

**BAY AREA ROOFERS HEALTH AND WELFARE
TRUST FUND**

TO: Participants in the Bay Area Roofers Health and Welfare Plan

This booklet outlines the Bay Area Roofers Health and Welfare Plan which became effective on October 1, 1991 and reflects plan changes up to January 1, 2005. The pages which follow give you an explanation of the coverages which are available to you. The Joint Board of Trustees may amend the Plan from time to time or discontinue all or any portion of the Plan.

The Plan was adopted by your Joint Labor and Management Board of Trustees after careful consideration and provides a comprehensive Major Medical Plan to all eligible participants and their dependents with excellent protection against both normal and catastrophic medical bills. The Group Health & Welfare Plan also includes Vision, Dental and Life insurance benefits. All of these benefits are paid for by contributions from your employer.

This is your Health and Welfare Plan. To secure maximum benefits, study the provisions and instructions in this booklet carefully.

Following your retirement as an active participant you and your dependents may qualify for retiree coverage. For more information refer to the retiree booklet.

If you have any questions regarding this program, please contact United Administrative Services at 1120 South Bascom Avenue, P.O. Box 5057, San Jose, California 95150-Telephone (408) 288-4400.

Sincerely yours,

BOARD OF TRUSTEES

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QUICK REFERENCE GUIDE

Self Funded Medical Plan:

Self-Funded Preferred Provider Medical Plan for active participants.

You may check the Blue Cross Web site at www.bluecrossca.com for current Blue Cross Prudent Buyer providers for the Self-Funded Medical Plan.

Prescriptions:

1. Can be submitted under major medical after a deductible and 20% co-pay. **See page 13.**
1. Can obtain prescriptions with Caremark prescription card at many major pharmacies. **See page 13.**
3. Can obtain prescriptions through the Caremark mail order plan. **See page 13.**

Alcohol and Drug Abuse:

2. Can be submitted under major medical with deductible and co-pay. **See pages 16, 17 and 18.**
2. Beat It! Program. Discounted Substance Abuse Plan. **See pages 17 and 18.**

Kaiser Health Plan

Provides prepaid medical benefits for active participants.

Prescriptions:

1. Can only be obtained from a Kaiser facility.

Alcohol and Drug Abuse:

1. Only for detoxification and emergency services.
2. Beat It! Program. Discounted Substance Abuse Plan. **See pages 17 and 18.**

Health Net:

Provides prepaid medical benefits for active participants.

Prescriptions

1. Can only be obtained through a participating Health Net Pharmacy.

Alcohol and Drug Abuse:

1. Only for detoxification and emergency services.
2. Beat It! Program. Discounted Substance Abuse Plan. **See pages 17 and 18.**

Self Funded Dental Plan:

Self-Funded Dental Plan for active participants. **See page 26.**

Bright Now Dental:

Provides prepaid dental benefits for active participants who elect this coverage. Must go to a Bright Now Dental facility. Call the Administrator's office for a current listing of facility locations. **See page 7.**

Vision Care Benefits:

Provides vision coverage for all active participants. **See page 29.**

Life Insurance and AD&D Insurance:

Provides Life coverage for all active participants. **See page 31.**

Provides AD&D coverage for all active participants. **See page 37.**

RETIREE ELIGIBILITY RULES

A. Eligibility for Contractual Retirees.

- (1) **Retirement.** This retiree medical plan is designed to provide benefits to individuals who retire from the roofing industry and remain retired and their eligible dependents. A "contractual retiree" is any person who is eligible for and actually is receiving pension benefits from the Pacific Coast Roofers Pension Plan for work covered by a collective bargaining agreement or as an Retiree of the Union. Retirees' spouses are also eligible as dependents, but no person is eligible both as a retiree and a spouse.
- (2) **Initial Eligibility.** To initially be eligible under this Plan a person must meet the following conditions:
 - (a) The person must be a contractual retiree (as defined above) or a contractual retiree's spouse or a dependent child of a contractual retiree.
 - (b) The contractual retiree must have used up his or her eligibility in the active plan.
 - (c) The contractual retiree must have been an eligible participant as a contractual Retiree in the active plan at any time during the 6 months immediately prior to being eligible for this retiree plan.
 - (d) The contractual retiree must have received at least 5 Vesting credits under the Pacific Coast Roofers Pension Plan during the five year period immediately prior to disability and/or retirement.
 - (e) The contractual retiree must pay a premium to the Plan in an amount as determined from time to time by the Plan's trustees.
- (3) **Continued Eligibility.** Once a contractual retiree is eligible, the contractual retiree and the retiree's spouse and dependent children will continue to be eligible for any month when the retiree remains eligible to receive a pension from the Pacific Coast Roofers Pension Plan for work covered by a collective bargaining agreement or as an Retiree of the Union and pays any premium required by the Plan Trustees, subject to the loss of eligibility rules specified below.
- (4) **Temporary Loss of Eligibility.** If a contractual retiree resumes work under a collective bargaining agreement of a local union of the United Union of Roofers, Waterproofers and Allied Workers, his or her eligibility and that of his or her dependents under this Plan will cease during the period he or she is eligible under the health and welfare plan of that local union. The retiree's and his or her dependents' eligibility under this Plan will be reinstated when his or her eligibility under that other roofers' plan is exhausted, subject to the permanent loss of eligibility rules specified in Article C (6) below.
- (5) **Special Rule for Valley Roofers Retirees.** Those retirees of the Valley Roofers Trust Fund who started receiving benefits under this retiree plan in 1997 will continue to be covered for the benefits they were receiving under the Valley Roofers Plan unless and until changed by the Trustees of this Plan.

B. Eligibility for Non-Contractual Retirees.

- (1) **Retirement.** This retiree medical plan is designed to provide benefits to individuals who retire from the roofing industry and remain retired and their eligible dependents. A Non-Contractual retiree is any person (a) who is not gainfully employed for 40 or more hours per month, and (b) meets the Plan's eligibility rules for Non-Contractual retiree coverage.
- (2) **General Rule.** Age (minimum of 55) plus years of participation in the active plan (minimum of 5) to equal at least 65. At least 5 years of participation in the active plan must be immediately prior to retirement, and a maximum of twelve (12) months of COBRA self-payment will be counted as participation in the active plan.
- (3) **Continued Eligibility.** Once a Non-Contractual retiree is eligible, the Non-Contractual retiree and the retiree's spouse and eligible dependent children will continue to be

eligible for any month when the retiree is retired, as defined in subparagraph (1), and pays the premium required by the Plan Trustees, subject to the permanent loss of eligibility rules specified in Article C (6) below.

C. General Rules Applicable to Contractual and Non-Contractual Retirees.

- (1) **Coverage to Begin after Exhaustion of Active Coverage.** Coverage under this retiree medical plan is designed to take effect only after a person's eligibility under the active plan has been exhausted.
- (1) **Application.** The retiree must apply for retiree coverage within 31 days of loss of active plan coverage, including any reserve, disability, self-pay and COBRA to which the retiree is entitled. The retiree premium must be paid retroactive to the loss of active coverage.
- (3) **Choice.** Upon initial enrollment in the retiree plan, retirees will be given a onetime choice of the following coverages;
 - (a) Full retiree plan benefits (including comprehensive major medical, prescription drugs, supplemental accident, dental, vision, life insurance and accidental death and dismemberment benefits); or
 - (b) Retiree comprehensive major medical, prescription drug and supplemental accident benefits only.
- (4) **Special Enrollment Period.** A retiree who is eligible but not enrolled under the retiree medical plan may enroll if each of the following conditions is met:
 - (a) The retiree was covered under a group health plan or had health insurance coverage at the time coverage was previously offered,
 - (b) The retiree stated in writing that the reason for originally declining enrollment was that he or she had coverage under another group benefit plan or health insurance coverage,
 - (c) The retiree's coverage described in (a) either was under COBRA which was exhausted, or the coverage was not under COBRA and terminated as a result of loss of eligibility or employer contributions toward such coverage were terminated.
- (d) The retiree requests enrollment under this Plan not later than 30 days after the exhaustion of COBRA coverage or other termination of coverage described in (c).

(5) Survivorship Rules For Retirees.

- (a) **Eligibility.** Subject to the permanent loss of eligibility rules in paragraph C (6) below, an eligible spouse and/or any eligible dependent children of a retiree shall remain eligible after the retiree's death upon payment of any required premium without interruption.
- (b) **Termination.** Subject to the permanent loss of eligibility rules in paragraph C (6) below, the dependents of a deceased retiree shall remain eligible under the retiree plan until the earliest of:
 - i) when the eligible dependent child reaches the disqualifying age, at which time COBRA will be available for the child, or
 - (ii) When the dependent child is legally adopted by someone who is not covered by the Plan, or
 - (iii) When the surviving spouse remarries, except that a covered dependent child will be allowed to continue coverage until the earliest date when one of the events described in (i) or (ii) above occurs with respect to that dependent child, or one of the events described in paragraph C (6) below occurs.
- (c) **Required Premium.** To continue survivorship coverage under the Retiree Plan, the Trust's required premium for dependent coverage must be paid. Multiple dependents of a deceased retiree are charged one composite premium for all of their coverage. No subsidies are currently provided by the Trust for this coverage.
- (d) **Notice.** Upon learning of the death of a retiree, the Plan will provide notice of these survivorship provisions to the participant's dependents and allow a reasonable amount of time as determined by the Trustees, in which to make the required premium

payments. All such payments must be retroactive to the date the dependents' coverage ceased due to the death of the retiree and survivorship coverage begins.

- (6) **Permanent Loss of Eligibility:** A retiree, his or her spouse and eligible dependent children will lose their eligibility permanently in the following situations.
- (a) If a retiree works at all in non-covered roofing service, the retiree, his or her spouse and dependent children will permanently lose all eligibility. "Non-covered roofing service" is any kind of work either as a roofer or waterproofer or in the roofing and/or waterproofing industry in the United States or any of its territories whether as an employed or self-employed person and whether compensated or not unless either the person doing the work or the legal entity for which the work is performed has a collective bargaining agreement with a local union of the United Union of Roofers, Waterproofers and Allied Workers, AFL-CIO requiring health and welfare contributions on behalf of Retirees covered by the agreement. The only exceptions are:
- (i) Work as an Retiree of a governmental agency (but not as an independent contractor or one of the independent contractor's Retirees) which agency has committed itself to compensate roofers at no less than the sum of the wage and fringe benefit rates required under current bargaining agreements of the local union of the United Union of Roofers, Waterproofers and Allied Workers, AFL-CIO with geographical jurisdiction over the area where the work is performed,
- (ii) Work as an Retiree of the United Union of Roofers. Waterproofers and Allied Workers, AFL-CIO or any local union thereof, and
- (iii) Work as an Retiree of Associated Roofing Contractors of the Bay Area Counties. Inc.
- (b) If a retiree (or a retiree's spouse or children after the retiree's death) becomes insured under or eligible to elect coverage under another group health and welfare plan (other than Medicare or a local roofers union health and welfare plan) the retiree, his or her spouse and all dependent children will permanently lose all eligibility.
- (c) If a retiree or a retiree's spouse or dependent child who is required to pay a premium to the Plan fails to do so, the retiree, his or her spouse and all dependent children will permanently lose all eligibility.
- (7) **Provisions Subject to Modification or Termination.** All coverage under this retiree medical plan is subject to modification or termination by the Trustees, including, but not limited to, the right to reduce or eliminate benefits, require additional contributions from retirees, modify the Plan's eligibility provisions and to terminate the Plan entirely.
- (8) **Medicare Part B Required.** Retiree and spouse must take Part B of Medicare when they become eligible to qualify for the Plan.
- (9) **Premium Required.** The retiree is required to pay a premium to the Trust, as determined by the Plan's Trustees, which may be changed from time to time. These payments must begin the first month for which he or she will not be covered under the active Plan. Payments are due on the last day of the month prior to the month of coverage, and no coverage will be provided until the required premium has been received. Coverage must be continuous. and coverage will not be provided for any retiree who is more than 90 days delinquent in payment of the required premium without special action of the Board of Trustees.
- (1) Kaiser Coverage. Kaiser coverage is available to all retirees effective August 1, 1997.
- (11) **Health Net.** Health Net medical coverage is available to the retirees who were covered under the Valley Roofers Trust Fund when they became covered under the Bay Area Roofers Health & Welfare Plan in September of 1997.
Effective September 1, 2000 Health Net is available to all retirees.

- (12) **Bright Now Dental Plan.** The Bright Now Dental Plan is available to all retirees who elect dental coverage upon initial enrollment.

- (13) **Local Area.** The Local Area attributable to a retiree will be the geographical area he or she or she was reported as an active Retiree.

ELIGIBLE DEPENDENTS

For the purpose of this Plan, eligible dependents are defined as:

1. Your lawful spouse, or if you have no lawful spouse, your Registered Domestic Partner. For this purpose, Registered Domestic Partner shall mean any person who has registered a domestic partnership with a governmental body pursuant to state or Participant law authorizing such registration.
2. Your unmarried natural born children and other children defined as follows:
 - (a) Adopted Children. Adopted children beginning on the date of placement for the purpose of adoption;
 - (b) Stepchildren. Stepchildren who are domiciled with the Participant in a regular parent-child relationship and are chiefly dependent upon the Participant for support and maintenance;
 - (c) Guardianship. Other children who are (i) domiciled with the Participant in a regular parent-child relationship, (ii) are chiefly dependent upon the Participant for support and maintenance, and (iii) either the Participant or the spouse is the dependent's legal guardian.

Coverage for Children. Children, as defined above, are covered as dependents until age 19. Thereafter, they can be covered as dependents until age 24 if they attend an accredited educational institution and are financially dependent upon you for support.

If your spouse is also an eligible person for coverage under this Plan as an Retiree, your spouse shall be eligible both as an Retiree and as a dependent. When both husband and wife are insured as Retirees, their children are eligible as dependents of both. During the time anyone is eligible as an Retiree, he or she cannot also be eligible as a dependent child.

If a person has dual coverage under the Plan because he or she is eligible as the dependent of two insured Retirees, the total amount of benefits payable by reason of such dual coverage shall in no event exceed the amount of the expense actually incurred for which benefits are provided for such person under the Plan.

Handicapped Children

If an unmarried insured dependent child is:

1. Incapable of self support due to mental or physical incapacity; and
2. Dependent upon you for support and maintenance;

his or her coverage will not be terminated because of age. The Plan will require due proof of the child's incapacity within 31 days after he or she reaches the termination age for children.

The coverage for the child may be continued for as long as:

1. The incapacity and dependency continues; and
2. The coverage remains in force for you.

Newborn or Adoptive Children

A child born to you or your dependent spouse or domestic partner will become covered as a dependent. The effective date of coverage for the child will be the date of birth or the date of placement for adoption.

Effective Date of Dependent Coverage

In general, coverage for your dependents will become effective on the date you become eligible for coverage.

When Dependent Coverage Ends

Except as provided herein for survivorship coverage (page 10) or COBRA continuation (page 57), a dependent's coverage ends when he or she is no longer a dependent or you are no longer eligible for benefits. In addition, a dependent's coverage will end at midnight on the earliest of:

1. The last day of the month the dependent is no longer eligible;
2. The day any dependent premium is due and unpaid;
3. The moment a dependent enters the Armed Forces of any country. Membership in the reserves is not deemed entry into the Armed Forces unless the dependent is on temporary active duty of more than two weeks; or
4. The day your coverage ends.

Continuation Coverage

After you or your dependents' eligibility terminates, you may be eligible for continuation coverage for a limited period of time. Please refer to page 57 for a description of this coverage.

GENERAL EXCLUSIONS APPLICABLE TO ALL HEALTH BENEFITS

With respect to the Plan's Comprehensive Major Medical, Dental and Vision Benefits, the following general exclusions apply, together with the specific limitations applicable to each of these benefits.

No coverage is provided for losses caused or expenses incurred by or resulting from the following:

1. Services, supplies or equipment for which a charge is not customarily made in the absence of insurance. This does not apply to covered expenses incurred at a charitable research Hospital.
2. Injury or Sickness (a) arising out of or in the course of any employment for wages or profit, or (b) which is covered by any Workers' Compensation or Occupational Disease policy or (c) which under applicable state law should have been covered by a Workers' Compensation or Occupational Disease policy, whether or not such a policy was in force, or (d) arising out of or in the course of performing work in the roofing industry as a licensed or unlicensed contractor, whether or not such work is performed for pay. If there are reasonable grounds for suspecting that coverage is not afforded to a person because of this exception, the burden of proof shall be upon the claimant to demonstrate by a preponderance of the evidence that this exception does not apply.
3. Declared or undeclared war or act of war.
4. Expenses which are not approved by a Physician.
5. Cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part, reconstructive surgery because of a congenital disease or anomaly of you or your dependent and initial reconstruction of a breast after a mastectomy.
8. For any treatment which is not a Necessary Treatment as defined on pages 72 and 73 including treatments which are experimental in nature or not medically necessary. A drug, device or medical treatment or procedure is Experimental:
 - a. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
 - b. If reliable evidence shows that the drug, device or medical treatment or procedures is the subject of ongoing Phase I, II or III clinical trials or under study to determine its: Maximum tolerate dose, toxicity, safety or efficacy, as compared with the standard means of treatment or diagnosis.
7. Intentionally self-inflicted Injury or Sickness as defined on page 72.
8. Treatments for military service-connected conditions for which care or reimbursement is available from a government agency or program, other than Medicaid.
9. Treatments covered under other prepaid health programs, except for co-payments required of all prepaid plan members.
1. Any expenses which are in excess of the Usual and Customary Charge as defined on page 73.

2. Expenses for injuries incurred during the commission or attempted commission of any criminal act as defined by the State or Federal Government, involving, but not limited to the following:
 - . Involving the use of alcohol or illegal drugs, excluding minor traffic violations; or
 - . Involving violence or the threat of violence to another person; or
 - . In which the covered person uses a firearm, explosive or other weapon likely to cause physical harm or death.Should an individual accused of an aforementioned act(s) subsequently have the criminal charge dismissed or is acquitted of the charge in its entirety the exclusion above shall no longer be applicable to injuries resulting from the specific act. No additional rights are stated or implied under the Policy for such circumstances.

ELECTION OF COVERAGES

Medical and Prescription Drug Benefits Elections

At initial enrollment and at such other times as the Board of Trustees may determine, Retirees must elect between the following major medical and prescription drug coverages:

- Self-funded Plan, including self-funded prescription drug benefits.
- Kaiser coverage, including its prescription drug benefits, described in a separate brochure.
- Health Net, including its prescription drug benefits, described in a separate brochure.

Dental Benefits

The Trust Fund does not provide Dental coverage for the first year of participation in the plan. The Trust Fund will also not provide dental insurance for those Retirees who have requalified for insurance under the same qualifications as a new Retiree.

During the second and third years dental coverage will be provided only under the Bright Now Dental Plan. For a list of providers under the Bright Now Dental Plan call the Administrator's office at (408) 288-4457 or (408) 288-4456.

After 2 years in the Bright Now Dental Plan the Retiree will be allowed to change to the Self-Funded Dental plan during the next yearly Open Enrollment period.

Other Benefits

There are no optional elections at enrollment for alcohol and drug abuse or supplemental accident benefits. In addition, there are no optional elections for vision, life insurance and accidental death and dismemberment benefits.

COMPREHENSIVE MAJOR MEDICAL BENEFITS
Schedule of Benefits

Preferred Providers	Under the medical plan certain hospitals, doctors, and laboratories have agreed to accept negotiated rates for services provided to participants and dependents insured under this Plan. To receive the maximum available benefits, use a Blue Cross Prudent Buyer Hospital or Doctor for your covered services. If you need a listing of Participating Providers, you may obtain one from the Administrator's Office. This listing may contain providers that have discontinued their relationship with Blue Cross or may not include providers who have recently joined the network. For most current information, please check the Blue Cross website at www.bluecrossca.com . Read the cost containment section of this booklet for other cost containment measures the Board of Trustees has implemented to save YOU and YOUR TRUST FUND money.
Maximum	Effective August 1, 2005, there is a lifetime maximum of \$2,000,000.00 per person for claims incurred on or after October 1, 1991, limited to a maximum of: <ul style="list-style-type: none"> (a) For outpatient and mental and nervous disorders: 60 office visits per calendar year paid at 50% of Usual and Customary Charges per person. (b) For inpatient Hospital mental and nervous disorders limited to maximum 30 days per any 12-month period. (c) \$25,000 lifetime maximum per person for all treatments of alcohol and drug abuse. (d) Outpatient benefits for alcohol and drug abuse are limited to up to 40 hours of therapy per authorized use of the program. The maximum payable for such outpatient benefits in a calendar year is \$500.00.
Deductible Amount	\$300.00 per person per calendar year limited to \$600.00 per family per calendar year.
Deductible Carryover	The deductible is reapplied on January 1 of each year. However, expenses applied toward the deductible in the last 90 days of a calendar year will be applied towards the deductible for the next calendar year.
Coinsurance Percentage	100% for Second Surgical Opinion (deductible waived) 100% of contract rate at preferred provider laboratory after a \$10.00 deductible.
	<p>For Individuals residing WITHIN the Preferred Provider Service Area: 90% of contract rate if by a preferred provider Hospital. For Office Visits to a Preferred Provider Physician the co-pay will be \$20.00. This co-payment will be paid directly to the Physician at the time of your visit. These co-payments do not apply to the deductible amounts. 70% of Usual and Customary Charges by non-preferred provider. 80% of Usual and Customary Charges for prescription drugs and other covered supplies and services 50% of Usual and Customary Charges for outpatient mental and nervous disorders and alcohol and drug abuse benefits.</p> <p>For Individuals residing OUTSIDE the Preferred Provider Service Area: 80% of Usual and Customary Charges by a Hospital or Physician. 80% of Usual and Customary Charges for prescription drugs and other covered supplies and services. 50% of Usual and Customary Charges for outpatient mental and nervous disorders and alcohol and drug abuse benefits.</p>

Caremark Mail Order Prescriptions	No deductible applied. \$10.00 co-payment for generic, and \$25 co-payment for preferred brand names, and \$40.00 for all other brands up to a 90-day supply. If a generic is available and you are prescribed a brand prescription, you will be required to pay the difference between the cost of the generic and the brand prescription.
Caremark Prescription Card	No deductible applied. \$10.00 co-payment for generic, and \$25.00 co-payment for preferred brand names and \$40.00 for all other brands. If a generic is available and you are prescribed a brand prescription, you will be required to pay the difference between the cost of the generic and the brand prescription. You may continue to send your prescriptions for reimbursement under the Self-Funded medical plan but you will be subject to the annual deductible and co-payment See page 26 for prescription exclusions.
Individual Stop Loss	<p>For Preferred Providers: After \$10,000 of Preferred Provider covered expense in excess of the Deductible in a calendar year, reimbursement is made at 100% of the contract rate if performed by a preferred Hospital or Physician during the remainder of the calendar year.</p> <p>For Individuals Residing WITHIN the Preferred Provider Service Area: (a) After \$10,000 of Preferred Provider covered expenses in excess of the Deductible in a calendar year, reimbursement is made at 100% of the Usual and Customary Charges for prescription drugs and covered expenses (Hospitals or Physicians) during the remainder of the calendar year. (b) After \$50,000 of Non-Preferred Provider covered expenses in excess of the Deductible in a calendar year, reimbursement is made at 100% of the Usual and Customary Charges for Non-Preferred Provider covered expenses (including Hospitals or Physicians) during the remainder of the calendar year.</p> <p>For Individuals residing OUTSIDE the Preferred Provider Service Area: After \$10,000 of covered expenses in excess of the Deductible in a calendar year, reimbursement is made as follows: (a) For Non-Preferred Provider Hospitals or Physicians <u>outside</u> the Preferred Provider Service Area, and for prescription drugs and covered expenses (other than Hospitals or Physicians in the Preferred Provider Service Area) reimbursement is made at 100% of the Usual and Customary Charges during the remainder of the calendar year. (b) For Non-Preferred Provider Hospitals or Physicians inside the Preferred Provider Service Area, reimbursement is made at 100% of the Usual and Customary Charges during the remainder of the calendar year, but only after at least \$50,000.00 of Non-Preferred Provider covered expenses in excess of the Deductible have been incurred in that calendar year.</p>
Maximum Daily Room and Board Allowance	<p>For ward, semi-private or private accommodations: The average semi-private room rate of the Hospital in which confined. For intensive care and cardiac care units: the intensive care or cardiac care unit charge in the Hospital where confined. In either case the Plan will not pay more than the Usual and Customary Charges for such accommodations.</p> <p>Charges incurred on a per diem basis with a Preferred Provider Hospital are considered as a covered expense up to the usual charge made by the Hospital for each day of confinement for which the per diem charge is assessed</p>
Supplemental Accident	100% of Usual and Customary Charges up to \$500 benefit per injury (no

deductible applied); regular benefit schedule applies thereafter

Routine Physical	100 % of Physician examination including X-ray and laboratory expenses (no deductible applied) up to a maximum reimbursement of \$200 per Retiree and \$200 per spouse per calendar year as follows: (a) Every five years through 35 years (b) Every two years ages 36 through 50 (c) Every year age 51 and over
Comprehensive Preventive Care Benefits for Children	Maximum Number of Exams: Benefits are limited to 19 periodic physical examinations at approximately each of the following intervals: Birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years and 18 years. Effective August 1, 2000 the maximum allowance per periodic physical examination per age interval is \$250.00 for preventive care, which includes examination, laboratory and inoculations.
Skilled Nursing Facility	50% of a Hospital average semi-private room rate, if confined within 14 days after a Hospital confinement for which benefits were payable (no deductible applied).

The Plan covers medical and surgical benefits for mastectomies. The coverage includes:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and physical complications of all states of mastectomy, including lymph edemas.

The coverage is subject to the annual deductible, coinsurance, and other applicable plan provisions.

MAJOR MEDICAL BENEFITS

If you or your dependents incur covered expenses which are in excess of the deductible, if any, during any calendar year, the Plan will pay the Major Medical Benefits as stated in the Schedule of Benefits.

Covered Expenses

Any expense will be considered a covered expense if it satisfies the following conditions:

1. Is Necessary Treatment (as defined on pages 72 and 73) of a Sickness or Injury (as defined on page 72);
2. To the extent that it does not exceed Usual and Customary Charges (as defined on page 73);
3. Is received while covered for this benefit; and
4. Is covered under the Plan.

The following is a listing of covered expenses under Major Medical:

1. Hospital room and board (including intensive and cardiac care units);
2. Hospital extras such as recovery room and operating room charges, medications, anesthesia, etc.;
3. Charges made by a Physician;
4. Charges made for diagnostic testing;
5. Charges made for radiation and chemotherapy treatment;
6. Charges made for private duty nursing;
7. Charges made for prescription drugs from any licensed pharmacy or through the Plan's mail order prescription service (see pages 25, 26 and 27 for complete details);
8. Charges made for rental (or if cheaper, purchase) of wheelchairs, Hospital type beds, oxygen and equipment for its administration, and mechanical equipment for the treatment of respiratory paralysis;
9. Charges for physical therapy;
10. Charge made for artificial limbs, eyes, casts, splints, crutches and braces (not including dental braces);
11. Charges for ambulance service will be paid as any other medical benefit;
12. Charges for blood and blood plasma except when replaced;
13. Charges incurred at a Skilled Nursing Facility as defined on page 72. Confinement therein must start within 14 days of a Hospital stay. It must also be for continued treatment of the condition causing the Hospital stay or any subsequent condition or complication related to the condition that caused the Hospital stay or that arose as a result of the Hospital stay;

14. Charges made by a licensed home health care agency for home health care services, subject to a maximum of 100 visits in 12 consecutive months. Each visit by an Retiree of a licensed home health care agency will be considered one home health care visit. A visit of more than 4 hours in a day will be considered as 2 visits. Multiple visits a day by one or more persons shall be considered as one visit if they total less than 4 person hours;

Coverage includes:

- (a) part-time or intermittent nursing care by or under the supervision of a registered nurse;
 - (b) part-time or intermittent home health aide services which consist primarily of caring for the individual;
 - (c) physical therapy provided by a home health care agency; and
 - (d) medical supplies, drugs and medications prescribed by a Physician and laboratory services provided by or on behalf of a licensed home health care agency, but only to the extent that such charges would have been payable had the insured been confined in a Hospital.
15. Charges for routine mammographic examinations as diagnostic screening procedures, as specified:
 - (a) A baseline mammogram for covered females age 35 through 39;
 - (b) For covered females age 40 through 49 a mammogram every 2 years unless recommended more frequently by her attending Physician; and
 - (c) For covered females age 50 or over a mammogram annually.
 16. Charges for:
 - (a) the cost of fitting of external breast prostheses (but not more than two in any calendar year for each breast); and inpatient or outpatient chemotherapy; after a mastectomy for which benefits are paid under this Plan.
 - (b) Reconstruction of the breast on which the mastectomy was performed.
 - (c) Surgery and reconstruction of the other breast to produce a symmetrical appearance; or prostheses and physical complications of all states of mastectomy, including lymphedemas.

DEFINITION

Mastectomy means the removal of all or part of the breast for medically necessary reasons.

17. Charges for a routine pap smear exam, but not to exceed one exam each calendar year; and
18. Charges for in vitro fertilization limited to the following conditions:
 - (a) Physical certification of infertility exclusively attributed to bilateral tubal obstruction.
 - (b) Compatible hormonal profile including, and not limited to, at least one functioning ovary.
 - (c) A sufficient level of sound health to permit full-term delivery without unforeseeable complications.

Alcohol and Drug Abuse (\$25,000 Lifetime Maximum)

The Plan has two basic programs for treatment of alcohol or drug abuse, the Beat It! Program and the Self-Funded program. In general, you and the Plan will save money if you use the Beat It! Program. Whichever program you use, pre-admission authorization is required before you receive any inpatient services.

Kaiser and Health Net members are also eligible for the Beat It! Program. Kaiser and Health Net will not directly provide for alcohol and drug dependency treatment benefits. They will continue to provide detoxification functions and emergency services.

Beat It!

Beat It! benefits include comprehensive inpatient and outpatient programs in a pre-approved facility or with a pre-approved therapist. Benefits are paid without any deductible for any Participant or beneficiary (including Kaiser and Health Net members) as follows:

First time use- 100% of inpatient or outpatient services approved by Beat It!

Second time use- 80% of inpatient or outpatient services approved by Beat It!

No benefits are provided after the second time use.

Beat It! approved inpatient treatment environments are flexible and are determined by the individual needs of the patient. Treatment through Beat It! is available through contracting facilities and include acute care Hospitals and residential treatment facilities. (These facilities may differ from those available under the self-funded Plan.) All inpatient programs include twenty-one (21) to twenty-eight (28) days of primary care and six months to one year of aftercare for patients and family members.

Outpatient counselors are carefully selected according to their specific area of expertise and are matched appropriately with patients. Outpatient treatment plans include up to forty (40) hours of individual and family therapy.

Remember: in order for substance abuse benefits to be payable, you **MUST** contact Beat It! PRIOR to treatment. The telephone number for Beat It! is (408) 232-9885 or 1-800-828-3939.

If you or a family member is admitted to a Hospital on an emergency basis, you **MUST** contact Beat It! the first business day following admission.

Kaiser Program

Kaiser members should consult their Kaiser brochure for a description of its emergency and detoxification benefits. Kaiser does not provide alcohol and drug dependency treatment benefits. Kaiser participants must obtain their prescriptions from Kaiser.

Health Net Program

Health Net members should consult Health Net for details of its emergency and detoxification benefits. Health Net does not provide alcohol and drug dependency treatment benefits. Health Net participants must obtain their prescriptions from a Health Net participating pharmacy.

Self-Funded Program

The Self-Funded program includes substantial inpatient benefits and limited outpatient benefits. Hospitalization for acute alcohol or acute drug detoxification for the removal of toxic substances from the system is limited to a lifetime maximum of two (2) times per person.

Inpatient benefits for alcohol and drug abuse which are pre-authorized by United Administrative Services are paid the same as inpatient benefits for other conditions after satisfaction of the Plan's deductible as follows:

For Individuals Residing within the Preferred Provider Service Area:

90% of contract rate at preferred provider.

70% of Usual and Customary Charges at non-preferred provider.

For individuals Residing outside the Preferred Provider Service Area:

80% of Usual and Customary Charges outside the preferred provider service area.

Inpatient benefits are those incurred in a Hospital or treatment center as a resident patient.

Outpatient benefits are those incurred while not confined as a resident patient in a Hospital or treatment center.

Outpatient benefits for alcohol or drug abuse do not require pre-authorization, and, after satisfaction of the Plan's deductible, are paid at 50% of the Usual and Customary Charge for such benefits. The maximum payable for such outpatient benefits in a calendar year is \$500.00.

If you plan to enter an alcohol or drug abuse treatment program and you are NOT using the Beat It! Program, you MUST get pre-admission authorization through United Administrative Services (408) 288-4570 or (408) 288-4571. If you or a family member is admitted to a Hospital on an emergency basis, you must contact United Administrative Services the first business day following admission.

Lifetime Maximum

All alcohol and drug abuse benefits payable by the Plan under any of its programs are subject to a lifetime maximum of \$25,000 in benefits per person while covered under the Plan after October 1, 1991.

Mental and Nervous Disorders

If, as a result of a nervous or mental disorder, you or your dependent incurs covered expenses:

- (a) while confined as a resident patient in a Hospital, we will pay benefits as shown in the Schedule of Benefits for inpatient services; (see page 16)
- (b) while not confined as a resident patient in a Hospital, we will pay benefits as shown in the Schedule of Benefits for outpatient mental and nervous disorders. (see page 16)

Maximum Benefit

The total maximum amount payable for all disablements shall not exceed the amount indicated in the Schedule of Benefits with respect to the entire duration of coverage of any one Retiree or dependent except as provided by the section entitled Reinstatement below.

Common Accident

If two or more insured members of one family are injured in the same accident, only one deductible will be applied in the current and next succeeding calendar year against expenses arising from that accident, in order to satisfy the deductible.

Reinstatement

On January 1, of each year, each eligible family member who has previously received benefits is entitled to automatic restoration of his or her Lifetime Maximum then in effect by the lesser of \$10,000 or the amount necessary to restore his or her Lifetime Maximum to \$2,000,000.

Extension of Benefits

In the event coverage terminates while you or your dependents are receiving benefits under the Plan and if:

1. You or your dependents are totally disabled on the date of termination;
2. The expenses result from the same Injury or Sickness which caused the total disability;
 1. The expenses are incurred within 12 months after coverage terminated; and
 2. You or your dependents remain totally disabled as the result of the same Injury or Sickness;

then benefits for that Injury or Sickness will be paid on the same basis as if your coverage was still in force.

Limitations

No coverage is provided for losses caused or expenses incurred by or resulting from the following:

1. Dental care and treatment except that necessitated by injury and rendered within 6 months of the injury, and expenses incurred in connection with replacement of teeth caused by such injury or fracture of the jaw;
2. Eye examination for the purpose of prescribing corrective lenses or for the fitting of glasses;
3. Eyeglasses, hearing aids, or contact lenses except contact lenses when necessitated because of surgical procedures;
4. Charges made by a health care provider if related to you or your dependent or ordinarily residing with the person requiring treatment;
5. Any period of custodial care confinement in a Hospital or Skilled Nursing facility; or
6. Treatment to alter the insured person's physical characteristics to those of the opposite sex.

MAJOR MEDICAL PRESCRIPTION DRUG COVERAGE

Prescription Drugs that are FDA approved medication prescribed by a Physician are covered and subject to the following:

1. **Prescriptions Filled at Your Participant Pharmacy through Caremark**

An important part of your medical insurance program is the Caremark Retail prescription drug plan. Your prescription benefit is managed by Caremark. Under this plan, The Self Funded Medical Plan pays for a large part of the cost of medically necessary drugs and medicines. You and your dependents can buy the prescriptions you need to preserve your health.

You may fill your prescription at any of more than 50,000 pharmacies in the United States who transmit claim information via the Caremark Electronic System. Because of this technology, you will receive fast, accurate pharmacy service. Also, you will rarely need to submit a written claim form.

Getting Started is Easy! Fill your prescriptions in three simple steps:

Select a pharmacy

Present your benefit card to your pharmacist

Pay your portion of the medication cost

Over 90% of all pharmacies are Caremark members. To find out if a certain pharmacy accepts your card, call the pharmacy directly or log on to www.caremark.com to find a nearby pharmacy. However, there may be a rare occasion when you might not utilize a member pharmacy. Under these circumstances, you will have to submit a claim form for reimbursement. These forms can be obtained from UAS at 408-288-4457.

Your out-of-pocket costs at the retail pharmacy is \$10.00 for a generic Drug, \$25 for a Preferred Brand Drug and \$40 for a Non Preferred Brand Drug for a 34 day supply. If a generic is available and you are prescribed a brand prescription, you will be required to pay the difference between the cost of the generic and the brand prescription. Your Participant pharmacy is a good choice for short term or one-time prescriptions.

2. **Mail Service Pharmacy – Caremark.com**

Members may save time and money by obtaining their prescription medication through the Mail Service Pharmacy. For the same co-payments as retail, you may obtain up to a 90-day supply of medication. The medication is mailed directly to your home. The Mail Service Pharmacy is designed mainly for maintenance type medication for treatment of chronic or long-term conditions such as diabetes, arthritis, heart conditions, and high blood pressure, but may be used for any prescription medication, including oral contraceptives.

The Mail Service Pharmacy is through **Caremark.com, a home RX delivery from Caremark**. Order envelopes which contain complete information about this service may be obtained from UAS at 408-288-4457.

To get started with the Mail Service Pharmacy have your doctor write two prescriptions. One prescription for a short-term supply (e.g., 30 days) to be filled immediately at a participating retail pharmacy. A second prescription for the maximum days' supply allowed (90 days) with as many as

three refills (if appropriate) to mail to Caremark. Complete the mail service order form. Mail your order form, along with your original prescription, and payment, in the Caremark envelope. They accept VISA, MasterCard, Discover or American Express. You also can pay by check or money order.

Once you have sent in your doctor's prescription and the Mail Service order form, refills may be ordered over the telephone by calling 1-866-885-4944, or on line at www.Caremark.com.

Using the Mail Service Pharmacy not only saves you time and money, but also yields significant savings to your health benefit plan, due to the lower cost of prescriptions obtained through the Mail Service Pharmacy.

3. **Prescription Exclusions**

Non-Prescription drugs, vitamins, minerals and nutritional supplements.

Experimental substances and/or treatments not approved by the Food and Drug Administration, or investigative drugs or substances labeled "Caution – limited by Federal law to investigational use," even though a charge is made to the individual. Upon approval by the Food and Drug Administration they will be considered covered expenses from that time on.

Non-legend or over the counter drugs other than insulin.

Contraceptives, non-oral dosage forms.

Therapeutic devices or appliances, support garments and other non-medicinal substances regardless of intended use.

Hair growth stimulants.

Prescriptions which are covered by workers' compensation laws, or other county, state or federal programs.

Drugs dispensed or administered in an outpatient setting, including but not limited to outpatient hospital facilities and doctors' offices.

Oxygen.

Immunization agents, biological sera, blood or blood plasma.

Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

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

Each prescription is limited to the amount normally prescribed by the physician but not to exceed a 34-day supply or 100-unit dose, whichever is greater.

Drugs obtained outside the United States.

Professional charges in connection with administering or injecting drugs.
Devices, appliances and medical supplies.
Medications for weight loss.

Tretinoin topical (e.g. Retin A) for individuals 26 years of age or older.

Anti-wrinkle agents.

Cosmetic hair removal products.

Infertility medications.

Yohimbine.

Prior authorization will be required before your pharmacist can fill the following prescription drugs:

Embrel Arava Remicade Kineret Humira

SUPPLEMENTAL ACCIDENT BENEFIT

If you or your dependent incurs Covered Expenses as listed below as the result of the Necessary Treatment of an Injury, the Plan will pay the amount of Covered Expenses incurred within a period of 90 days from the date of the Injury, but the Plan will not pay more than \$500 per injury.

Covered Expenses

Covered Expenses with respect to this benefit consist of the following charges to the extent that they are Usual and Customary:

1. Hospital charges for daily board and bed or room and services.
2. Professional Participant ambulance service charges for transportation to a Hospital.
3. Charges made by a Physician for medical care and treatment for performing a surgical procedure.
4. Charges made by a Registered Nurse (R.N.).
5. Licensed practical nursing charges during Hospital confinement.
6. Charges made for the cost and administration of an anesthetic.
7. Charges made for x-ray examinations, microscopic tests, or any laboratory tests or analyses made for diagnosis or treatment purposes.
8. Charges made for treatments by a physiotherapist.
9. Charges made for the following supplies:
 - (a) Drugs and medicines requiring the written prescription of a Physician and which must be dispensed by a licensed pharmacist.
 - (b) Blood and blood plasma, except when replaced.
 - (c) Artificial limbs or eyes (but not replacement thereof).
 - (d) Casts, splints, trusses, crutches and braces (except dental braces).
 - (e) Oxygen and rental of equipment for the administration of oxygen.
 - (f) Rental of a wheel chair or Hospital bed.
10. Repair of sound, natural teeth, including replacement of such teeth.

MAJOR MEDICAL COST CONTAINMENT MEASURES

Your Board of Trustees has implemented some very important cost containment measures in order to save YOU and YOUR TRUST FUND money. Their success depends upon you.

Preferred Hospital and Physician Program

Your Trust Fund has negotiated reduced rates for you and your eligible dependents at several Hospitals and with numerous Physicians through the Blue Cross Prudent Buyer Plan. In obtaining treatment through a Blue Cross Prudent Buyer provider you will only have to pay 10% of the first \$10,000.00 of covered expenses in excess of the deductible in a calendar year instead of 30% of the first \$50,000.00 of covered expenses. Contact the Administrator's Office for a listing the Blue Cross Prudent Buyer Hospitals and Physicians or go to the web site at www.bluecrossca.com.

Upon your first visit to a Blue Cross Physician, show the receptionist or billing clerk your Blue Cross Prudent Buyer identification card. The Physician will bill the Administrator's Office which will remit payment directly to the doctor based upon the Blue Cross Prudent Buyer allowances.

Remember that referral to any Physician or Hospital that is not a Blue Cross Prudent Buyer provider will be considered under the standard policy format (i.e., 70% of Usual and Customary Charges).

Precertification Review Program

Before you are Hospitalized, you must have your Hospital admission certified through the Precertification Office at Blue Cross at (800) 274-7767. These instructions are on your identification card.

Discount Clinical Laboratory Program

Your Trust Fund has negotiated with numerous laboratories throughout California for lower rates on clinical laboratory tests. Simply by telling your Physician that you wish to go to one of the participating laboratories for your tests, you can save your Trust Fund money and **the maximum you will have to pay is \$10.00**. Your Trust Fund will pay 100% after a \$10.00 deductible for lab tests when you utilize one of the participating laboratories. Contact the Administrator's Office for a list of these laboratories.

Second Surgical Opinion Program

Benefits will be paid for the actual, Usual and Customary Charges, including laboratory and x-ray examinations when you consult with a participating doctor for a second surgical opinion. The surgery for which the opinion is obtained must be of a non-emergency nature and be a covered expense under the policy.

If the second opinion does not confirm the need for the surgery, benefits are also payable for a third opinion. These charges are also reimbursed at 100% for the actual, Usual and Customary Charges.

Normal benefits will be paid under the Plan for covered expenses incurred for elective surgery, subject to the other terms and conditions of the Plan.

If you have any questions about the Cost Containment Measures or want a list of participating Hospitals, Physicians and laboratories, please contact the Administrator's Office at 1120 South Bascom Avenue, San Jose, California 95128. Telephone – (408) 288-4400.

DIABETIC SELF-MANAGEMENT EDUCATION BENEFIT

Notwithstanding any provisions to the contrary, the Plan shall provide coverage for diabetic self-management education programs subject to all applicable terms and conditions of the Plan including those pertaining to the deductible and coinsurance.

This coverage shall pertain only to programs directed and supervised by a licensed Physician who is Board certified in internal medicine or pediatrics, and shall not provide coverage for programs whose sole or primary purpose is weight reduction.

These programs must be provided by health care professionals including, but not limited to, Physicians, registered nurses, registered pharmacists and registered dietitians who are knowledgeable about the disease process of diabetes and the treatment of diabetic patients.

Coverage provided hereunder will be under the same terms and conditions, subject to all the foregoing, as coverage for any other Sickness provided under the Plan.

DENTAL BENEFITS
(Applicable to those Retirees electing this coverage upon initial enrollment)

The Plan's self-funded dental benefit coverage is provided directly by the Plan, and is not insured by any insurance company.

Schedule of Benefits

Deductible Amount	The amount of Dental Expense Benefits which must be incurred before benefits are payable under Dental Expense Coverage. Effective January 1, 2004 the deductible increased to \$50 per person per calendar year and the family maximum per calendar year increased to \$150. The deductible amount does not apply to preventative services.	
Maximum Benefit	Dental Services per calendar year (effective January 1, 2004)	\$1,500
	Effective January 1, 2001: Orthodontia lifetime maximum while insured (per child)	\$2,000
Coinsurance Coverage (Paid by Plan)	Preventative, 100% of Usual and Customary Charges. Limited to one prophylaxis and bitewing X-rays per 6 month interval; full mouth X-rays, once any 3 year interval; topical fluoride for children under 15 limited to once in any 12 month interval. Other dental services covered, 80% of Usual and Customary Charges. Orthodontics (children only), 50% of Usual and Customary Charges.	

Alternate Courses of Treatment

If alternate procedures, services or courses of treatment may be performed for the treatment of the injury or disease concerned or to accomplish the desired result, the amount included as Covered Dental Expense will not exceed the Usual and Customary Charge for the least expensive procedure, service or course of treatment which, as determined by the Plan Administrator, will produce a professionally adequate result.

Covered Dental Expenses

COVERED DENTAL EXPENSES. Covered charges are limited to Usual and Customary Charges as defined on page 78, for the same services performed within the particular geographic area concerned.

Covered Dental Expenses included hereunder are the charges of a licensed dentist for Necessary Treatment for which you and your dependents are charged and liable for payment in connection with the following dental services and supplies received, while eligible:

1. Preventative Services (100% of Usual and Customary Charges)
 - (a) Routine periodic examinations at 6 month intervals including bitewing X-rays.
 - (b) Full mouth X-rays once in any 3-year interval unless special need is shown.
 - (c) Dental prophylactures as prescribed by the dentist but not more than once every 6 months.
 - (d) Topical fluoride applications as prescribed by the dentist but not more than once in any 12-month interval and only if the family member has not reached the age of 15 years.

2. Regular Restorative (70% of Usual and Customary Charges)
 - (a) Emergency treatment for relief of pain.
 - (b) Regular restorative services – amalgam, stainless steel crowns, synthetic porcelain and plastic restorations.
 - (c) Oral surgery provides for extractions and other oral surgery, including pre- and post-operative care.

3. Special Restorative (70% of Usual and Customary Charges)
 - (a) Gold restorations when the teeth cannot be restored with another filling material; crowns and jackets when the teeth cannot be restored with a filling material.
 - (b) Non-surgical periodontics – procedures necessary for the treatment of diseases of the gums.
 - (c) Endodontics – includes pulpal therapy and root canal filling.

4. Prosthetics, Removable and Fixed (70% of Usual and Customary Charges)
 - (a) Provides bridges, partial dentures and complete dentures.
 - (b) Replacement of an existing partial or full removable denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or to bridgework to replace extracted natural teeth, but only if evidence satisfactory to the Administrator's Office is presented that:
 - (i) The replacement or addition of teeth is required to replace one or more additional natural teeth;
 - (ii) The existing denture or bridgework was installed at least 5 years prior to its replacement and that the existing denture or bridgework cannot be made serviceable; or
 - (iii) The existing denture is an immediate temporary denture and replacement by a permanent denture is required, and takes place within 12 months from the date of installation of the immediate temporary denture.
 - (c) Space Maintainers.
 - (d) Repair or recementing of crowns, inlays, bridgework, or dentures or relining of dentures.
 - (e) Implants (appliances inserted into bone or soft tissue in the jaw, usually to anchor a denture) are covered after June 1, 2005. The Plan will not pay for any replacement for five years following the completion of the service

5. Periodontics (70% of Usual and Customary Charges)

The surgical procedures necessary for the treatment of diseases of the gums and bone supporting the teeth.

6. Injection of antibiotic drugs by attending dentist (70% of Usual and Customary Charges)

7. Orthodontic care, treatment, services and supplies (50% of Usual and Customary Charges)

Extension of Benefits

No payment will be made under this benefit for dental services or supplies furnished on or after the date of termination of your or your dependent's coverage, except under the following specified circumstances:

1. In the case of appliances or modifications of appliances, if the master impression was taken while dental coverage was in force, benefits will be payable if the appliance was delivered or installed within 2 calendar months after the termination of coverage.

2. In the case of a crown, bridge or inlay or onlay restorations, if the tooth or teeth were prepared while dental coverage was in force, benefits will be payable if such crown, bridge or cast restoration was installed within 2 calendar months after the termination of coverage.

3. In the case of root canal therapy, if the pulp chamber was opened while dental coverage was in force, benefits will be payable if such root canal therapy is completed within 2 calendar months after the termination of coverage.

Limitations

No coverage is provided for loss caused by or resulting from:

1. A service not reasonably necessary, or not customarily performed, for the dental care of you or your dependent;
2. A service furnished to you or your dependent for:
 - (a) Cosmetic purposes, unless necessitated as a result of injury. For purposes of this limitation, facings on crowns, or pontics, posterior to the second bicuspid shall always be considered cosmetic;
 - (b) Dental care of a congenital or developmental malformation;
3. Replacement of lost or stolen appliances;
4. Appliances, restorations, or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting, or replacing tooth structure lost as a result of abrasion or attrition, or treatment of disturbances of the temporomandibular joint;
5. A service not furnished by a dentist, unless the service is performed by a licensed dental hygienist under the supervision of a dentist or is an X-ray ordered by a dentist;
6. The replacement of any prosthetic appliance, crown, inlay or onlay restoration or fixed bridge or implant within 5 years of the date of the last placement of such appliance, crown, inlay or onlay restoration or fixed bridge or implant unless such replacement is required as a result of injury;
7. An initial placement of a partial or full removable denture or fixed bridgework if it involves replacement of one or more natural teeth lost prior to the person becoming covered, until such person has been covered by the Plan for a period of 12 months after initial eligibility. This limitation does not apply if the denture or fixed bridgework also includes replacement of a natural tooth which is extracted while the person is covered and before he or she has been covered for 12 months as described above.

No benefits will be paid for any expenses incurred after termination of coverage for any reason whatsoever except as specifically provided under Extension of Benefits on page 32.

VISION BENEFITS
(Applicable to those retirees electing this coverage upon initial enrollment)

Schedule of Benefits

STANDARD EYE EXAMINATION AND GLASSES

Eye Examination:	Once each 12 months*
Spectacle Lenses:	Once each 12 months*
Frames:	Once each 24 months*

** from your last date of service*

Subject to a co-payment of twenty dollars (\$20.00). See Step Three on page 35.

SPECTACLE LENSES AND FRAME:

Vision Service Plan covers a wide selection of frames, but not all frames will be covered in full. When a patient selects a frame that exceeds the Plan's allowance, these additional charges are administered at VSP's controlled costs. VSP also has controlled costs for cosmetic options, and these charges are typically less than usual and customary fees. Please consult your participating doctor about lens options which may be cosmetic in nature, and may result in additional costs.

VSP offers you even more value by providing you with a 20% discount on a second pair of prescription glasses.

CONTACT LENSES:

Elective or medically necessary contact lenses may be provided instead of glasses.

Elective contact lenses: The standard eye examination is covered in full, less a \$20.00 co-payment. An allowance will be provided toward the contact lens evaluation examination, fitting costs, and materials. Any costs exceeding the allowance are the patient's responsibility.

Contact lens frequency is the same as for spectacle lenses (eyeglasses). Under this plan, if you elect contact lenses, you will be eligible for a frame **24 months after** the last date of obtaining the contact lenses.

VSP's additional value is also extended to include a 15% discount off the participating doctor's professional services when you purchase prescription contact lenses. Materials are provided at usual and customary fees. This benefit is available in conjunction with your VSP contact lens allowance, or you can use it to purchase contacts in addition to glasses.

You may use these discounts for 12 months following the date of the covered eye examination. Also, these discounts are only offered through the VSP participating doctor who provided the last covered eye examination.

Medically necessary contact lenses: Covered in full when prescribed by a participating doctor for one of the following conditions:

- following cataract surgery;
- to correct extreme vision problems that cannot be corrected with spectacle lenses;
- with certain conditions of anisometropia; or
- with certain conditions of keratoconus.

The participating doctor must secure prior approval from VSP for medically necessary contact lenses.

HOW DOES THE VISION PLAN WORK?

STEP ONE: When you are ready to obtain vision care services, call your VSP participating doctor. If you need to locate a VSP participating doctor, call Vision Service Plan at (800) 877-7195 (T.D.D. for the hearing impaired 1-800-428-4833) or visit their World Wide Web site at www.vsp.com.

STEP TWO: When making an appointment, identify yourself as a VSP member. The participating doctor will also need the covered member's identification number (usually the social security number), and the covered member's group name which is the Bay Area Roofers Health and Welfare Plan. The participating doctor will contact VSP to verify your eligibility and plan coverage. The participating doctor will also obtain authorization for services and materials. If you are not eligible, the VSP doctor will notify you.

STEP THREE: At your appointment, the participating doctor will provide an eye examination and determine if eyewear is necessary. If so, the participating doctor will coordinate the prescription with a VSP approved, contract laboratory. The participating doctor will itemize any non-covered charges and have you sign a form to document that you received services. VSP will pay the participating doctor directly for covered services and materials. You are responsible for paying the doctor a \$20.00 co-payment, and any additional costs resulting from cosmetic options, or non-covered services and materials you have selected. Selecting a participating doctor from VSP's network assures direct payment to the doctor and guarantees quality services and materials.

WHAT IF I DON'T USE A PARTICIPATING DOCTOR?

More than 90% of VSP patients receive services from participating doctors, although you may select any licensed vision care provider for services. Your reimbursement schedule does not guarantee full payment, nor can VSP guarantee patient satisfaction, when services are obtained from a non-participating provider.

Follow these steps if you obtain services and/or materials from a non-participating provider:

1. Pay the provider the full amount of the bill and request a copy of the bill that shows the amount of the eye examination, lens type and frame.
2. Send a copy of the itemized bill(s) to VSP. The following information must also be included in your documentation:
 - Member's name and mailing address.
 - Member's social security number.
 - Member's group name (Bay Area Roofers Health and Welfare Plan).
 - Patient's name, relationship to member and date of birth.

You may submit the information on a HCFA-1500 form or any generic insurance claim form that may be available from you non-participating provider upon request.

Please mail the itemized bill(s) and form to the following address:

VISION SERVICE PLAN
Attn. Out-of Network Claims
P. O. Box 997100
Sacramento, California 95899-7100

All claims must be filed within six months of the date services were completed. Reimbursement benefits are made directly to the covered member and are not assigned to the provider. Contact the Administrator's Office for further information about the Plan's non-member provider schedule.

**LIFE INSURANCE
(INSURED BY PACIFIC LIFE AND ANNUITY)
SCHEDULE OF BENEFITS**

The group policy uses certain terms that have special meanings. These terms are defined in the definition sections and other parts of the text.

INSURANCE CLASSES

Class I Retired Retirees under age 65.

Class 2 Retired Retirees age 65 and over.

RETIREE LIFE INSURANCE

BENEFIT:

Class 1	\$10,000
Class 2	\$6,000

RETIREE AD&D INSURANCE

FULL BENEFIT:

Class 1	\$10,000
Class 2	\$6,000

DEPENDENT LIFE INSURANCE

Spouse	\$3,000
Child – Age:	
From birth through 5 months	\$200
6 months but under 19 years	\$3,000
Full-time students 19 years but under 24 years	\$3,000

Benefit Limit. The amount of life insurance for each of your dependents will not be more than 50% of the amount of your life insurance. If the amount shown above for a dependent is more than 50% of you life insurance amount, it will be reduced to 50% of you life insurance amount.

RETIREE LIFE INSURANCE

Pacific Life & Annuity will pay an Retiree Life Benefit if you die while insured for the Retiree Life Insurance.

RETIREE LIFE BENEFIT

Benefit

The “Retiree Life Benefit” is the benefit that will be paid if you die. The amount of the Retiree Life Benefit is the amount determined from the Schedule of Benefits. The Retiree Life Benefit will be paid to your beneficiary in one sum unless a settlement option is in effect.

Beneficiary

A “beneficiary” is the person, or one of the persons, you designate to receive any benefit to be paid under the group policy for the loss of your life.

Beneficiary Designation. By written request to Pacific Life & Annuity at its Home Office:

1. You may designate anyone as your beneficiary; and
2. You may change your beneficiary designation at any time.

The consent of a beneficiary is not required. Pacific Life & Annuity shall not be held liable for a payment made to another person before your written request is received at Pacific Life & Annuity’s Home Office.

More Than One Beneficiary. Benefits will be paid in equal shares to your beneficiaries unless you state otherwise in your beneficiary designation. The share of a beneficiary who does not live to receive payment will pass equally to those who survive unless you state otherwise in your beneficiary designation.

Beneficiary Not Designated. If you do not designate a beneficiary or if no beneficiary lives to receive payment, then the benefits shall be paid to the person or persons who appear first in the list below and who live to receive payment:

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

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

Settlement Options

A “settlement option” is an option to have your Retiree Life Benefit paid in installments rather than in one sum. With the written consent of Pacific Life & Annuity:

1. you may elect a settlement option of your choice;
2. you may change the terms of a settlement option; and
3. your beneficiary may elect a settlement option if none is in effect at the time of your death.

FOR TOTAL DISABILITY/EXTENDED BENEFITS

The Extended Life Insurance Benefit and Premium Waiver Benefit are referred to here as the “Extended Benefits”. Pacific Life & Annuity will provide the Extended Benefits, as set forth below, if you become totally disabled while you are under age 60 and while you are insured for the Retiree Life Insurance.

The Extended Life Insurance Benefit applies during the period of your total disability before Pacific Life & Annuity determines whether or not you qualify for the Premium Waiver Benefit.

Extended Life Insurance Benefit

If your Retiree Life Insurance ends while you are totally disabled and you die before you qualify for the Premium Waiver Benefit, Pacific Life & Annuity will pay the Extended Benefit Amount (see page 39) to your beneficiary provided:

1. you became totally disabled while you were insured for the Retiree Life Insurance;
2. you were under 60 years of age when you became totally disabled;
3. you die within 12 months of the date your total disability started; and
4. you stayed totally disabled from the date your total disability started until the date of your death.

The Extended Benefit Amount shall be paid in place of the Retiree Life Benefit (see page 39).

Premium Waiver Benefit

Waiver. Pacific Life & Annuity will keep in force or reinstate your Retiree Life Insurance and waive the payment of premiums for it during the premium waiver period described below if:

1. you become totally disabled while you are insured for the Retiree Life Insurance;
2. you are under 60 years of age when you become totally disabled;
3. you stay totally disabled for six consecutive months; and
4. you give written proof of your total disability to Pacific Life & Annuity, at no cost to Pacific Life & Annuity, during the last three months of each 12-month period that follows the start of your total disability.

During the premium waiver period, you will be insured for an Extended Benefit Amount in place of the Retiree Life Benefit (see page 39).

Premium Waiver Period. A premium waiver period begins on the later of: (a) the first day of the tenth consecutive month of your total disability; or (b) the date Pacific Life & Annuity approves the proof of your total disability.

The premium waiver period continues only while you stay totally disabled. You must give written proof to Pacific Life & Annuity, at no cost to Pacific Life & Annuity, that you are still totally disabled. That proof must be submitted during the last three months of each 12-month period during which the total disability continues. If, for any reason, you do not give that proof to Pacific Life & Annuity, the premium waiver period will end as stated below. During the premium waiver period, Pacific Life & Annuity has the right to have a Physician of its choice examine you, at Pacific Life & Annuity’s cost, whenever Pacific Life & Annuity may reasonably require it. If, for any reason, you fail to have an examination that is asked for by Pacific Life & Annuity, the premium waiver period will end as stated below.

The premium waiver period will end on the earliest of the dates that follow:

1. The date you stop being totally disabled;
2. The date Pacific Life & Annuity requests proof of your total disability, if you fail to furnish the proof;
3. The date Pacific Life & Annuity requests that you have an examination, if you fail to have the examination; or
4. The date you convert your Retiree Life Insurance under the terms of the Retiree Life Conversion Privilege.

Other Extended Benefits Provisions

Total Disability. As used here, “total disability” and “totally disabled” mean that you are unable, due to disease or injury, to perform the substantial and material duties of any gainful occupation for which you are reasonably fitted by education, training, or experience.

If, prior to attaining age 60, you irrecoverably lose the sight of both eyes, the use of both hands or both feet, or the use of one hand and one foot, you will be considered totally disabled for the remainder of your life even though you are able to resume gainful employment.

Effect of Life Conversion Privilege. If you die during the conversion period, an Retiree Life Benefit will be provided as stated in the Retiree Life Conversion Privilege. If you convert your Retiree Life Insurance under the terms of the Retiree Life Conversion Privilege:

1. the Extended Benefits will not apply to you; and
2. any coverage that may be in force under the Extended Benefits will end on the date your Retiree Life Insurance is converted.

The Extended Benefits will again apply to you if you are still eligible for them and your individual policy is surrendered to Pacific Life & Annuity without any claim for benefits.

Coverage When Extended Benefits End. When your total disability and your coverage under these Extended Benefits end:

1. you may again be insured for the Retiree Life Benefit that applies to your insurance class if you are then eligible; or
2. your rights under the Retiree Life Conversion Privilege will apply if you are not then eligible.

Written Notice of Death. No Extended Benefit Amount will be paid unless written notice of your death is given to Pacific Life & Annuity at its Home Office within 12 months of the date you die.

RETIREE LIFE CONVERSION PRIVILEGE

You can convert to an individual policy of life insurance if your Retiree Life Insurance ends under the conditions set forth below. You must apply and pay the first premium to Pacific Life & Annuity within the conversion period.

If Your Eligibility Ends

If your Retiree Life Insurance ends because: you are no longer in an eligible class of Retirees for a reason other than: (a) termination of the group policy; or (b) termination of the Retiree Life Insurance, you can then convert to an individual policy of life insurance. In this event, the individual policy will be for an amount equal to the amount that ended, unless Pacific Life & Annuity agrees to convert a lesser amount.

If Retiree Life Insurance Terminates

You can also convert to an individual policy of life insurance if you have been insured for the Retiree Life Insurance for at least five consecutive years and your insurance ends because:

1. the group policy terminates; or
2. the Retiree Life Insurance terminates for the eligible class of Retirees you are in.

In this event, the amount of the individual policy will not be more than the lesser of:

1. \$2,000; or
2. the amount of Retiree Life Insurance that terminated, reduced by the amount of life insurance for which you are or become eligible under a group policy issued or reissued by Pacific Life & Annuity or by any other insurer during the conversion period.

Following Total Disability Extension

You can convert to an individual policy of life insurance if:

1. you qualified for the Total Disability Extended Benefits;
2. your Extended Benefits end; and
3. you are not then in an eligible class of Retirees.

In this event, the individual policy will be for an amount equal to the Extended Benefit Amount that ended, unless Pacific Life & Annuity agrees to convert a lesser amount.

Individual Policy

The individual policy of life insurance:

1. will not require evidence of insurability from you for its issue;
2. may be in any one of the forms, except term insurance, chosen by you from the forms customarily issued by Pacific Life & Annuity at the age and amount applied for;
3. will not have any disability or supplementary benefits; and
4. will be in exchange for all of your rights under the Retiree Life Insurance, except as stated in the Total Disability Extended Benefits provisions.

The premium charged for the individual policy will be Pacific Life & Annuity's customary rate that then applies: (a) to the form and amount of that policy; and (b) to your age and class of risk on the effective date of that policy.

Conversion Period

As used here, a “conversion period” is the period of 31 days that follows: (a) the date your Retiree Life Insurance ends; or (b) the date your Total Disability Extended Benefits end.

Notice of Conversion Rights

If you do not receive notice of the right to convert at least 15 days before the end of the conversion period, then you will have an additional period to apply. This additional period:

1. will be the period of 25 days that follows the date you are given such notice, but will in no case extend beyond 60 days after the end of the conversion period; and
2. will in no case be deemed a part of the conversion period.

Notice in writing that is given to you in person or that is mailed to your last known address by Pacific Life & Annuity or by the Policyholder will constitute notice for the purposes of this conversion privilege. To the extent that Pacific Life & Annuity is required to give notice of the right to convert, the Policyholder is the agent of Pacific Life & Annuity provided the notice is given in the manner and at the time directed by Pacific Life & Annuity.

Death Benefit During Conversion Period

The amount of life insurance you are entitled to convert will be paid by Pacific Life & Annuity under the Retiree Life Insurance:

1. if you die during the conversion period and before the effective date of the individual policy; and
2. whether or not you have applied and paid the first premium for the individual policy.

RETIREE ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Pacific Life & Annuity will pay an Accidental Death and Dismemberment (AD&D) Benefit for a covered loss due to an injury you sustain in an accident that occurs while you are insured for the Retiree AD&D Insurance. AD&D is in addition to the Retiree Life Insurance.

Benefit

An “AD&D Benefit” is the benefit that will be paid for the covered losses you sustain. The AD&D Benefit for a covered loss is the Full Benefit or one half the Full Benefit, as shown in the Table of Losses and Benefits below. Pacific Life & Annuity will not pay more than the Full Benefit for all covered losses from one accident. The amount of the Full Benefit is shown in the Schedule of Benefits.

The AD&D Benefit for loss of life will be paid to your beneficiary as stated in the beneficiary provision of the Retiree Life Insurance. All other AD&D Benefits will be paid to you.

Covered Loss

A “covered loss” is a loss:

1. that is shown in the Table of Losses and Benefits;
2. that results, directly and independently of all other causes, from an injury you sustain in an accident that occurs while you are insured for the Retiree AD&D Insurance;
3. that occurs within 90 days from the date of the accident; and
4. that is not excluded by the AD&D Exclusions or the General Health Limitations.

Table of Losses and Benefits

Please refer to page 36 for the Full Benefit amount under the Retiree AD&D Insurance.

Loss of:

Life.....	Full Benefit
Both Hands.....	Full Benefit
Both Feet.....	Full Benefit
Both Eyes.....	Full Benefit
A Hand & a Foot.....	Full Benefit
A Hand & an Eye.....	Full Benefit
A Foot & an Eye.....	Full Benefit
A Hand.....	Half the Full Benefit
A Foot.....	Half the Full Benefit
An Eye.....	Half the Full Benefit

Loss of a hand or foot means the complete and permanent severance of the hand or foot at or above the wrist or ankle joint. Loss of an eye means the entire and permanent loss of the sight of that eye.

AD&D Exclusions

No AD&D Benefit will be paid for a loss: (a) that is excluded by the General Health Limitations; or (b) that is caused or contributed to by any:

1. disease;
2. drug, chemical, poison, or inhalation of gas; or
3. injury that is sustained:
 - a. in the course of any medical or dental diagnosis or treatment, including the therapeutic use of nuclear energy; or
 - b. while you are in or upon any aircraft, unless you are a fare-paying passenger on a regularly scheduled flight.

Exception to General Health Limitations. The General Health Limitation that excludes benefits for an injury that arises out of or in the course of employment does not apply to the Retiree AD&D Insurance.

DEPENDENT LIFE INSURANCE

Pacific Life & Annuity will pay a Dependent Life Benefit if a dependent dies while insured for the Dependent Life Insurance.

Benefit

A "Dependent Life Benefit" is the benefit that will be paid if a dependent dies. The amount of the Dependent Life Benefit is the amount determined from the Schedule of Benefits. The Dependent Life Benefit will be paid in one sum to you if you are living; if you are not living, it will be paid as follows:

1. If it is your dependent spouse who dies, the benefit will be paid in one sum to your spouse's beneficiary; if there is no beneficiary, the benefit will be paid in equal shares to your surviving children; if these are no surviving children, the benefit will be paid to the estate of your deceased dependent spouse.
2. If it is a child who dies, the benefit will be paid to your surviving spouse, if living. If there is no surviving spouse, the benefit will be paid in equal shares to the child's surviving brothers and sisters, or if none survive, the benefit will be paid to the estate of the deceased child.

B. Beneficiary

A "beneficiary" is the person, or one of the person(s), that your spouse designates to receive any benefit to be paid under the group policy for the loss of your spouse's life if you are no longer living.

Beneficiary Designation. By written request to PL&A at its Home Office:

1. the spouse may designate anyone as his beneficiary; and
2. the spouse may change his beneficiary designation at any time.

The consent of a beneficiary is not required. PL&A shall not be held liable for a payment made to another person before the spouse's written request is received at PL&A's Home Office.

More Than One Beneficiary

Benefits will be paid in equal shares to the spouse's beneficiaries unless stated otherwise in the spouse's beneficiary designation. The share of a beneficiary who does not live to receive payment will pass equally to those who survive unless stated otherwise in the spouse's beneficiary designation.

Continued Dependent Life Insurance Benefits During Your Total Disability

If you are eligible for Total Disability Extended Benefits as described in the Retiree Life Insurance provisions, your dependents may be eligible for Continued Dependent Life Insurance Benefits. The Continued Dependent Life Insurance Benefits will apply only to your dependents who are insured under the Dependent Insurance on the date you become eligible for the Total Disability Extended Benefits. If your covered dependent dies while you are eligible for the Total Disability Extended Benefits, the Dependent Life Benefit will be payable as provided above.

If your eligibility for the Total Disability Extended Benefits ends, your dependents' eligibility for Continued Dependent Life Insurance Benefits will also end. If you die while you are insured for an Extended Benefit Amount, your covered dependents may be eligible to continue the Dependent Insurance under the terms of the Survivor Benefit provision or to convert to an individual policy of life insurance as explained in the Dependent Life Conversion Privilege provision, below.

Dependent Life Conversion Privilege

A dependent can convert to an individual policy of life insurance if the Dependent Life Insurance ends for the dependent under the conditions set forth below. The dependent must apply in writing and pay the first premium to Pacific Life & Annuity for the individual policy within the conversion period.

If a Dependent's Eligibility Ends. If the Dependent Life Insurance ends for your dependent because:

1. you die; or
2. you are no longer in an eligible class of Retirees for a reason other than: (a) termination of the group policy; or (b) termination of the Retiree Life Insurance,

then the dependent can convert to an individual policy of life insurance. In this event, the individual policy will be for an amount equal to the amount that ended, unless Pacific Life & Annuity agrees to convert a lesser amount.

If a Dependent's Eligibility Ends. If the Dependent Life Insurance ends for your dependent because:

1. you are no longer married; or
2. he or she reaches the age limit for a dependent child,

then the dependent can convert to an individual policy of life insurance. In this event, the individual policy will be for an amount equal to or less than the amount that ended.

If Dependent Life Insurance Terminates. A dependent can also convert to an individual policy of life insurance if:

1. the group policy terminates or the Dependent Life Insurance terminates for the eligible class of dependents the dependent is in; and
2. the dependent has been insured for the Dependent Life Insurance for at least five consecutive years at the date of such termination.

In this event, the amount of the individual policy will not be more than the lesser of:

- a. \$2,000; or
- b. the amount of Dependent Life Insurance that terminated, reduced by the amount of any life insurance for which the dependent is or becomes eligible under a group policy issued or reissued by Pacific Life & Annuity or by any other insurer during the conversion period.

Individual Policy. The individual policy of life insurance:

1. will not require evidence of insurability from the dependent for its issue;
2. may be in any one of the forms, except term insurance, chosen by the dependent from the forms customarily issued by Pacific Life & Annuity at the age and amount applied for;
3. will not have any disability or supplemental benefits; and
4. will be in exchange for all of the dependent's rights under the Dependent Life Insurance.

The premium charged for the individual policy will be Pacific Life & Annuity's customary rate that then applies: (a) to the form and amount of that policy; and (b) to the dependent's age and class of risk on the effective date of that policy.

Conversion Period. As used here, a "conversion period" is the period of 31 days that follows the date the Dependent Life Insurance ends for a dependent.

Notice of Conversion Rights. If your dependent does not receive notice of the right to convert at least 15 days before the end of the conversion period, then the dependent will have an additional period to apply. This additional period:

1. will be the period of 25 days which follows the date the dependent is given such notice, but will in no case extend beyond 60 days after the end of the conversion period; and
2. will in no case be deemed a part of the conversion period.

Notice in writing that is given to you in person or that is mailed to your last known address by Pacific Life & Annuity or by the Policyholder will constitute notice for the purposes of this conversion privilege. To the extent that Pacific Life & Annuity is required to give notice of the right to convert, the Policyholder is the agent of Pacific Life & Annuity provided the notice is given in the manner and at the time directed by Pacific Life & Annuity.

Death Benefit During Conversion Period. The amount of life insurance the dependent is entitled to convert will be paid by Pacific Life & Annuity under the Dependent Life Insurance:

1. if the dependent dies during the conversion period and before the effective date of the individual policy; and
2. whether or not the dependent has applied and paid the first premium for the individual policy.

NOTICE, PROOF, AND PAYMENT OF AD&D CLAIMS

These Notice, Proof, and Payment of Claims provisions apply to Accidental Death and Dismemberment but not to any life insurance under the group policy.

Time of Notice

You must send written notice of a claim to Pacific Life & Annuity at its Home Office, or to an agent of Pacific Life & Annuity, within 20 days after an expense or loss occurs. If you can not send it within that time, you must send it as soon as reasonably possible.

Forms

When Pacific Life & Annuity receives the notice of claim, Pacific Life & Annuity will send a claim form to you for filing proof of loss. If Pacific Life & Annuity does not send the claim form within 15 days, you will be deemed to comply with the proof of loss requirements by sending written proof of loss as set forth below. The written proof must show: (a) the date the loss occurred or began; (b) the cause of the loss; and (c) the extent of the loss.

Proof of Loss

In the case of a health claim for expense or loss for which a periodic benefit is paid while the loss continues, you must send written proof of loss:

1. to Pacific Life & Annuity at its Home Office; and
2. within 90 days after the end of each period for which the benefits are to be paid.

In the case of a health claim for any other expense or loss, you must send written proof of loss to Pacific Life & Annuity within 90 days after the date the expense or loss is incurred. Pacific Life & Annuity will not deny or reduce a claim due to the fact that you are not able to send the proof of loss within 90 days, if you send the proof of loss to Pacific Life & Annuity:

1. as soon as it is reasonably possible to do so; and
2. in no case, but for the lack of legal capacity, more than one year after it is otherwise required.

Time of Payment

If you send written proof of loss to Pacific Life & Annuity as required:

1. Pacific Life & Annuity will pay periodic health benefits as they accrue, at least once each month. Any balance that has not been paid at the end of the period of liability will be paid as soon as Pacific Life & Annuity receives due written proof.
2. Pacific Life & Annuity will pay all other health claims as soon as Pacific Life & Annuity receives the proof of loss.

To Whom Benefits Are Payable

Any benefits payable for loss of your life will be paid to the beneficiary you have designated to receive such benefits. Except as set forth below, any other benefits that have not been paid when you die may be paid, at the option of Pacific Life & Annuity, either to your beneficiary or to your estate. All other amounts will be paid to you for reasons other than death.

Benefits Unpaid at Death; Incompetency

Pacific Life & Annuity may pay, to any person or institution that Pacific Life & Annuity finds to be entitled to the payment, as much as \$500 of any benefits that:

1. are to be paid at the time of your death; or
2. are to be paid to a person who is a minor or who is not able to execute a valid release and for whom no guardian has been appointed.

To the extent of the payment, Pacific Life & Annuity will have no more liability under the group policy.

Physical Examination and Autopsy

Pacific Life & Annuity shall have the right and opportunity to have a covered person examined by a Physician of its choice to determine the extent of any Sickness or Injury for which you have made a claim. This right may be used as often as it is reasonable to do so. If a covered person dies, Pacific Life & Annuity may require an autopsy where the law does not forbid it. Such an examination or autopsy shall be made at Pacific Life & Annuity's expense.

Legal Action

No legal action can be started with respect to health claims under the group policy:

1. until 60 days after the required proof of loss has been sent to Pacific Life & Annuity; or
2. more than three years after the time proof of loss is required.

DISCONTINUANCE PROVISIONS

POLICY TERMINATION DURING TOTAL DISABILITY

Your Life Conversion Privilege

You can convert your Retiree Life Insurance to an individual policy of life insurance as if your employment had ended, if:

1. you become totally disabled while insured for the Retiree Life Insurance under the group policy; and
2. you are still totally disabled on the date the group policy terminates,

but the amount that you can convert at that time will not be more than any part of your Retiree Life Insurance which:

1. is not replaced by some other group life coverage within 60 days; and
2. is not continued under the Total Disability Extended Benefits section of the Retiree Life Insurance.

GENERAL HEALTH LIMITATIONS

The General Health Limitations apply only to the AD&D Insurance under the group policy.

Excluded Charges List

No benefit will be paid for or in connection with any injury or disease:

1. that is intentionally self-inflicted while sane or that is self-inflicted while insane; or
2. that results from: (a) any act of war; (b) the covered person's commission of a crime; or (c) nontherapeutic release of nuclear energy.

GENERAL PROVISIONS

These General Provisions apply to all insurance under the group policy.

Assignment

No assignment of the group policy or any rights or benefits under the group policy will have any force or effect unless and until Pacific Life & Annuity consents to it in writing.

Incorrect Reporting

The facts shall be used to determine to what extent, if at all, a covered person is or was insured under the group policy when:

1. any information that pertains to the covered person is found to have been reported incorrectly to Pacific Life & Annuity; and
2. the error affects the existence or amount of the insurance.

In this event, a fair adjustment in premiums or in the amount of insurance, or both, shall be made.

Exemptions

To the full extent the law permits, all rights and benefits that accrue under the group policy shall be exempt from execution, attachment, or other legal process for the debts or liabilities of any covered person or beneficiary.

Workers' Compensation

The group policy is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

Entire Contract

The entire contract will be made up of: (1) the group policy; (2) the application of the Policyholder, a copy of which is attached to the group policy; and (3) the applications, if any, of the Retirees.

Statements Not Warranties

All statements made by the Policyholder or by an insured Retiree will, in the absence of fraud, be deemed representations and not warranties. No statement made by the Policyholder or by the Retiree to obtain insurance will be used to avoid or reduce the insurance unless it is made in writing and is signed by the Policyholder or the Retiree and a copy is sent to the Policyholder, the Retiree, or his or her beneficiary.

Right to Contest

After the group policy has been in force for two years, Pacific Life & Annuity has no right to contest its validity except for non-payment of premiums. Pacific Life & Annuity has no right to contest the insurance of an Retiree on the basis of any statement made by the Retiree after the Retiree's Insurance has been in force for two years during his or her lifetime; and before then only if the statement was in writing on a form signed by the Retiree and a copy of it is given to the Retiree or his or her beneficiary.

Addresses for Complaints

If you have a complaint about this insurance, please let us know. If your question is on a specific claim, call the TOLL FREE NUMBER which is provided in the correspondence from our claims office at 1-800-733-7020, ext. 4203 or 1-800-733-3227.

The Administrator's Office will be able to provide you with the address and phone number of the appropriate office where you should direct any other questions concerning this insurance.

If the problem is not resolved, you may write:

Yves Pinkowitz
Corporate Audit
Pacific Life & Annuity Life Insurance Company
P.O. Box 9000
Newport Beach, California 92658

If, after contact with the above, you do not have a satisfactory solution to the problem, you may also contact:

**Consumer Services Bureau
Department of Insurance
300 South Spring Street, South Tower
Los Angeles, California 90013**

Consumer Hotline Toll Free Number: 1-800-927-4357

This notice of complaint procedure is for information only and does not become a part or condition of the policy.

1. Where to File a Claim

All Life, Dental and **Professional Medical** claims should be sent to the Administrator's Office at:

UNITED ADMINISTRATIVE SERVICES
1120 South Bascom Avenue
San Jose, California 95128
Telephone (408) 288-4400

MAILING ADDRESS:

P.O. Box 5057
San Jose, California 95150

All **Hospital** Claims should be sent to:

Prudent Buyer Plan
P. O. Box 6007
Los Angeles, CA 90060-0007

PROVIDERS may call (800) 274-7557 for medical pre-authorization or pre-service review.

2. When to File a Claim

You should file a claim as soon as you or one of your eligible dependents have incurred covered expenses for which the Plan provides benefits. You should not wait until the end of the year to submit your claim. **It is the member's responsibility to verify with their provider that the claim was filed on a timely basis.**

1. Payment

Payment of the benefits to which you are entitled under the Plan will be paid directly to you unless you have assigned them to the doctor, Hospital or dentist, in which case you will be notified of the payments made by the Plan on your behalf so that you will know the amount paid toward your bills by the Plan and the balance, if any, due from you.

2. Claim Forms

Obtain the proper claim form from the Administrator's Office, your Participant Union, or your employer and remember that a separate claim form must be submitted for each family member for whom a claim is being made.

3. Medical Claims

A signed claim form is necessary in order to make sure you receive the maximum benefits under the Plan. In order to help speed the processing of your claims, may we suggest you use the following procedure:

- a. Part 1 completed and signed by the Participant; if an accident, please give complete information as to date, time and place.
- b. The attending Physician must either complete the reverse side of Part 1 or attach his or her own form, or an itemized statement which contains an ICDA code.
 1. We do not need a claim form completed by the lab technologist, radiologist, or consulting Physician.
 2. Only one (1) claim is needed for an illness from an insured Person each calendar year.
 3. A new claim form is required for each accident.
 4. On all subsequent bills put your Participant Union, the name of the group (Bay Area Roofers Health and Welfare Plan) or the policy number (#39-001).

4. Dental Claims

Obtain a claim form from the Administrator's Office, your Participant Union, or your employer. Complete Part 1 of the dental claim form and ask your dentist to complete Part II and forward it to the Administrator's Office for processing. Please note that for non-emergency services totaling more than \$300, the dentist should submit a Dental Treatment Plan to the Administrator's Office for approval.

5. Vision Claims

If you go to a VSP participating doctor he or she will submit the claim to VSP. If services are received from a provider other than those in the listing, reimbursement will be made to the subscriber up to the schedule of allowances for like services and/or materials. Send a copy of the itemized bill(s) to VSP. The following information must also be included in your documentation:

- Member's name and mailing address.
- Member's identification number (usually the social security number).
- Member's group name (Bay Area Roofers Health and Welfare Plan).
- Patient's name, relationship to member and date of birth.

Please mail the itemized bill(s) and form to the following address:

VISION SERVICE PLAN
Attn. Out of Network Claims
P. O. Box 997100
Sacramento, California 95899-7100

I. General Rules

A. HMO Claims

(1) Plan Eligibility Rules. Issues regarding the Plan's eligibility for benefits rules will be decided in accordance with the eligibility rules of these claims procedures.

(2) Benefit Determinations. Issues regarding the benefits to be provided under an HMO contract will be decided in accordance with the claims procedures contained in that contract or adopted by the HMO.

B. Other Claims.

(1) Plan Eligibility Rules. Issues regarding the Plan's eligibility for benefits rules will be decided in accordance with the eligibility rules of these claims procedures.

(2) Benefit Determinations. Issues regarding the benefits to be provided other than under an HMO contract will be decided in accordance with the benefit determination rules of these claims procedures.

II. Filing Initial Claim Forms

A. Initial Claims. Initial urgent care claims may be made orally. All other initial claims must be filed in written form or electronically using such forms or standards as the Plan may specify from time to time. If an urgent care claim or a pre-service claim does not contain all the necessary information, the Plan Administrator shall notify Claimant or the Claimant's authorized representative as soon as possible but not later than (1) 24 hours in the case of urgent care, or (2) 5 days in the case of pre-service claims. The Plan Administrator's notice of incomplete claims may be oral unless written notification is requested by the Claimant or the Claimant's authorized representative.

B. Written Urgent Care Claims. Any initial urgent care claim filed in written or electronic form should prominently designate on its cover that it is an urgent claim requiring immediate attention.

III. Time of Initial Claims Determinations

A. Urgent Care Claims.

(1) An urgent care claim is any claim for medical care or treatment with respect to which the time periods for making non-urgent care determination could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or in the opinion of a physician with knowledge of Claimant's medical condition would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(2) Any claim that a physician with knowledge of the Claimant's medical condition determines is an urgent care claim shall be treated as one provided that the Plan Administrator is notified of the physician's determination.

(3) If paragraph (2) above does not apply, whether a claim is an urgent care claim will be determined by the Plan Administrator or other entity to which the Joint Board has delegated this function applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(4) If an urgent care claim is incomplete, the Plan Administrator will notify the Claimant within 24 hours after receipt of the specific information necessary to complete the claim. The Claimant will be given at least 48 hours to provide the specified information.

(5) The Plan Administrator shall notify the Claimant of the Plan's initial determination as soon as possible, taking into account the medical urgency, but within the following time periods:

(a) If the claim was complete when filed, within 72 hours after receipt by the Plan

(b) If the claim was incomplete, within 48 hours after the earlier of the provision of specified information referred to in paragraph (4) or the end of the period afforded to the Claimant to provide such information.

B. Concurrent Care Decisions

(1) Concurrent care decisions can occur when the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments.

(2) Any decision by the Plan to reduce or terminate such a course of treatment before the end of such period of time or course of treatment must be given to the Claimant sufficiently in advance to allow the Claimant to appeal and obtain a decision on review before the benefit is reduced or terminated.

(3) Any request by a Claimant to extend the course of treatment that is a claim involving urgent care shall be decided as soon as possible, but within 24 hours, provided the claim is made to the Plan at least 24 hours prior to the expiration of the prescribed treatment.

C. Pre-Service Claims

(1) A pre-service claim is any claim for a benefit under the Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

(2) The Plan Administrator or other entity to which the Joint Board has delegated this function shall notify the Claimant of the Plan's initial determination of a pre-service claim within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim.

(3) If the Plan Administrator or other entity to which the Joint Board has delegated this function determines that there is not sufficient information to determine the claim within the time limit in paragraph (2) and notifies the Claimant prior to the expiration of that time limit of the circumstances requiring an extension and the date by which a decision is expected to be rendered, then the time period for a decision can be extended for up to 15 days.

(4) If the extension described in paragraph (3) is necessary due to failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specify the required information and the Claimant will be given at least 45 days from receipt of the notice to provide the information.

D. Post-Service Claims

(1) A post-service health care claim is any health care claim for a benefit under the Plan that is not a pre-service claim, a concurrent claim, or an urgent care claim.

(2) The Plan Administrator shall notify a Claimant of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim.

(3) If the Plan Administrator determines that there is not sufficient information to determine the claim within the time limit in paragraph (2) and notifies the Claimant prior to the expiration of that time limit of the circumstances requiring the extension and the date by which a decision is expected to be rendered, then the time period for a decision can be extended for up to 15 days.

(4) If the extension described in paragraph (3) is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specify the required information and the Claimant will be given 45 days from receipt of the notice to provide the information.

E. Extension of Benefits For Disability Claims

(1) An extension of benefits for disability claim is any claim under the Plan for an extension of coverage due to total disability prior to the date coverage would otherwise terminate.

(2) The Plan Administrator shall notify a Claimant of any adverse benefit determination within a reasonable period of time but not later than 45 days after receipt of the claim.

(3) If the Plan Administrator determines that there is not sufficient information to determine the claim within the time limit in paragraph (2) and notifies the Claimant prior to the expiration of that time limit of the circumstances requiring the extension and the date by which a decision is expected to be rendered, then the time period for a decision can be extended for up to 30 days.

(4) If prior to the extension period referred to in (3) above, the Plan Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period may be extended for up to an additional 30 days provided the Plan Administrator notifies the Claimant prior to the expiration of the first extension the circumstances requiring the second extension and the date the Plan expects to render a decision.

(5) Any notice of extension with respect to an extension of benefits for disability claims shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and that the Claimant will be offered at least 45 days from receipt of the notice to provide the specific information.

F. Expiration of Time Periods. If a claim is not acted upon within the time periods prescribed by this Article III, the Claimant may proceed to the appeal procedure as if the claim were denied.

IV. Notification of Initial Claims Denials

A. Contents of Notification. The Plan's notification of an adverse benefit determination on an initial claim shall set forth, in a manner calculated to be understood by the Claimant, the following matters:

(1) The specific reason or reasons for the decision.

(2) Reference to the specific Plan provision on which the decision is based.

(1) A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary.

(4) A description of the Plan's review procedures and the time limits applicable to such procedures.

(1) If an internal rule, guideline, protocol or other similar criteria was relied upon, a statement that such document will be provided free of charge upon request.

(2) If the decision was based on medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's medical circumstances will be provided free of charge upon request.

(7) A statement of the Claimant's right to bring a court action under ERISA §502(a) following an adverse decision on review.

B. Manner of Notification. The notification shall be in written or electronic form, except that the following special rules will apply to urgent care decisions:

(1) The information described in paragraph A may be provided to the Claimant orally within the time frame described in III-A, provided that written or electronic notification is furnished not later than 3 days thereafter.

(2) Any notification of an adverse determination concerning urgent care shall contain a description of the expedited review process available under V-B.

V. Appeals of Adverse Initial Claims Determinations

A. General Rules. All adverse decisions of initial claims, other than urgent care claims, may be appealed by Claimants pursuant to the following rules:

(1) Claimants must file an appeal in writing within 180 days following receipt by the Plan

(2) Claimants may submit written comments, documents, records or other information relating to the claim.

(3) Upon written request, Claimant will be provided, free of charge, reasonable access to and copies of any documents, records and other information if they (a) were relied upon in making the initial determination, (b) were submitted, considered or generated in the course of making the benefit determination even if not relied upon, (c) demonstrate that the Plan provisions have been followed and applied consistently with respect to similarly situated individuals, or (d) constitute a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, whether or not relied upon.

(4) The appeal will take into account all comments, documents, records, and other information submitted by Claimant relating to the claim. Without regard to whether such information was submitted or considered in the initial determination.

(5) The appeal will not afford deference to the initial determination.

(6) The appeal will not be conducted by a person who is either the individual who made the initial adverse determination, or the subordinate of such individual.

(7) In deciding an appeal based in whole or in part on a medical judgment, the named fiduciary for appeals shall consult with a health care professional who has appropriate training and experience in the field of medicine involved, which individual shall not be either an individual consulted in connection with the initial adverse determination or the subordinate of any such person.

(8) Upon request, Plan Administrator will identify the medical or vocational experts whose advice was obtained in connection with the initial determination, whether or not it was relied upon.

(9) The Claimant shall have no right to personally appear before the named fiduciary for appeals unless the named fiduciary for appeals in its sole discretion concludes that such an appearance would be of value in enabling it to review the adverse initial determination.

B. Urgent Care Claims. The following expedited procedures will apply to urgent care appeals:

(1) A request for an expedited appeal of a denied urgent care claim may be made orally or in writing by the Claimant or his authorized representative. A written appeal should prominently designate on the cover that it is an urgent care claim requiring immediate attention.

(2) All necessary information, including the Plan's determination on review, shall be transmitted between the Plan and the Claimant by telephone, facsimile, e-mail or other available similarly expeditious method.

VI. Time of Claims Appeal Determinations

A. Urgent Care and Concurrent Care Claims. The named fiduciary for appeals shall notify the Claimant of the decision on review as soon as possible taking into account the medical condition of Claimant, but not later than 72 hours after receipt of Claimant's appeal showing that it is an urgent care appeal.

B. Pre-Service Claims. The named fiduciary for appeals shall notify the Claimant of the decision on review within a reasonable period of time applicable to the medical circumstances, but not later than 30 days after receipt of Claimant's appeal.

C. Post-Service Claims.

(1) In general, the named fiduciary for appeals shall decide appeals at the next regularly scheduled meeting. However, if the appeal is received within 30 days preceding the date of such meeting, the appeal may be decided by no later than the date of the second meeting following receipt of the appeal.

(2) If special circumstances require a further extension, the appeal will be decided not later than the third meeting following receipt of the appeal. Before the start of the extension the Plan Administrator shall notify the Claimant in writing of the extension describing the special circumstances and the date as of which the benefit determination will be made.

(3) The Plan Administrator shall notify the Claimant of the decision of the named fiduciary for appeals as soon as possible, but not later than 5 days after the appeal is decided.

D. Extension of Benefits For Disability Claims. Extension of benefits for disability claims appeals will be decided the same as post-service claims as provided in paragraph C.

VII. Notification of Appeals Decisions

A. Manner of Notification. Except in the case of urgent care decisions which may be made orally, decisions on appeals will be communicated to Claimants by written or electronic notification.

B. Contents of Notification. Adverse benefit determinations on appeal shall set forth in a manner calculated to be understood by the Claimant the following information:

- (1) The specific reason or reasons for the decision.
- (2) Reference to the specific Plan provisions on which the appeal is based.
- (3) 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 the Claimant's claim.
- (4) If an internal rule, guideline, protocol or other similar criteria was relied upon in deciding the appeal, a statement that such document will be provided free of charge upon request.
- (5) If the appeal is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claimant's medical circumstances will be provided free of charge upon request.
- (6) A statement of the Claimant's right to bring a court action under ERISA §502(a).

C. No Further Appeals. Following issuance of the decision on appeal, there is no further right under these procedures to appeal or arbitrate the decision.

VIII. Legal Proceedings

A. Legal Actions. Claimants may pursue their claims for benefits in court under ERISA §502(a) but only after they exhaust their administrative remedies as provided in these claims procedures. Failure of a Claimant to exhaust his or her administrative remedies will preclude further judicial review.

B. Legal Standards.

(1) The named fiduciary for appeals is given full discretionary authority (a) to finally determine all facts relevant to any claim, (b) to finally construe the terms of the Plan and all other documents relevant to the Plan, and (c) to finally determine what benefits are payable from the Plan.

(2) Any decision made by any named fiduciary for appeals shall be binding on all persons affected to the fullest extent permitted by law.

(3) No decision of a named fiduciary for appeals shall be revised, changed or modified by any arbitrator or court unless the party seeking such action is able to show by clear and convincing evidence that the decision of the named fiduciary for appeals was an abuse of discretion in light of the information actually available to it at the time of its decision.

IX. Miscellaneous Provisions

A. Authorized Representatives. A Claimant may appoint in writing an authorized representative to act on his behalf in pursuing a claim or appeal under these claim procedures, including a health care professional with knowledge of the Claimant's medical condition. There is no required form for this purpose. In the case of a claim involving urgent care, a health care professional with knowledge of the Claimant's medical condition shall be permitted to act as an authorized representative of Claimant even without written authorization by Claimant.

B. Plan Records. The Plan Administrator shall maintain records designed to ensure and verify that determinations are made in accordance with Plan documents and that where appropriate, the Plan provisions have been followed and applied consistently with respect to similarly situated Claimants. Plan participants' privacy will be protected at all times.

C. Appeal of Adverse Determinations. Any decisions affecting a Claimant's benefits under the Plan may be appealed under these claims procedures, including:

- (1) A denial, reduction or termination of any Plan benefit.
- (1) A failure to provide or make payment in whole or in part for any Plan benefit.
- (3) A refusal to provide a Plan benefit based on a determination that the Claimant is not eligible under the terms of the Plan.
- (4) A denial, reduction or termination of or failure to provide or make payment for a benefit resulting from the application of any utilization review.
- (5) A failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

D. Rights of Joint Board. The Joint Board retains the right to interpret and amend these Claims Procedures. Furthermore, if these procedures are ambiguous or do not provide an explicit procedure for a specific circumstance, the Joint Board is authorized to adopt such rules as it in its discretion deems necessary and appropriate to provide Claimants with appropriate initial determinations and an opportunity for a full and fair review of any adverse benefit determination.

CLAIMS APPEALS FOR HMOs

If a claim for medical or dental benefits provided by a Health Maintenance Organization (HMO) is denied in whole or part, notice will be given by that organization and appeals can be made in accordance with that organization's appeal procedure as briefly outlined below:

6. Kaiser: Kaiser Permanente has four different types of procedures for resolving disputes and grievances. The first procedure is used in order to request reconsideration of denied requests for payment, services or supplies. The second procedure is to request an immediate Peer Review Organization review if they deny coverage of continued stay in a Hospital because hospitalization is no longer necessary. The third procedure is used when members have complaints that have not been resolved satisfactorily regarding items other than claims for emergency or urgent care or other health care services or supplies. The fourth procedure is binding arbitration and is required when a member asserts any claim on account of medical or Hospital malpractice and premised liability. Details of these procedures are contained in the booklet from Kaiser titled Disclosure Form & Evidence of Coverage.

7. Health Net: Members are entitled to have their complaints heard through a grievance and appeals process and have a contractual right to arbitrate claims that are not resolved to the member's satisfaction. Grievances are complaints about such things as quality of care, access to care or delay in referral. Appeals are requests to reconsider an initial determination that denies coverage. You must first file a grievance or appeal against Health Net by calling the Member Services Department at 1-800-522-0088. You may also file your complaint in writing by sending information to:

Health Net
Members Services Appeals and Grievances Department
P.O. Box 10348
Van Nuys, CA 91410-0348

3. Bright Now Dental: Complaints should first be brought to the attention of the dentist providing services. Complaints not satisfactorily resolved should be sent, in writing, to: Chairperson, Grievance Committee, Bright Now! Dental, Appeals – Plan Department, 201 E. Sandpointe Drive, Suite 200, Santa Ana, CA 92707.

VSP GRIEVANCE SYSTEM

If a subscriber/enrollee (hereafter “enrollee”) has a complaint/grievance (hereafter “grievance”) regarding VSP service or claim payment, the enrollee may communicate the grievance to VSP by using the form which is available by calling VSP Customer Service Department’s toll free number (1-800-877-7195) Monday through Friday, 6:00 a.m. to 6:00 p.m. Pacific Stand Time. Grievances may be filed in writing with VSP at 3333 Quality Drive, Rancho Cordova, California 95670.

Upon receipt of a verbal or written grievance, VSP will respond in writing to the enrollee acknowledging receipt and/or disposition of the grievance within five business days. If a resolution cannot be reached within thirty days, a fifteen-day interim notification will be sent to the enrollee informing him or her of the grievance’s status. (VSP will keep all grievances and the responses thereto on file for seven years.)

COBRA GROUP HEALTH INSURANCE CONTINUATION PROVISION (As Federally Mandated)

What is Continuation Coverage?

Federal law requires that most group health plans (including this Plan) give Retirees and their families the opportunity to continue their health care coverage at their own expense when there is a “qualifying event” that would result in a loss of coverage under a group health or employer’s plan. Depending on the type of qualifying event, “qualified beneficiaries” can include the Retiree covered under the group health plan, the covered Retiree’s spouse, and the dependent children of the covered Retiree.

Continuation coverage is the same coverage that the Plan offers to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

How long will Continuation Coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued only for up to 18 months. In the case of losses of coverage due to an Retiree’s death, divorce, or a dependent child ceasing to be a dependent under the terms of the Plan, coverage may be

continued for up to 36 months. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage,
- the group ceases to provide any group health plan for its Retirees, or
- You or another family member on COBRA due to a disability extension is no longer disabled based on a determination made by Social Security. Your coverage will end as of the last day of the month in which you were no longer disabled.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a Participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA Continuation Coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is determined by Social Security to be disabled or a second qualifying event occurs. You must notify United Administrative Services of such a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has 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. A qualified beneficiary must notify the plan of the SSA determination within 60 days of its issuance and within the original 18-month COBRA coverage period. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact immediately but no later than 30 days after SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered Retiree or divorce from the covered Retiree, the covered Retiree's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

California COBRA HMO Extension

If you are enrolled in an HMO in the State of California, you may have additional election rights. Please contact your HMO if you are covered on the HMO plan.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form, which will be sent to you, and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the Retiree's spouse may elect continuation coverage even if the Retiree does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children and pay the required premium. The Retiree or the Retiree's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not obtain continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and Retiree contributions) for coverage of a similarly situated plan Participant or beneficiary who is not receiving continuation coverage.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Retirees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at: www.doleta.gov/tradeact/2002act_indez.asp

Conversion

If you have health maintenance or insurance company coverage under the Plan, you have the right, when your group health coverage ends, to enroll in an individual conversion health insurance or HMO policy, without providing proof of insurability. The benefits provided under such an individual conversion policy may not be identical to those provided under the Plan. You may exercise this right in lieu of electing continuation coverage, or you may exercise this right after you have received the maximum continuation

coverage available to you. You should note that if you enroll in an individual conversion policy you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your conversion policy ends. You must contact the HMO or insurance company directly to receive individual conversion coverage. Time limits apply so you must contact the HMO or insurance company immediately upon the expiration of your health plan coverage.

Life Insurance

If elected, your continuation coverage may consist of medical and prescription drug coverage with dental and vision coverage as an option. It does not include life insurance or accidental death and dismemberment benefits. To convert your life insurance and accidental death and dismemberment coverage to an individual policy contact United Administrative Services at 408-288-4400.

When and how must payment for COBRA continuation coverage be made?

Initial payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your initial payment for continuation coverage, retroactive to the date you lost your coverage, not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your initial payment for continuation coverage in full within 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your initial payment is correct. Your initial COBRA payment must cover the cost of continuation coverage from the time your coverage under the plan terminated up to the time you make the initial payment. You may contact United Administrative Services to confirm the correct amount of your initial payment.

Periodic payments for continuation coverage

After you make your initial payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The periodic payments are made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first day of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.

Grace periods, for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your initial payment and all periodic payments for continuation coverage should be sent to:

Bay Area Roofers Trust Funds
P. O. Box 5057
San Jose, CA 95150-5057
(408) 288-4400

All payments must include the member's name, Plan name and the last four digits of the member's Social Security Number.

For more information

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, contact the U.S. Department of Labor's Retiree Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional mid District EBSA Offices are available through EBSA's website.)

Keep your Plan informed of address changes

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

HIPAA COVERAGE AND CONVERSION

If your coverage for medical benefits under this plan ends, you may be eligible to enroll for coverage with any carrier or health plan that offers individual medical coverage.

HIPAA Coverage

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides an option for individual coverage when coverage under the employer's group plan ends. To be eligible for **HIPAA** coverage, you must meet all of the following requirements:

1. You must have a minimum of 18 months of continuous health coverage, most recently under an employer-sponsored health plan, and have had coverage within the last 63 days.
2. Your most recent coverage was not terminated due to nonpayment of subscription charges or fraud.
3. If continuation of coverage under the employer plan was available under COBRA, CalCOBRA, or a similar state program including PostCOBRA, such coverage must have been elected and exhausted.
4. You must not be eligible for Medicare, Medi-Cal, or any group medical coverage and cannot have other medical coverage.

You must apply for HIPAA coverage within 63 days of the date your coverage under this plan ends. Any carrier or health plan that offers individual medical coverage must make HIPAA coverage available to qualified persons without regard to health status.

GENERAL PROVISIONS

Providing of Care. The Plan is not responsible for providing any type of hospital, medical or similar care, nor is it responsible for the quality of any such care received.

Independent Contractors. The Plan's relationship with providers is that of an independent contractor. Physicians, and other health care professionals, hospitals, skilled nursing facilities and other community agencies are not the Plan's agents nor is the Plan an Retiree or agent of any hospital, medical group or medical care provider of any type.

Non-Regulation of Providers. The benefits of this Plan do not regulate the amounts charged by providers of medical care, except to the extent that rates for covered services are regulated with participating providers.

Terms of Coverage

1. In order for you to be entitled to benefits under the Plan, both the Plan and your coverage under the Plan must be in effect on the date the expense giving rise to a claim for benefits is incurred.
2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.
3. The Plan is subject to amendment, modification or termination according to the provisions of the Plan without your consent or concurrence.

Free Choice of Provider. This Plan in no way interferes with your right as a Participant entitled to hospital benefits to select a hospital. You may choose any physician who holds a valid physician and surgeon's certificate and who is a member of, or acceptable to, the attending staff and board of directors of the hospital where services are received. You may also choose any other health care professional or facility which provides care covered under this Plan, and is properly licensed according to appropriate state and Participant laws. However, your choice may affect the benefits payable according to this Plan.

Continuity of Care. If the Plan terminates its contractual relationship with a participating provider and you are undergoing a course of treatment from that provider at the time the contract is terminated, you may be able to continue to receive services (but only if such provider agrees to continue to comply with the same contractual requirements that applied prior to termination). To qualify, you must have an acute or a serious chronic condition, a high risk pregnancy, or a pregnancy in the second or third trimester. You may request this continuity of care by calling us at the customer service telephone number listed on your ID card. If approved, services may be received for a limited period of time, but no longer than 90 days, unless you cannot be safely transferred to a participating provider. Coverage is provided according to the terms and conditions of this Plan applicable to participating providers.

Provider Reimbursement. Physicians and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. A participating physician may, after notice from us, be subject to a reduced negotiated rate in the event the participating physician fails to make routine referrals to participating providers, except as otherwise allowed (such as for emergency services). Hospitals and other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis.

Necessary Treatment. The benefits of this Plan are provided only for services which the Plan, or its agent for this purpose, determines to be medically Necessary Treatment. The services must be ordered by the

attending physician for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in the United States.

Expense in Excess of Benefits. The Plan is not liable for any expense you incur in excess of the benefits of this Plan.

Benefits Not Transferable. Only the Participant is entitled to receive benefits under this Plan. The right to benefits cannot be transferred.

Notice of Claim. You or the provider of service must send properly and fully completed claim forms to us within 90 days of the date you receive the service or supply for which a claim is made. Services received and charges for the services must be itemized, and clearly and accurately described. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. The Plan is not liable for the benefits if you do not file claims within the required time period. Claim forms must be used; cancelled checks or receipts are not acceptable.

Payment to Providers. The Plan will pay the benefits of this Plan directly to contracting hospitals, participating providers, COE and medical transportation providers. Also, the Plan will pay non-contracting hospitals and other providers of service directly when you assign benefits in writing. If you are a Medical beneficiary and you assign benefits in writing to the State Department of Health Services, we will pay the benefits of this Plan to the State Department of Health Services. These payments will fulfill our obligation to you for those covered services.

Right of Recovery. When the amount the Plan pays exceeds its liability under this Plan, the Plan has the right to recover the excess amount. This amount maybe recovered from you, the person to whom payment was made or any other plan.

Plan Administrator – COBRA and ERISA. United Administrative Services is the Plan Administrator and is contracted by the Bay Area Roofers Health and Welfare Plan to provide claim payment services based on the Plan design contained in this summary plan description.

Workers' Compensation Insurance. The Plan does not affect any requirement for coverage by workers' compensation insurance. It also does not replace that insurance.

Confidentiality and Release of Medical Information. The Plan will use reasonable efforts, and take the same care to preserve the confidentiality of the participants' and beneficiaries' medical information. The Plan may use data collected in the course of providing services hereunder for statistical evaluation and research. If such data is ever released to a third party, it shall be released only in aggregate statistical form without identifying the member.

Medical information may be released only with the written consent of the Participant or as required by law. It must be signed, dated and must specify the nature of the information and to which persons and organizations it may be disclosed. Participants may access their own medical records.

The Plan may release your medical information to professional peer review organizations and to the group for purposes of reporting claims experience or conducting an audit of our operations, provided the information disclosed is reasonably necessary for the group to conduct the review or audit.

HIPAA PRIVACY RULE
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date of Notice: April 14, 2003.

General Privacy Rules:

The Welfare Plan (“Plan”) is required by law to maintain the privacy of protected health information and to inform you about:

- the Plan’s uses and disclosures of protected health information;
- your privacy rights with respect to such information;
- the Plan’s duties with respect to such information;
- the person or office to contact for further information about the Plan’s privacy practices.

Section 1. Notice of Uses and Disclosures

(a) Uses and disclosures to carry out treatment, payment and health care operations without your consent or authorization. The Plan and its business associates will use protected health information without your consent, authorization or opportunity to agree or object to carry out “treatment, payment and health care operations” as defined below.

(i) *Treatment* is the provision, coordination or management of health care and related services. For example, your pharmacy may contact your treating physician to refill your prescription for medication.

(ii) *Payment* includes but is not limited to actions to make coverage determinations and payment. For example, the Plan may tell a doctor whether you are eligible for coverage.

(iii) *Health care operations* include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts and related business services. For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs and audit the accuracy of its claims processing functions.

(b) Individual. The Plan will disclose to you, or your duly authorized personal representative, your own protected health information.

(c) Department of Health and Human Services. The Plan will disclose to the Secretary of the U.S. Department of Health and Human Services your protected health information if required by it to investigate or determine the Plan’s compliance with its privacy regulations.

(d) Other uses and disclosures for which consent, authorization or opportunity to object is not required. Use and disclosure of your protected health information is allowed without your consent, authorization or request under the following circumstances:

() When required for judicial or administrative proceedings, provided certain conditions are met. Those conditions include that satisfactory assurances are given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

(ii) When required by law.

(i) When permitted for purposes of public health activities.

(ii) To a public health oversight agency for oversight activities authorized by Law.

(v) When required for law enforcement purposes.

(vi) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

(vii) When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

(viii) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

(e) Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or disclosure. Disclosure of your protected health information to family members, other relatives and your close personal friends is allowed if the information is directly relevant to the family or friend's involvement with your care or payment for that care and you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

(f) Uses and disclosures that require your written authorization.

(i) In general, the Plan will obtain a written authorization before using or disclosing your protected health information whenever it is required to do so under the privacy rules. Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. The Plan may use and disclose psychotherapy notes when needed by the Plan to defend against litigation filed by you. The Plan will not disclose to third parties the results of genetic testing in a manner which includes individually identifying characteristics without your written authorization.

(ii) The Plan may require your authorization to disclose protected health information, even to carry out treatment, payment or health care operations, to certain individuals or organizations. For example, if your union representative is helping you with a claim the Plan may require you to sign an authorization form before it will disclose protected health information to that person.

Section 2. Rights of Individuals

(a) Right to Request Restrictions on Protected Health Information Uses and Disclosures.

You may request the Plan to restrict uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

The Plan will accommodate reasonable requests to receive communications of protected health information by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your protected health information. Such requests should be made to the Plan Manager identified in Section 5.

(b) Right to Inspect and Copy Protected Health Information. You have a right to inspect and obtain a copy of your protected health information for as long as the Plan maintains the protected health information. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the protected health information. Requests for access to protected health information should be made to the Plan Manager. If access is denied, you and your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise rights to review and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

(c) Right to Amend Protected Health Information. You have the right to request that the Plan Manager amend your protected health information or a record about you for as long as the protected health information is maintained by the Plan. You or your personal representative will be required to complete a form to request amendment of the protected health information.

The Plan has 60 days after the request is made to act on the request. A single 30 day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

(d) The Right to Receive an Accounting of Protected Health Information Disclosures. At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your protected health information during the six years prior to the date of your request. However, such accounting need not include protected health information disclosures made:

- (i) to carry out treatment, payment or health care operations;
- (ii) to individuals about their own protected health information; or
- (iii) prior to April 14, 2003.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

(e) Personal Representatives. You may exercise your rights through a personal representative recognized by law. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your protected health information or allowed to take any action for you. The Plan retains discretion to deny access to your

protected health information to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 3. The Plan’s Duties

(a) General Duty. The Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any protected health information received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to all past and present participants and beneficiaries for whom the Plan still maintains protected health information. The revised notice will also be mailed to all active and retired plan participants. Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual’s rights, the duties of the Plan or other privacy practices stated in this notice.

(b) Minimum Necessary Standard. When using or disclosing protected health information or when requesting protected health information from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- (i) disclosures to or requests by a health care provider for treatment;
- (ii) uses or disclosures made to the Participant or beneficiary;
- (iii) disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- (iv) uses or disclosures that are required by law; and
- (v) uses or disclosures that are required for the Plan’s compliance with legal regulations.

(c) De-Identified Information. This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify the individual.

In addition, the Plan may use or disclose “summary health information” for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

Section 4. Your Right to File A Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the Plan Manager. You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S. W, Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

Section 5. Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan Manager:

Sandy Stephenson
United Administrative Services 1120
Bascom Avenue
San Jose, CA 95128-3590

Phone: (408) 288-4400 Fax: (408) 288-4419

TERMINATION OF COVERAGE

Unless terminated earlier under other provisions of the Plan, coverage for you and your dependents will terminate on the earliest of:

1. The last period for which you made any required self-payment;
2. The moment you enter the Armed Forces of any country. Membership in the reserves is not deemed entry into the Armed Forces unless you are on temporary active duty of more than two weeks; or
3. The date you are no longer eligible for coverage under the Plan's Eligibility Rules.

PAYMENT ERRORS

If you or your dependent receive more than you are entitled to with respect to a particular claim, regardless of whose fault the overpayment is, you will have to return any excess over the correct amount. If it is not returned, such excess may be deducted from future claims payable to you or your dependents.

COVERAGE INQUIRIES

If you need information about specific benefit coverage, you may write or call United Administrative Services or write to the Board of Trustees. To avoid misunderstandings you should request a written response.

THIRD PARTY LIABILITY AND WORKERS' COMPENSATION

1. Non-Covered Roofing Service. No expenses incurred as a result of working in non-covered roofing service will be paid or advanced by this Plan regardless of when incurred.
2. Injuries in the Roofing Industry Not Covered by Workers' Compensation. No expenses incurred as a result of performing work in the roofing or waterproofing industry, whether or not such work is performed for pay, will be paid or advanced by the Plan if there is no Workers' Compensation policy in force to cover such expenses.
3. Injuries While Working for Participating Employer. Notwithstanding any other provision of the Plan, if an eligible individual has an Injury or Sickness arising out of or in the course of any employment for a Participating Employer who has Workers' Compensation insurance, the Plan will advance the amounts determined under the Plan rules and file a lien on the Participant's Workers' Compensation claim for reimbursement of that advance.
4. Third Party Liability. If an eligible individual is injured through the act or omission of another party, Plan benefits are provided only on the following conditions:
 - a. Such eligible individual, or anyone receiving any Plan benefits as a result of the injury to the eligible individual, shall be required to pay to the Plan any and all proceeds whatsoever, including but not limited to proceeds designated as being for pain and suffering, received by way of judgment, settlement or otherwise (including receipt of proceeds under any uninsured motorists coverage) arising out of any claims for money or other damages by the eligible individual or his or her heirs, parents, or legal guardians, or anyone else acting on his or her behalf, to the extent of the payments made or to be made by the Plan for which the third party may be responsible. The assets so recovered shall be considered Plan assets and the recipient shall be under a fiduciary duty to pay them over to the Plan. In addition to any other remedy provided hereunder, the Plan shall be entitled to enforce this requirement by way of restitution or constructive trust.

- b. Any eligible individual, or anyone acting on his or her behalf, who accepts payments from the Plan, or authorizes Plan payments to be made to anyone else, or on whose behalf any benefits are paid with respect to the eligible individual's injuries, agrees that a present assignment of the eligible individual's rights against such third party is automatically made to the extent of the payments made by the Plan.
- c. These rules are automatic, but the Plan may require that any eligible individual or his or her representative sign an Agreement to Reimburse or Assignment of Recovery in such form or on such forms as the Plan may require. If an eligible individual, or his or her representative, refuses to sign an Agreement to Reimburse and/or Assignment of Recovery in a form satisfactory to the Plan, the eligible individual shall not be eligible for Plan benefit payments related to the injury involved. This remedy is in addition to all other remedies the Plan may have.
- d. If Plan benefits are paid on behalf of an eligible individual and upon recovery of any proceeds from or on behalf of the third party such benefits are not reimbursed to the Plan as set forth above, then the eligible individual will be ineligible for any future Plan benefit payment until the Plan has withheld an amount equal to the amount which has not been reimbursed. This remedy is in addition to all other remedies the Plan may have.
- e. Any eligible individual on whose behalf the Plan pays benefits agrees that the Plan may intervene in any legal action brought against a third party or any insurance company, including the eligible individual's own carrier for uninsured motorists coverage.
- f. A lien shall exist in favor of the Plan upon all sums of money recovered by the eligible individual against any third party responsible for the injuries to the eligible Retiree. The lien may, but is not required to, be filed with the third party, the third party's agents, or the court. The eligible individual, and those acting on his or her behalf, shall do nothing to prejudice the Plan's rights as described above without the Plan's written consent.
- g. If an eligible individual settles or compromises a third party liability claim in such a manner that the Plan is reimbursed in an amount less than its lien, or which results in the third party or its insurance carrier being relieved of any future liability for medical costs, then the eligible individual shall receive no further benefits from the Plan in connection with the medical condition forming the basis of the third party liability claim, unless the Plan or its duly authorized representative has previously approved the settlement or compromise, in writing, as one which is not unreasonable from the standpoint of the Plan.
- a. In addition to all other remedies the Plan may have, the Plan shall be subrogated to the rights of the eligible individual against the responsible third party.
- i. By accepting benefits under the Plan, a Participant and any eligible individual on whose behalf benefits are paid, agrees as a contractual matter enforceable under state or federal law, that upon receipt of recovery from the responsible third party, the person receiving the payment shall reimburse the Plan the amount of benefits it has paid to the eligible individual caused by the responsible third party.

COORDINATION OF BENEFITS

Our Group Health and Welfare Plan contains a Coordination of Benefits (“COB”) provision which applies to this Plan when an individual has medical or dental care coverage under more than one plan so that the total benefits available will not exceed, but in some cases can approach or equal 100% of the allowable expenses.

An Allowable Expense is any Usual and Customary Charge for a Necessary Treatment covered at least in part by one of the Plans.

“Plans” mean when benefit or services are provided by:

1. Group insurance or group-type coverage, whether insured or uninsured;
2. Employer sponsored Blue Cross, Blue Shield or other prepayment coverage;
3. Group-type contracts;
4. Coverage under a governmental plan;
5. Coverage required or provided by law; or
6. Medical benefits coverage in group or group type and individual automobile “no fault” type contracts, then, the same Benefits or Services will not be duplicated by this Plan.

“Plan” does not include:

1. A state plan under Medicaid;
2. Benefits under a law or plan when, by law, its benefits are in excess to those of any private insurance plan;
3. Individual or family coverage, except as provided above;
4. Medicare with respect to:
 - (a) Any actively employed Retiree age 65 and over or to any spouse age 65 and over of an actively employed Retiree; or
 - (b) Any disabled active Retiree or dependent of an active Retiree; nor
5. School accident type coverages. These cover grammar, high school, and college students for accidents only including athletic injuries, either on a 24-hour basis or on a “to and from school” basis.

All benefits described in this booklet for medical or dental care and treatment are subject to this provision.

When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plan adjusts its benefits so that the total benefits available will not exceed the allowable expenses. No plan pays more than it would without the coordination provision.

A plan without a coordination provision is always the primary plan. If all plans have such a provision the following rules apply:

1. The plan covering the patient directly, rather than as a dependent, is primary and others are secondary;
2. When this Plan and another plan cover the same child as a dependent of different persons, called “parents”:

- (a) The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of a plan of the parent whose birthday falls later in that year; but
 - (b) If both parents have the same birthday, the benefits of the plan which covered the other parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
3. In the case of a child of separated or divorced parents, the designation of the plan which will be primary is determined as follows:
- (a) The plan of the natural parent having legal custody of the child;
 - (b) The plan of the current spouse, if any, of the natural parent, having legal custody of the child;
 - (c) The plan of the natural parent not having legal custody of the child.
4. The plan covering a person as an active Retiree is primary to the plan covering the person as a retired or laid-off Retiree or any dependent thereof.
5. If 1., 2., 3. or 4. do not apply, the plan covering the patient longest is primary.

DEFINITIONS

The following is a brief listing of important definitions.

“Insurance Company” means Pacific Life & Annuity Life Insurance Company with respect to life insurance and accidental death benefits.

“Injury” means a bodily injury caused by an accident or other means.

“Sickness” means an illness or disease.

“Complications of Pregnancy” means:

- (a) any condition resulting in Hospital confinement, the diagnosis of which is distinct from pregnancy, but is adversely affected or caused by pregnancy; or
- (b) a nonelective Caesarean section, an ectopic pregnancy which is terminated, a spontaneous termination of pregnancy when a viable birth is not possible. A puerperal infection, eclampsia and toxemia.

False labor, occasional spotting, Physician prescribed rest, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with a difficult pregnancy are not complications of pregnancy.

“Hospital” means any general acute care Hospital which is licensed under any applicable state statute and must provide: (a) 24-hour inpatient care, and (b) the following basic services on the premises: medical, surgical, anesthesia, laboratory, radiology, pharmacy and dietary services.

“Mental and Nervous Disorders” means any mental or nervous condition which affects thinking, perception, mood and/or behavior. Such conditions are recognized by psychiatric symptoms that appear as distortions of normal thinking and/or perception, moodiness, sudden and/or extreme changes in mood, depression, and/or unusual behavior. Any condition meeting this definition is a Mental Disorder regardless of whether the psychiatric symptoms are caused by a psychiatric disorder, by a physical disorder, or by a combination of physical and psychiatric causes. Included within the definition of Mental Disorder, without limitation, are schizophrenia; manic depression and other conditions usually classified in the medical community as psychosis; depressive, phobic, manic and anxiety conditions (including panic disorders); bipolar affective disease, including mania and depression; obsessive compulsive disorders; autism; hypochondria; personality disorders (including paranoid, schizoid, dependent, antisocial and borderline);

dementia and delirious states; post traumatic stress disorders; organic brain syndrome; and hyperkinetic syndromes (including attention deficit disorders).

“Skilled Nursing Facility” means an institution or that part of an institution which provides skilled nursing care and is certified as a Skilled Nursing Care Facility under Medicare.

“Physician” means a licensed practitioner of the healing arts. The term “Physician” also includes a Certified Nurse Midwife acting within the scope of her license.

“Necessary Treatment” means medical or dental treatment which is consistent with currently accepted medical or dental practice. Any confinement, operation, treatment or service which is not a valid course of treatment recognized by an established medical society in the United States is not considered “Necessary Treatment.” No treatment or service, or expense in connection therewith, which is experimental in nature, is considered “Necessary Treatment”.

The Plan may use Peer Review Organizations or other professional medical opinion to determine if health care services are:

1. Medically necessary;
2. Consistent with professionally recognized standards of care with respect to quality, frequency and duration; and
3. Provided in the most economical and medically appropriate site for treatment.

If services are not considered to be:

1. Medically necessary; or
2. Consistent with professionally recognized standards of care with respect to quality, frequency or duration, expenses related to those services will not be deemed “Necessary Treatment.”

“Usual and Customary Charges” as used herein means a charge for a service or supply which is no higher than the 90th percentile of United Administrative Service’s determination of the prevailing health care charges based on data it maintains. If such data are unavailable, usual and customary charges will be determined by the charges generally incurred for cases of comparable nature and severity in the particular geographical area covered.

PLAN INFORMATION

A. NAME OF PLAN:

This Plan is known as the Bay Area Roofers Health and Welfare Plan.

B. TYPE OF PLAN:

This is a Health and Welfare Plan which includes the following types of benefits: major medical, supplemental accident, dental, vision, life insurance and accidental death and dismemberment.

C. PLAN ADMINISTRATOR:

The Joint Board of Trustees is the official administrator and is responsible for the overall administration of the Trust. The Board employs a contract administrator, consultants, attorneys, accountants, and other necessary personnel to assist and advise them. The Joint Board makes rules and regulations, and all rights and benefits from the Plan are subject to such rules and regulations as may be adopted or amended from time to time by the Joint Board. Any representations of individual Trustees or others are not binding on the Joint Board unless specifically authorized by the Joint Board. The benefits established by this Plan have been adopted by the Joint Board based on the best information available to them as to the cost of benefits and the contributions which they anticipate receiving under applicable collective bargaining agreements. The Joint Board reserves the right to modify benefits at any time, or to reduce or even eliminate benefits if necessary to maintain the financial soundness of the Plan.

An attempt has been made to summarize pertinent provisions of the Plan as accurately as possible. In the event of any conflict between this booklet and the official Plan or insurance policy, the latter will govern. For specific information in regard to your rights under this Plan, you may contact the Administrator's Office, the address and telephone of which are shown below. The Administrator's Office can answer your questions authoritatively only if you furnish full and accurate information concerning your situation.

Name: Joint Board of Trustees of the Bay Area Roofers Health and Welfare Trust

Address of Board and Trust Fund Office: 1120 Bascom Ave.
San Jose, CA 95128-3590

Mailing Address:
P.O. Box 5057
San Jose, CA 95150-5057

Telephone: (408) 288-4400

Employer Identification No: 94-6074642

Plan Number: 501

D. TYPE OF ADMINISTRATION:

This Plan is administered by the Joint Board of Trustees with the assistance of United Administrative Services, a contract administrative organization.

E. NAME OF AGENT FOR SERVICE OF PROCESS:

Service of legal process may be made on the Joint Board at the above address or upon any member of the Joint Board of Trustees.

F. NAMES AND ADDRESSES OF JOINT BOARD OF TRUSTEES:

Retiree Trustees

Daniel Garcia
Roofers Participant Union #95
293 Brokaw Road
Santa Clara, CA 95050
(408) 987-0440

Bruce Lau
Roofers Participant Union #40
150 Executive Park Blvd., Ste 3625
San Francisco, CA 94134-3309
(415) 508-0321

Carlos Opfermann
Roofers Participant Union #81
8400 Enterprise Way, Rm 122
Oakland, CA 94621
(510) 632-0505

Daniel E. Smith
Roofers Participant Union #95
293 Brokaw Road
Santa Clara, CA 95050
(408) 987-0440

Steven D. Tucker
Roofers Participant Union #40
150 Executive Park Blvd., Ste 3625
San Francisco, CA 94134-3309
(415) 508-0321

Douglas Ziegler
Roofers Participant Union #81
8400 Enterprise Way, Rm 122
Oakland, CA 94621
(510) 632-0505

Employer Trustees

William T, Callahan, Jr.
Associated Roofing Contractors
8301 Edgewater Drive, Ste. 202
Oakland, CA 94621
(510) 635-8800

John Dissmeyer
Acme Roofing Company
1400 Wallace Avenue
San Francisco, CA 94124
(415) 587-5869

Steve Henris
Henris Roofing Company
P. O. Box 138
Petaluma, CA 94952
(707) 763-1535

Richard J. Lawson
Lawson Roofing Company
1495 Tennessee Street
San Francisco, CA 94107
(415) 285-1661

Larry Reardon
Enterprise Roofing Service
P. O. Box 27368
Concord, CA 94527
(925) 689-8100

Keith Robnett
Blue's Roofing Company
1181 Campbell Avenue
San Jose, CA 95126
(408) 984-3494

G. SPONSORING ORGANIZATIONS AND DESCRIPTIONS OF COLLECTIVE BARGAINING AGREEMENTS;

The Plan is maintained pursuant to the terms of labor agreements between Associated Roofing Contractors of the Bay Area Counties, Inc. and Locals 40, 81 and 95 of the United Union of Roofers, Waterproofers and Allied Workers, AFL-CIO. These agreements provide that employer parties thereto will make the required contributions to this Fund for the purpose of enabling the Retirees working under the collective bargaining agreements to participate in Health and Welfare Benefits. Copies of any labor agreement can be obtained from the appropriate Participant Union Office. Participants and beneficiaries, upon written request, may obtain information from the Plan Administrator as to whether a particular employer or Retiree organization is a contributor to this Fund and if so, the employer's or the Retiree organization's address.

H. SOURCE OF CONTRIBUTIONS:

For Contractual Retirees, the Plan is funded through participating employer contributions, the amount of which is specified in the collective bargaining agreements, as well as Retiree contributions, which are fixed from time to time by the Board of Trustees. For Non-Contractual Retirees the contribution rate is determined from time to time by the Board of Trustees and paid pursuant to the Employer’s subscription agreement.

I. HMO DUAL CHOICE OPTION

The Life, Accidental Death and Dismemberment and Vision benefits described in this booklet apply to all Retirees who elect them at initial enrollment. The Self-Funded Dental benefits described in this booklet apply to all Retirees who elect the Self-Funded Dental Plan when eligible to elect the Self Funded Dental Plan. For those Retirees who elected a HMO plan, the eligibility provisions in this booklet apply and the provisions on elective benefits apply, but the Major Medical and Prescription Drug Benefits do not apply. Separate booklets describing the HMO plans, and their related prescription drug plans will be provided by the Administrator’s Office. For those Retirees who are eligible for the Bright Now dental coverage, a separate brochure describing the Bright Now dental benefits will be provided by the Administrator’s Office.

J. ENTITIES USED FOR ACCUMULATION OF ASSETS AND PAYMENT OF BENEFITS:

Benefits are provided from the Fund’s assets which are accumulated under the provisions of the collective bargaining agreements and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable expenses.

K. PLAN YEAR:

The fiscal year of the Plan is the twelve-month period ending each July 31st, and the Plan’s records are maintained on that basis.

L. PLAN TERMINATION:

The Joint Board of Trustees may terminate the Plan, pursuant to its authority under the Trust Agreement. If the Plan is terminated, its remaining assets will be used to continue to provide its benefits for so long as Plan assets permit, or else they will be transferred to a successor plan providing health care benefits. However, the Joint Board would have the right to revise, reduce or otherwise adjust benefits in any reasonable manner in connection with such termination.

In no event will the termination of the Plan or Trust result in a reversion of any assets to any contributing employer.

D. HEALTH PROVIDERS:

In accordance with the new disclosure requirements of the Health Insurance Portability and Accountability Act, we are informing you of the name and address of all Health providers for the Bay Area Roofers Health & Welfare Trust Fund and their roles (i.e., whether they guarantee the payment of benefits or provide administrative services.)

<p><i>United Administrative Services</i> <i>1120 South Bascom Avenue</i> <i>San Jose, CA 95128</i> Administers the self-funded medical, dental and prescription plans for active and retired Retirees.</p>	<p><i>Beat It Program, Inc.</i> <i>P. O. Box 20896</i> <i>San Jose, CA 95160</i> Administers Drug and Alcohol Plan for active and retired participants, Does not guarantee payment of</p>
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Does not guarantee payment of these benefits.	these benefits.
<p>Bright Now Dental 3540 Howard Way Costa Mesa, CA 92626 Provides prepaid dental benefits for active and retired participants with guaranteed payment of these benefits.</p>	<p>Caremark 9501 E. Shea Boulevard Scottsdale, AZ 95260 Administers Pharmacy Plan for active and retired participants. Does not guarantee payment of these benefits.</p>
<p>Health Net 3400 Data Drive Rancho Cordova, CA 95670 Provides prepaid medical benefits for active and retired participants with guaranteed payment of these benefits</p>	<p>Caremark.com P.O. Box 961066 Fort Worth, TX 76161-9854 Administers mail-in Pharmacy Plan for active and retired participants. Does not guarantee payment of these benefits.</p>
<p>Kaiser Foundation Health Plan Northern California Region 1950 Franklin Street Oakland, CA 94612 Provides prepaid medical benefits with guaranteed payment of these benefits for active and retired participants.</p>	<p>Blue Cross Prudent Buyer Plan 21555 Oxnard Street Woodland Hills, CA 91367 Administers the PPO and Utilization Management services. Does not guarantee payment of these benefits.</p>
<p>Pacific Life & Annuity P. O. Box 2890 New Port Beach CA 92658-9010 Fully insures life and accidental death and dismemberment benefits for active and retired participants.</p>	<p>Vision Service Plan 3333 Qualify Drive Rancho Cordova, CA 95670 Administers vision plan for active and retired participants. Does not guarantee payment of vision benefits.</p>

YOUR RIGHTS UNDER ERISA

The following Section contains information provided to you by the Administrator of your Plan to meet the requirements of the Retiree Retirement Income Security Act of 1974. It does not constitute a part of the Plan or of any insurance policy issued in connection with the Plan. All inquiries relating to the following material should be referred directly to the Administrator.

As a Participant in the Bay Area Roofers Health and Welfare Plan, you are entitled to certain rights and protections under the Retiree Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Administrator's Office and at other specified locations, such as work sites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Administrator is required by law to furnish each participant with a copy of this summary annual report.
4. 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.
5. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Retiree benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the persons designated for such purpose review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (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 \$110.00 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. If it should happen that the Plan fiduciaries misused 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 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.

If you have any questions about your rights under ERISA, you should contact the Administrator's Office. You may also direct such questions to the nearest office of the Retiree Benefits Security Administration, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Retiree Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.