NORTHERN CALIFORNIA PLASTERERS HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION
AND FORMAL PLAN RULES

January 1, 2016

Working 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 January 1, 2016. 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.

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 Fund Office, Allied Fund Administrators, whenever you acquire a new dependent, or when any of the following events occur:

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

PLAN SERVICE PROVIDERS INFORMATION

If you need further information about your eligibility status or your rights and duties under the Plan, contact the Trust Fund Office:

Northern California Plasterers Health and Welfare Trust Fund
c/o Allied Fund Administrators
1640 South Loop Drive
Alameda, CA 94502
(mailing address: P.O. Box 24160, Oakland, CA 94623-2416)
Phone: (415) 986-6276
Toll Free: (888) 877-8363
Website: www.plasterersbenefits.com

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.kponline.org

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

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

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HIGHLIGHTS OF THE PLAN

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

" Medical, hospital, surgical and prescription drug benefits for active employees are currently provided 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 Premier Access.

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

" Life and Accidental Death & Dismemberment Insurance benefits are provided 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 be enrolled within 30 days, or 60 days as applicable, to guarantee their right to immediate enrollment. For example, you must enroll a new spouse within 30 days of your marriage, and 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 9 and 13 for more information about enrollment rights and requirements.

3. Authority to Act on Behalf of the Board of Trustees. Only the Trust Fund 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 Fund 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 Fund 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 Fund 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 Fund 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 law suit 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 Fund 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 or 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 Fund 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 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 Fund 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.

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

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 work 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 Fund 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 K.

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 Fund 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 Fund 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; or

(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.

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 Fund Office. See the section entitled Your Rights Under COBRA and Article VIII 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 are your spouse or domestic partner, and your children, up to the Plan's limiting age, as described below.

Your "children" means:

(a) your natural children;

(b) your stepchildren, foster children, children of your domestic partner, or children under your legal guardianship;

(c) any minor child placed with you for the purpose of legal adoption, from the moment the child is placed in your physical custody, or from the moment you have assumed and retained a legal obligation to provide total or partial support for the child in anticipation of adoption of the child, whichever is earlier;

(d) any dependent grandchild for whom you have assumed sole custody and liability for maintenance and support.

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

2. Limiting Age for Children. Children are covered until the end of the calendar month that they reach age 26 for medical benefits, unless extended due to disability. 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 23rd birthday.

3. Exception for Disabled Dependents. Coverage for medical benefits may be extended after a child's 26th birthday, and coverage for life insurance may

be extended after a child's 21st birthday, if the child has a physical or developmental disability which began before coverage would otherwise have ended, and which makes the child incapable of self-sustaining employment, so long as the child remains disabled, unmarried and dependent on you for support and maintenance. Proof of the disability must be provided within 31 days of the termination of regular coverage of the child, and from time to time as requested by the Trust Fund Office, or the life insurance carrier.

4. 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 enroll 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 enroll your new spouse within 30 days of your marriage. If you have a newborn child, you must enroll 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 in July. The decision whether or not to allow late enrollment is up to your chosen medical plan, not the Board of Trustees.

5. Special Enrollment Rules for Dependents.

(a) If you have failed to enroll your spouse, and you have a newborn baby, the mother of the baby may be enrolled within 30 days of the baby's birth along with the baby.

(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 submit your enrollment form 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 submit your enrollment form within 60 days of the termination from, or eligibility for, such assistance.

6. 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 twelve (12) months immediately preceding your retirement and remained continuously covered under this 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. Retiree coverage under the Plan, other than COBRA, consists of core medical benefits (not including dental and vision coverage), life insurance, 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 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 UnitedHealthcare Medicare Advantage 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 UnitedHealthcare Senior Supplement 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 Fund 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, <u>and</u> 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.

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 (or were not covered under the Plastering Industry 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 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 21.

At open enrollment in July, members will receive summaries of each provider's benefits. A full set of enrollment documents is also available at any time from the Trust Fund 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 July 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 & 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.

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 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 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	No charge*
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) …………………………………………..	$100 after Deductible
(After Deductible, charge does not apply if admitted directly to the hospital as an inpatient (see Hospitalization Services for inpatient Cost Sharing).	
Ambulance Services	**You pay**
Ambulance services (per trip)…….	$100 after Deductible
Prescription Services	**You pay**
Covered outpatient items in accord with Kaiser's drug formulary guidelines:	
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

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
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).............	$250 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% coinsurance
Skilled nursing care (Coverage limited to 100 days)	40% coinsurance

Blue Shield Access+ HMO - Active Employees & Early Retirees (continued)

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

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

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	50% coinsurance for office visit; 40% coinsurance for outpatient hospital
Habilitation services	$25 copayment for office visit	50% coinsurance for office visit; 40% coinsurance for outpatient hospital
Durable medical equipment	20% coinsurance	40% coinsurance
Hospice	No charge	Not covered

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	$10 for up to a 100-day supply
Most brand-name items	$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 …………………………………………………….	$250 per admission
Individual outpatient mental health evaluation and treatment………..	$15 per visit
Group outpatient mental health treatment	$7 per visit
Chemical Dependency Services	**You pay**
Inpatient detoxification per admission ………………………………………….	$250 per admission
Individual outpatient chemical dependency evaluation and treatment…	$30 per visit
Group outpatient chemical dependency treatment.......................... …	$5 per visit
Home Health Services	**You pay**
Home health care (part-time, intermittent)..….	No charge

Kaiser Senior Advantage - Medicare-Eligible Retirees (continued)

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. United Healthcare Medicare Advantage 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	$50 copay
Urgently needed care	$10 copay
Other Medicare-Covered Benefits	
Chiropractic services	$10 copay
Podiatry services	$10 copay
Eye exam	$10 copay
Hearing exam	$10 copay

UnitedHealthCare Medicare Advantage - 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: Specialty	$35 copay	$70 copay
Coverage gap stage (after prescription costs reach $2,970)	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 $4,750 out-of-pocket)	The greater of $2.65 copay for generic, $6.60 copay for brand name, or 5% coinsurance	

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

3. United Healthcare Senior Supplement - Out-of-Area Only - Benefit Summary

Covered Service	**Senior Supplement Pays**	**You Pay**
Inpatient Hospital		
Days 1-60	100% of Part A Deductible	$0
Days 61-90	100% Coinsurance	$0
Days 91-150	100% Coinsurance	$0
Days 151-365	100% Coinsurance	$0
Beyond 365	Not covered	All costs
Inpatient Mental Health Services	Same as above	Same as above
Skilled Nursing Facility Care		
Days 1-20	$0	$0
Days 21-100	100% Coinsurance	$0
Days 101 and after	Not covered	All costs
Blood & Blood Products		
Blood (first 3 pints are covered)	100% Coinsurance	$0
Other Inpatient Services		
Hospice	100% Coinsurance	$0
Respite	100% Coinsurance	$0
All other inpatient services billed by hospital or facility	100% Coinsurance	$0
Outpatient and Part B Benefits		
Part B Deductible	100% of Part B Deductible	$0
Part B excess charges	0% Coinsurance	100% Coinsurance
Ambulance	100% Coinsurance	$0
Office visits	100% Coinsurance	$0
Outpatient surgery	100% Coinsurance	$0
Outpatient mental health and Substance abuse treatment	100% Coinsurance	$0
Durable medical equipment	100% Coinsurance	$0
Home health care	100% Coinsurance	$0
Immunizations for adults	100% Coinsurance	$0
Preventive health screenings	100% Coinsurance	$0
Pap smears	100% Coinsurance	$0
Infusion therapy	100% Coinsurance	$0
Diabetic self-management	100% Coinsurance	$0
Outpatient injectables	100% Coinsurance	$0
Outpatient prescription drugs covered by Medicare	100% Coinsurance	$0
All other outpatient services	100% Coinsurance	$0

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 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.

* Does not apply to an eligible dependent aged 14 years or younger.

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.

V. SUMMARY OF INSURANCE BENEFITS

The Plan provides life insurance and accidental death and dismemberment insurance through Lincoln Life.

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:
Under 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 handicapped............$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 Two 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 Two 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 Fund 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 Fund 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 their 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 benefit on eligibility grounds, you may submit a claim for eligibility for benefits by contacting the Trust Fund Office. Your authorized representative or, if the situation is urgent, your doctor, may also contact the Trust Fund 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 Fund Office.

The Trust Fund 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

If you disagree with the action of the Trust Fund Office on a claim, you may appeal to the Board of Trustees by sending a letter to the T rust Fund 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 your appeal will be heard at a meeting of the Board of Trustees, you and/or your authorized representative may be permitted to appear, and you may be permitted to present witnesses. If you file an appeal, contact the Trust Fund 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.

<u>Appeals Procedures Regarding Eligibility and Other Matters</u>

If you disagree with the decision of the Trust Fund 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 Fund 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 60 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, and whether a personal appearance is required. For further information about the procedures for your appeal, contact the Trust Fund 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 Fund Office will notify you of the Board's action. Please note that the Board's final action on an appeal is binding on all parties affected by the appeal.

A law suit 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 IX 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, Allied Fund Administrators. (the "Trust Fund 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 Allied Fund Administrators
1640 South Loop Drive
Alameda, CA 94502
(mailing address: P.O. Box 24160, Oakland, CA 94623-2416)
Phone: (415) 986-6276
Toll Free: (888) 877-8363
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 429 101 College Avenue, Suite 2 Modesto, CA 95350	Ms. Nancy Brinkerhoff Ironwood Commercial Builders, Inc. 201 Ironwood Court Pleasant Hill, CA 94523
Mr. Jeff Crothers Plasterers' Local Union No. 66 8400 Enterprise Way, Suite 113 Oakland, CA 94621	Mr. Roger Henley Henley & Company 621 Galveston Street West Sacramento, CA 95691
Mr. Chester Murphy, Jr. Plasterers' Local Union No. 66 39 South Linden Avenue South San Francisco, CA 94080	Mr. Chet O'Donnell O'Donnell Plastering 2318 Lafayette Street Santa Clara, CA 95050
Mr. Marshall Vasquez Operative Plasterers' and Cement Masons' Local Union No. 300, Area 224 2102 Almaden Road, #120 San Jose, CA 95125	Mr. Jim Ruane Patrick J. Ruane, Inc. 283 Wattis Way South San Francisco, CA 94080

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

Katherine A. McDonough. Esq.
Kraw Law Group
605 Ellis Street, Suite 200
Mountain View, CA 94043
650 314-7829

Legal process may also be served on the Plan or Trust Fund by service on any of the Trustees or at the Trust Fund 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 Fund Office, or may be inspected by participants and beneficiaries at the Trust Fund 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, 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 Rules under the Section entitled "COBRA Continuation Coverage." A more complete explanation is also available from the Trust Fund Office on request, and is provided whenever a person receives a COBRA election.

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 Heath and Welfare Plan ("the Plan") due to a qualifying event. The following pages 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;
- when COBRA continuation coverage may become available to you and your family and for how long; and
- what you need to do to protect the right to receive it.

1. What is COBRA Continuation Coverage?

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

After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary". You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for the coverage on their own. COBRA coverage is also coordinated with other forms

of extended coverage, so 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:

- o The parent-employee dies;
- o The parent-employee's hours of employment are reduced;
- o The parent-employee's employment ends for any reason other than his or her gross misconduct;
- o The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- o 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 Fund 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 dependant 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. <u>Length of COBRA Coverage: 18 Months and May be Extended</u>

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 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 Allied Fund Administrators
1640 South Loop Drive
Alameda, CA 94502
(mailing address: P.O. Box 24160, Oakland, CA 94623-2416)
Phone: (415) 986-6276
Toll Free: (888) 877-8363
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.

APPENDIX 1
FORMAL PLAN RULES