 65, Medicare will provide primary coverage.

(c) If the employee is eligible for Medicare solely because he or she has end-stage renal disease, this Plan will continue to provide primary coverage for the first eighteen (18) months of his or her eligibility for Medicare.

(d) If a retiree or the spouse or dependent of a retiree is eligible for Medicare, Medicare will provide primary coverage. Benefits under this Plan will be coordinated so that no more than 100% of covered charges are paid.

(e) Where Medicare provides primary coverage, the employee will first be reimbursed under the Medicare program. If any covered expenses remain unpaid by Medicare, this Plan will reimburse the employee for such expenses, up to the maximum amount payable under the Plan. The combined payments of Medicare and this Plan shall not exceed the total amount of covered expenses.

(f) An employee will be considered to be insured under both Part A and Part B of Medicare as soon as he or she is eligible for these coverages, whether or not he or she has registered for Part A or enrolled in Part B.

5. Right to Obtain or Release Information.

(a) The Board of Trustees and/or the medical plan in which the employee is enrolled may obtain or release any information necessary to implement these provisions. An employee must declare his or her coverage under other plans. A medical plan which pays another paying organization amounts warranted to satisfy the intent of this provision will be discharged from liability for that claim, to the extent of that payment. The Board of Trustees and the medical plan in which the employee is enrolled can also recover from the employee, from another insurance company, or from another organization, amounts that are overpaid under this provision.

(b) An employee will be required to provide information necessary to administer this provision at the time he or she submits a claim.

C. Right of Reimbursement

1. This Plan does not cover any illness, injury, disease or other condition for which a third party may be liable or legally responsible, by reason of negligence, an intentional act or breach of any legal obligation on the part of that third party.

If any service is provided or medical claims paid in connection to any injury caused by a third party, and the covered participant and/or eligible dependents receive reimbursement from or on behalf of a third party or from uninsured motorist coverage, the Plan is entitled to recover the full amount of benefits paid under the Plan for such services, up to the gross amount recovered by the covered participant and/or eligible dependents.

2. A lien shall exist in favor of the Plan upon all sums of money recovered by the covered person in connection with such injuries to the extent of the benefit

payments the Plan has made. The covered person shall do nothing to prejudice the rights given to the Plan by this provision without its consent. The covered person shall execute and deliver such instruments and take such other actions as the Plan may require to implement this right. Payment of benefits may be conditioned on the execution by a participant, or a participant and dependent, of a written agreement to reimburse the Plan in full.

3. The Plan also reserves the right to seek reimbursement from any party who may be liable for costs which were the basis of claims paid by the Plan. The Plan may assert these rights regardless of any agreement between the employee or his or her dependent and any third party.

4. Benefit providers may also assert a right of subrogation. See their governing documents for further information.

D. Rights of States.

1. Payment of benefits with respect to a participant shall be made in accordance with any assignment of rights made by or on behalf of such participant or beneficiary of a participant as required by a state plan for medical assistance approved under title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of that Act.

2. In enrolling an individual as a participant or beneficiary or in determining or making any payments for benefits of an individual as participant or beneficiary, the fact that the individual is eligible for, or is provided, medical assistance under a state plan for medical assistance under title XIX of the Social Security Act shall not be taken into account.

3. To the extent that payment has been made under a state plan for medical assistance approved under title XIX of the Social Security Act in any case in which the Plan has a legal liability to make payments for items or service constituting such assistance, payment for benefits under the Plan shall be made in accordance with any state law which provides that the state has acquired rights with respect to a participant to such payment for such items or services.

E. Assignment.

The rights, coverage, and eligibility of a participant, beneficiary, or dependent under this Plan, or under any applicable law, 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 institute any court proceeding.