

North Coast Builders Exchange
Insurance Trust

SUMMARY PLAN DESCRIPTION

Effective April 1, 2008

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INTRODUCTION

The North Coast Builders Exchange Insurance Trust maintains the North Coast Builders Exchange Health Plan for the exclusive benefit of and to provide various welfare benefits to eligible employees of the members of the North Coast Builders Exchange and, if applicable, to their eligible dependents.

The North Coast Builders Exchange Health Plan, hereafter referred to as the “Plan,” may include health care benefits such as medical, dental, vision, chiropractic, chiropractic/acupuncture benefits, and group life and accidental death and dismemberment (AD&D) benefits. The benefits are provided through insurance contracts and policies (“Insurance Carrier Contracts”) negotiated by the North Bay Builders Exchanges, Inc. (“NBBE”) on behalf of the North Coast Builders Exchange Insurance Trust. Those contracts and policies are part of the official Plan documents.

The Insurance Carriers (“Carriers”) have provided booklets (Evidences of Coverage or Certificates of Coverage) to describe the coverage available under the program(s) they insure. Those booklets, referred to throughout this document as “Evidence(s) of Coverage,” contain important information about each program; however, they may not contain all of the information required by the Employee Retirement Income Security Act of 1974, as amended (“ERISA”) and other federal laws. This document, along with the Evidence(s) of Coverage that apply to the program(s) in which you are enrolled, and any Summaries of Material Modifications (“SMMs”), constitute your Summary Plan Description for the Plan. The provisions of those Evidence(s) of Coverage are incorporated into this document by reference. Any reference to the “Summary Plan Description” includes this document, the SMMs and each of the Evidence(s) of Coverage which apply to the program(s) in which you are enrolled. These documents should be read and kept together.

Certain provisions of the North Coast Builders Exchange Health Plan are summarized in this document. This description does not state all of the terms and conditions of the Plan. In all cases, the official Plan documents and the Declaration of Trust (the “Trust Document”) shall govern.

This document, together with the group insurance policies and contracts issued by the various Insurance Carriers, also serves as the plan document required by ERISA.

If the terms of this document conflict with the terms of any Evidence of Coverage, Certificate of Coverage or group insurance policy or contract, the terms of the Evidence of Coverage, Certificate of Coverage or group insurance policy or contract will control, unless required by applicable law.

Your Employer’s plan may not include all of the programs offered by the North Coast Builders Exchange Health Plan — a participating Employer may choose to offer only certain programs to its eligible employees, and eligibility to participate in certain programs may depend on certain variables, such as where you live. Call your Employer or the Plan Administrator, North Coast Builders Exchange Insurance Trust at (707) 542-9502 for information regarding the benefit programs your Employer has made available to you under the Plan and for information regarding the benefit programs in which you are enrolled.

If you have any questions about this document or about the Plan, contact the Plan’s Administrator, North Coast Builders Exchange Insurance Trust, 1030 Apollo Way, Santa Rosa, CA 95407; telephone number (707) 542-9502.

If you have questions about a particular program, contact the applicable insurance Carrier.

CAPITALIZED TERMS

Many of the capitalized terms appearing in this document have a special meaning and are defined in the **Glossary of Terms** section of this document.

GENERAL INFORMATION ABOUT THE PLAN

NAME AND TYPE OF PLAN

The Plan name is the North Coast Builders Exchange Health Plan (the "Plan"). The Plan is a welfare benefits plan which may include health care benefits such as medical, dental, vision, chiropractic, chiropractic/acupuncture benefits, and group life and accidental death & dismemberment ("AD&D") benefits.

PLAN SPONSOR

The Plan Sponsor is the North Coast Builders Exchange. The North Coast Builders Exchange is located at 1030 Apollo Way, Santa Rosa, CA 95407. The phone number is (707) 542-9502.

ADMINISTRATION OF THE PLAN AND TRUST

In order to provide group insurance benefits to its members, the North Coast Builders Exchange ("NCBE") formed the NCBE Insurance Trust.

The members of the Board of Trustees of the NCBE Insurance Trust (the "Trustees") are elected annually by the Board of Directors of the NCBE.

Responsibilities of the Trustees include determining the group insurance programs to be offered under the Plan, review contracts and rates with the health insurance broker and/or Carriers, and establishing policies governing the Trust.

The Trustees have general supervision over the operation of the Trust and shall conduct the business and activities of the Trust in accordance with the Trust Document and all applicable laws.

The Trustees have the power to establish, amend, interpret and promulgate rules and regulations regarding the administration and function of the NCBE Insurance Trust and the group insurance programs.

The group insurance programs under the Plan are insured and administered by various Carriers. The insurance Carriers shall have full discretion to construe and interpret the terms and provisions of the programs(s) they insure.

PLAN ADMINISTRATOR

The **PLAN ADMINISTRATOR** is the named fiduciary with the authority to control and manage the operation and administration of the Plan. The principal duty of the Plan Administrator is to see that the Plan is carried out in accordance with its terms for the exclusive benefit of persons entitled to participate in the Plan. The Plan Administrator shall make such rules, interpretations, and computations and take such other actions, such as retaining legal counsel and accountants, to administer the Plan as it, in its sole discretion, may deem appropriate. The Plan Administrator has full discretion and authority to administer the Plan except as otherwise delegated to the Insurance Carriers that have contracted to provide Plan benefits. The Plan Administrator has delegated the right to sign insurance contracts with Insurance Carriers that provide benefits under the Plan to the NBBE Board of Directors, including amendments to those contracts. The Plan Administrator or the Plan, to extent permissible, will bear the costs of administering the Plan.

The Plan is fully insured. The Insurance Carriers, as provided in the group contracts or policies between the Carriers and the NBBE on behalf of the Plan Administrator, have full discretion to interpret and administer the terms of the group contract or policy. The Insurance Carriers are the named fiduciaries for benefit appeals and are responsible for (1) determining eligibility for and the amount of any benefits payable under the Plan, and (2) prescribing claims procedures to be followed.

The Plan Administrator is the Board of Trustees of the NCBE Insurance Trust, located at 1030 Apollo Way, Santa Rosa, CA 95407; phone number (707) 542-9502.

PLAN TRUSTEES

The Trustees of the NCBE Insurance Trust, effective as of January 1, 2008, are:

Jerry Minton, Minton Electric, 7796 Bell Road, Windsor, CA 95492

Todd Cowan, Cowan and Associates/Designers Inc. 2833 Dowd Drive, Santa Rosa, CA 95407

Doug Donmon, Dimensions 4 Engineering, Inc., PO Box 1625, Santa Rosa, CA 95402

David Elie, Elie Development, 5083 Bodega Avenue, Petaluma, CA 94952

Lee Morton, Morton Building Solutions, 200 Clear Ridge Drive, Healdsburg, CA 95448

Richard Owens, Siri Grading & Paving, Inc., PO Box 3638, Santa Rosa, CA 95402

Ken Porter, Kimco Construction, Inc., PO Box 7129, Santa Rosa, CA 95407

Keith Woods, B.E.A.M.S., Inc., 1030 Apollo Way, Santa Rosa, CA 95407

CONTRACT ADMINISTRATOR (B.E.A.M.S., INC.)

The Trustees have contracted with B.E.A.M.S., Inc. to provide administrative services to the NCBE Insurance Trust pursuant to an administrative services agreement. All administrative inquiries, benefit verification requests and requests for general information about the Plan should be directed to: North Coast Builders Exchange Insurance Trust, 1030 Apollo Way, Santa Rosa, CA 95407; phone number (707) 542-9502.

B.E.A.M.S., Inc. is responsible for the administration of the Plan on a day-to-day basis. This includes premium billing, Carrier statement reconciliation, forwarding premium payments to Carriers, enrollment, benefit changes, termination of coverage and providing termination notification to Carriers.

SOURCE OF CONTRIBUTIONS

The cost of Plan benefits is funded in part by contributions made by the Employer, which are deposited into a Trust account operated for the sole benefit of participants and their employees. Employees may also be required to make contributions. The employee rate of contribution is set by the Employer (within guidelines established by the Carriers) as set forth in the Employer's Participation Agreement with the NCBE Insurance Trust, and may be adjusted from time to time.

Employer contributions are paid from the Employer's general assets.

FUNDING MEDIUM

The Plan is fully insured. Benefits are provided under group insurance contracts entered into by the NBBE on behalf of the employers who are members of the North Coast Builders Exchange that participate in the NCBE Health Plan. The Insurance Carriers are responsible for the payment of benefits under the Plan. Your Employer has no responsibility for the payment of benefits beyond the obligation to timely pay Employer contributions and to timely transmit employee contributions to the Plan Administrator. Plan contributions are deposited into the NCBE Insurance Trust, which is maintained by the Trustees.

PLAN YEAR

The plan year begins on April 1 and ends on March 31. Carrier contracts are generally negotiated annually, usually with an effective date of April 1. Open Enrollment is generally held during the month of February, with an effective date of April 1.

EFFECTIVE DATE OF THE PLAN

The Plan was originally effective as of March 1, 1981. The terms described in this document are effective as of April 1, 2008.

TRUST IDENTIFICATION NUMBER/IRS PLAN NUMBER

The NCBE Insurance Trust's identification number (EIN) is 94-6220648. The Plan has been assigned number 501.

DESIGNATED AGENT FOR SERVICE OF LEGAL PROCESS

The designated agent for service of legal process is the North Coast Builders Exchange Chief Executive Officer, 1030 Apollo Way, Santa Rosa, CA 95407. Service of legal process may also be made upon a Plan Trustee or the Plan Administrator.

INSURANCE CARRIERS

The NBBE on behalf of the NCBE Insurance Trust, contracts with various Carriers to provide group insurance programs under the Plan. The benefits (and any limitations on benefits) and the terms and conditions of coverage under each of the programs are described in separate booklets, called "Evidences of Coverage" or "Certificates of Coverage" (hereinafter, collectively "Evidence of Coverage") which are provided at no charge by the medical insurance Carriers. If you do not have a copy of any of these Evidence of Coverage booklets, contact the Plan Administrator or the applicable Carrier.

The contact information for each Carrier is (note that additional contact information may appear on your enrollment identification card, or in the applicable Evidence of Coverage):

Kaiser Permanente (Medical/Prescription Drug)

PO Box 23127
San Diego, CA 92193
(800) 464-4000

Health Net HMO (Medical/Prescription Drug)

PO Box 10348
Van Nuys, CA 91410-0348
(800) 522-0088

Health Net PPO (Medical/Prescription Drug)

PO Box 10348
Van Nuys, Ca 91410-0348
(800) 361-3366

Blue View Vision (Vision)

21555 Oxnard Street
Woodland Hills, CA 91365
(866) 723-0515

Vision Service Plan (Vision)

3333 Quality Drive
Rancho Cordova, CA 95670
(800) 852-7600

MetLife (Dental)

PO Box 981282
El Paso, TX 79998-1282
(800) 942-0854

Premier Access (Dental)
PO Box 659010
Sacramento, CA 95865
(888) 715-0760

MetLife (Group Life and AD&D)
PO Box 3016
Utica, NY 13504
(800) 638-6420

MetLife (Optional Term Life and AD&D)
PO Box 3016
Utica, NY 13504
(800) 638-6420

American Specialty Health Plans of California (Chiropractic, Chiropractic/Acupuncture)
777 Front Street
San Diego, CA 92101
(800) 848-3555

AMENDMENT / TERMINATION PROVISION

The Trustees reserve the right to amend or modify the Trust Document and/or the Plan at any time by a majority vote of the Trustees. The Trustees may amend or terminate the Plan at any time and for any reason in its sole discretion by written amendment duly adopted by the Trustees. This includes, but is not limited to, increasing contributions and reducing benefits. No amendment shall divert any of the assets of the Trust from the purposes and objectives of the Trust, nor shall any amendment permit any return or payment of any part of the NCBE Insurance Trust to any person, including any Exchange member. Likewise, the Plan may be terminated at any time by your Employer. Any amendment or termination of the Plan will not affect the payment of benefits for claims for periods prior to the date of the amendment or termination. The Trustees have delegated the authority to sign group insurance contracts and any amendments to those group insurance contracts to the NBBE Board of Directors.

CLAIMS REVIEW PROCEDURES

To obtain benefits from any benefit program in which you are enrolled, you must follow the claims procedure described in the Carrier's Evidence of Coverage. You may be required to complete and submit a claim form. The Carriers are responsible for evaluating all benefit claims under the Plan programs. The Carriers will decide all claims in accordance with their reasonable claims procedures, as required by ERISA. The Carriers have the right to seek independent medical advice and to require you to provide other evidence as they deem necessary to decide your claims.

If the Carrier denies your claim, in whole or in part, you will receive a notice of the denial and an explanation of how you may appeal the decision, as required by ERISA. If you appeal a claim denial, the Carrier will decide your appeal in accordance with reasonable appeals procedures, as required by ERISA. The Carriers have the right to seek independent medical advice and to require you to provide other evidence as they deem necessary to decide your appeal. You must exhaust all required appeals prior to bringing any civil suit under ERISA.

Refer to the applicable Evidence of Coverage for information regarding claims and appeals and for descriptions of the Carrier's claims and appeals procedures under a particular program.

The Plan Administrator generally does not receive information regarding individual benefit claims. However upon request by an individual participant and with appropriate authorization from the individual(s) involved, the Plan Administrator may in its sole discretion assist with claims for benefits (to the extent permitted by law). The Plan Administrator does not have any authority over claim disputes. Claim resolution is at the sole discretion of the Carrier.

If any Participant has a dispute with the Plan as to eligibility or any other dispute within the control of the Plan Administrator such dispute shall be resolved by the Plan Administrator or its designee in its sole discretion and any decision shall be final and binding on all parties.

ELIGIBILITY AND PARTICIPATION IN THE PLAN

ELIGIBILITY FOR PLAN PARTICIPATION

Eligible Employers–Exchange Members

An Employer must be a member of the North Coast Builders Exchange (an “Exchange Member”) to be eligible to become a participating Employer in the Plan. Other requirements for participation are set forth in the Participation Agreement entered into by the Exchange Member, and in the NCBE Insurance Trust Health Insurance Group Health Plans booklet provided to the participating Employer annually.

Participating Employers are generally required to contribute a minimum of 50% of the “employee only” premium toward health insurance coverage. All eligible employees must be accounted for by enrollment or declination forms. A minimum of 75% of all eligible employees not covered by other group health insurance must enroll.

Eligible Employees

The eligibility and participation rules described in this section are general and may differ in a particular insurance program. Specific eligibility requirements and limitations for a particular program are described in the Evidence of Coverage for that program.

You are generally eligible for the Plan if you are an owner, officer, key supervisory personnel, or an active employee working at least twenty (20) hours a week during a thirty (30) calendar day period of continuous service for a participating Employer, provided you have satisfied the initial eligibility Waiting Period set forth in the participation agreement entered into by your Employer, the Exchange Member, with the NCBE Insurance Trust. (Your employer’s initial eligibility Waiting Period may be a period, for example, of 30, 60, 90, 120, or 180 days)

Eligible employees must generally elect to participate in the Plan:

- a. During their initial eligibility period, or
- b. During an Open Enrollment period, or
- c. During a special enrollment period (described below under **Special Enrollment Rights**).

Generally, only “active employees” of a company that is an Exchange member can be covered.

All present active employees of a participating Employer who are eligible to participate in the Plan may have as their eligibility date the date the Employer’s Participation Agreement with the NCBE Insurance Trust becomes effective. Employees who first meet the eligibility requirements after that date shall have as their eligibility date the first of the month following the date on which the employee satisfies the continuous period of employment required by the Employer, provided that all other requirements for eligibility and participation are met.

Benefits desired must be chosen at the time of enrollment in the Plan. You generally may not add or delete or change benefits unless there is an Open Enrollment period.

Late enrollment must be medically underwritten. Late enrollment is subject to all of the Carrier’s requirements, restrictions and/or limitations.

Eligible Dependents

The eligibility and participation rules described in this section are general and may differ in a particular insurance program. Specific eligibility requirements and limitations for a particular program are described in the Evidence of Coverage for that program.

Eligible dependents are generally your legal spouse and unmarried child(ren) under age 19 (or other such age as specified by the Carrier) who have not provided over one-half of their own support for the calendar year and who

live with you for more than one-half of the calendar year. Unmarried children who meet the preceding requirements, but who are age 19 or older may be eligible under certain circumstances as specified by the insurance Carrier [for example, an unmarried child age 19 or older who is a full-time student may be considered an eligible dependent to some extended age; or an unmarried child age 19 or older who is disabled (i.e., unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment may be considered an eligible dependent) may be considered an eligible dependent – to obtain or continue coverage for a disabled child age 19 or over, the Carrier may require that the child be covered under the Plan prior to the child’s attainment of age 19]. An eligible employee’s domestic partner may also be eligible for coverage. Refer to the section entitled **Domestic Partner Eligibility** below for more information.

Dependents may not be enrolled unless the employee is enrolled. The Plan Administrator or Carrier may require proof of eligibility (for example, proof of your child’s full-time student status or disabled status) at any time to the extent permitted by applicable law.

Special Enrollment Rights

In certain circumstances, enrollment may occur outside the Open Enrollment period, as explained in the Evidence of Coverage. For example, if you initially decline coverage because you have other health coverage and you lose that coverage, you may be able to enroll yourself and your dependents within 30 days after losing other coverage. In addition, if you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to add the new spouse or child, or enroll yourself and your dependents within 30 days. See the section of this SPD titled “**HIPAA PORTABILITY**” and the Evidence of Coverage for additional information.

Domestic Partner Eligibility

The eligibility and participation rules described in this section are general and may differ in a particular insurance program.

Please be advised that when you decide to cover your domestic partner and his or her children, such coverage generally will be taxable to you (the employee) under federal law.

Eligible employees under the Plan may be able to enroll their domestic partner in certain programs, provided that all of the applicable requirements of the Plan and the Carrier are met. An eligible employee’s domestic partner may be eligible to enroll in the Plan if the employee and his or her domestic partner satisfy the requirements of California Family Code Section 297 (see paragraph A below).

A. California Family Code Section 297

To be eligible for coverage, an eligible employee and his or her domestic partner must have chosen to share one another’s lives in an intimate and committed relationship of mutual caring and have filed a Declaration of Domestic Partnership with California’s Secretary of State and have satisfied all of the following requirements of California Family Code Section 297 at the time of the filing of their Declaration of Domestic Partnership:

1. Both share the same residence;
2. Neither the employee nor the domestic partner is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity;
3. Neither are related by blood in a way that would prevent them from being married to each other under California law;
4. Both are at least 18 years of age;
5. Satisfy either of the following:
 - a. Both are members of the same sex; or
 - b. One or both are over the age of 62 and meet the eligibility criteria for Social Security benefits;
6. Both are capable of consenting to the domestic partnership.

The employee and his or her domestic partner may be required to submit to the Carrier from whom they desire coverage a copy of the Domestic Partnership registration certificate as filed with any state or local governing

agency that includes the basic requirements described above, and any other information or documents required by the Carrier.

A complete copy of such documents must be provided to the Plan Administrator.

ENROLLING IN THE PLAN

To enroll in the Plan, you must complete and submit the application(s) prescribed by the Plan's Administrator and the Carrier(s) to the Plan Administrator (via your Employer) within 30 days of becoming eligible. All applications will be reviewed by the Plan Administrator for completeness.

If you are enrolling your domestic partner, you must obtain a enrollment application from your Employer. This form must be completed and timely returned to your Employer and the Plan Administrator during any Open Enrollment period or at your commencement of initial eligibility.

REQUIRED PREMIUM PAYMENTS

Employees are generally required to contribute a percentage of the premium for coverage under a particular program. Coverage for your dependents is voluntary and requires payment of an additional contribution. The Employer will send such payments on behalf of employees and their eligible family members to the Plan Administrator. Contact your Employer for information about your share of the cost of coverage under the Plan.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

With respect to programs that are group health plans (as defined by ERISA), the Plan will provide benefits as required by any Qualified Medical Child Support Order (or "QMCSO"), as required under ERISA. The Plan Administrator has established guidelines for determining whether a medical child support order is a QMCSO. You may obtain a free copy of the guidelines by contacting the Plan Administrator. All correspondence and questions concerning a Qualified Medical Child Support Order should be directed to the Plan Administrator.

BENEFITS PROVIDED UNDER THE PLAN

The benefits provided under the Plan are provided by Carriers pursuant to group insurance contracts which are part of the official Plan documents. The benefits under a particular program are summarized in the section entitled **Summary of Programs Offered**, and are described in detail in the applicable Evidence of Coverage prepared by the Carrier.

If a program utilizes a provider network, a provider listing will be furnished upon request, without charge, as a separate document. For information regarding a program's provider network, use of the network, etc. under a particular program, refer to the applicable Evidence of Coverage or contact the Carrier.

CIRCUMSTANCES WHICH MAY AFFECT BENEFITS

You and your dependents' eligibility for Plan benefits will terminate upon the occurrence of any of the events listed in the **Termination of Benefits** section of this document, or as otherwise described below or in the applicable Evidence of Coverage. Other circumstances may result in the termination, reduction, loss, offset or denial of benefits including, but not limited to, exclusions for preexisting conditions, exclusions for certain medical procedures, limitations on preventive care, limitations on coverage for new drugs, and rights of recovery of benefits paid by a particular program (for example, the program's rights of reimbursement and subrogation). Benefits under a particular program may also be subject to coordination of benefits if you have coverage under another plan. *Refer to the applicable Evidence of Coverage for information regarding the circumstances which may affect benefits under a particular program.*

INELIGIBILITY, DENIAL OR LOSS OF BENEFITS

Participation in the Plan and the program(s) will terminate if the Employer fails to make the monthly premium payment, or fails to keep its membership in good standing in the North Coast Builders Exchange. You and/or your dependents may be ineligible if you make false statements on any application to the Plan and/or Carrier(s). *Refer to the Evidence of Coverage for other circumstances which may affect your coverage under a particular program.*

TERMINATION OF BENEFITS

Your benefit coverage can be terminated when:

- The participation agreement between the Employer and the NCBE Insurance Trust ends;
- The Employer fails to timely pay subscription (premium) charges (benefits will generally end on the last day of the month for which subscription charges have been paid);
- You cease to live or work within a program's service area; or
- You no longer work for the Employer covered under this Plan, or you cease to meet the Plan's or a particular program's eligibility requirements.

Refer to the Evidence of Coverage for other circumstances under which your coverage may be terminated.

CONVERSION PRIVILEGES

Participants in the North Coast Builders Exchange Health Plan may have the right to convert to individual coverage upon leaving the group program. Benefits and monthly premiums generally differ from your group coverage under the Plan. If you wish to obtain conversion coverage, you must do so within the time period specified by the Carrier. If you elect conversion coverage, your benefits will be provided by the Carrier, not by the NCBE Health Plan, and your rights will be determined under that policy. Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely. *Refer to the applicable Evidence of Coverage for information about conversion privileges under a particular program.*

COBRA INFORMATION

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). (If there are changes to this law or other laws concerning continuation coverage, those laws, and not these Plan rules, will govern.) *COBRA applies to most employers with at least 20 or more employees on payroll for at least 50% of the working days of the previous calendar year.*

COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage (for example, medical, dental and vision). It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan's COBRA Administrator, North Coast Builders Exchange Insurance Trust, 1030 Apollo Way, Santa Rosa, CA 95407, phone number (707) 542-9502.

COBRA – CONSIDER COBRA COVERAGE CAREFULLY

Under Federal law (the Health Insurance Portability and Accountability Act or HIPAA), a preexisting condition exclusion or limitation of your new group health plan might not apply at all to you, depending on the length of your creditable health plan coverage under the Plan prior to enrolling in a new group health plan. However, if there has been a break of 63 days or more after you lose Plan coverage and before you are covered by any new plan, the benefit of HIPAA creditable coverage would be lost. Your new plan could disregard your old coverage

prior to this break, and it could enforce preexisting condition limitations against you or your dependents. Therefore, carefully consider electing COBRA coverage, before letting this 63-day period expire. Additionally, you will lose the guaranteed right to purchase individual health insurance policies that do not impose a preexisting condition limitation if you do not elect and exhaust the COBRA coverage available to you. Finally, special enrollment rights might apply to other group health plan coverage available to you due to loss of Group Health Program coverage or loss of COBRA coverage.

Please examine your options carefully before declining COBRA coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

WHAT IS COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you may become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- a reduction in your hours of employment; or
- the termination of your employment for any reason other than your gross misconduct.

If you are the spouse of an employee, you may become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- your spouse dies;
- your spouse’s hours of employment are reduced;
- your spouse’s employment is terminated for any reason other than for his or her gross misconduct;
- your spouse becomes entitled to and enrolled in Medicare (under Part A, Part B, or both); or
- you become divorced or legally separated from your spouse.

Your dependent child(ren) may become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- the parent-employee dies;
- the parent-employee’s hours of employment are reduced;
- the parent-employee’s employment is terminated for any reason other than for his or her gross misconduct;
- the parent-employee becomes entitled to and enrolled in Medicare (under Part A, Part B, or both);
- the parents become divorced or legally separated; or
- the child ceases to be a “dependent child” as defined under the Plan.

If you and your family members lose eligibility due to non-payment of premiums or because your employer no longer contributes to the Plan, COBRA continuation coverage is not available under this Plan.

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred.

YOU MUST PROVIDE NOTIFICATION OF SOME QUALIFYING EVENTS

You (or your dependent) must notify the COBRA Administrator in writing of the occurrence of a qualifying event that is either *your divorce or legal separation*, or *your child ceasing to be a “dependent child” under the terms of the Plan*. The notification must be sent to the COBRA Administrator within 30 days after the later of:

- the date of the qualifying event; or
- the date on which there is or would be a loss of coverage.

If you fail to provide timely notice of the qualifying event, your spouse’s and/or dependent’s right to COBRA continuation coverage will be lost.

You must include in your notification all the following information:

- name of the individual(s) experiencing the qualifying event,
- name and Social Security Number of the employee,
- date of the qualifying event,
- type of qualifying event, and
- address of each qualified beneficiary.

When the qualifying event is the end of employment (other than for gross misconduct), or reduction of hours of employment, death of the employee, or the employee’s becoming entitled to and enrolled in Medicare benefits (under Part A, Part B, or both), your Employer must notify the COBRA Administrator of the qualifying event within 30 days of the event.

Within 14 days after receiving notice of the qualifying event, the COBRA Administrator will send the COBRA Continuation of Coverage Election Notice and Election Form (the “COBRA Election Notice”) to the qualified beneficiary(ies). If you want to be sure the COBRA Administrator has notice that your coverage has been terminated and you want to elect COBRA continuation coverage as soon as possible, you should notify the COBRA Administrator that you are eligible for, and that you wish to apply for, COBRA continuation coverage.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED

To have COBRA continuation coverage, you must timely elect it

The COBRA Administrator, upon notification from the employer, employee, and/or dependent that a qualifying event has occurred, will send a COBRA Election Notice and COBRA Election form to the qualified beneficiary(ies). Note that each qualified beneficiary may make an independent COBRA election. An employee may elect coverage on behalf of his or her spouse and a parent or legal guardian may make an election on behalf of a minor child. An election on behalf of a person who is incapacitated or dies can be made by the spouse of the person or by the legal representative of the person or the person’s estate, as determined under applicable state law.

To continue coverage, a qualified beneficiary must complete and submit the election form to the COBRA Administrator within sixty (60) days from the later of the date of notice or the date plan coverage is lost.

Note that upon notification of a qualifying event, coverage will be terminated as of the date coverage is lost under the Plan because of the qualifying event. Coverage will be reinstated retroactively, to the date of loss, once COBRA continuation coverage is timely elected *and* the initial COBRA premium payment is timely received by the COBRA Administrator.

In considering whether to elect COBRA 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 preexisting condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not elect COBRA continuation coverage for the maximum time available to you. This guaranteed right will only be preserved if you elect COBRA continuation coverage. 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 giving rise to your right to elect COBRA continuation coverage. You will also have the same special enrollment right at the end of the maximum COBRA continuation coverage period available to you.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment (other than for gross misconduct) or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). [Note: To obtain this extended coverage period, the COBRA Administrator must receive notice of the qualified beneficiary request for the extension and a copy of the employee's Medicare card within the initial 18 months of COBRA coverage.] Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Cobra Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. *You must make sure that the COBRA Administrator is notified of the Social Security Administration's determination within 60 days after the latest of the following:*

- *the date of the Social Security Administration's disability determination; or*
- *the date of the qualifying event; or*
- *the date on which there is a loss of coverage.*

Notwithstanding the foregoing, notice of a disability must be provided before the 18 month period of COBRA continuation coverage ends. Notice of the disability must be made in writing and timely sent to the COBRA Administrator. The notice must include the name(s) and address(es) of the qualified beneficiary(ies) who want the extension, the name of the individual determined to be disabled, the name and Social Security Number of the employee, and a copy of the Social Security Administration's determination.

You or your dependent must also notify the COBRA Administrator within 30 days of the date of a determination by the Social Security Administration that the covered person is no longer disabled if that occurs while you or your dependent(s) is (are) receiving COBRA continuation benefits.

If the disabled individual elects this disability extension, COBRA continuation coverage after the 18 month period may require payment of up to 150% of the applicable group premium; except that if the disabled individual does not elect COBRA continuation coverage for the additional 11 months, the cost for those individuals electing COBRA continuation coverage for the additional 11 months will not exceed 102% of the applicable group premium.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the COBRA Administrator. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to and enrolled in Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under

the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. **NOTE:** A termination of employment following a reduction of hours is not a second “qualifying event” which may entitle you to an extension of COBRA continuation coverage.

You must notify the COBRA Administrator within 60 days after the later of (1) the date of the second qualifying event; and (2) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan); otherwise you will lose the right to the 36-month COBRA continuation coverage period. You must include in your notification all the following information:

- name of the individual(s) experiencing the qualifying event,
- name and Social Security Number of the employee,
- date of the qualifying event,
- type of qualifying event, and
- address of each qualified beneficiary.

PAYMENT OF COBRA PREMIUMS

The current amount of the premium and the due date for payment will be explained in the COBRA Continuation Coverage Election Notice and Election Form provided to you by the COBRA Administrator. The premiums for COBRA continuation coverage are subject to change.

You must self-pay for COBRA continuation coverage. COBRA continuation coverage generally requires payment of up to 102% of the applicable group premium. Each month you must send your payment to the COBRA Administrator or to the Carrier if they bill directly. The COBRA Administrator or the Carrier may send you monthly notices of premiums due. *These are provided only as a courtesy—the failure to receive such a notice does not relieve you of the obligation to timely pay your premium for that month.*

The initial payment must be made within 45 days of your COBRA election or you will lose all COBRA rights under the Plan. Your first COBRA premium payment must cover the cost of benefits from the date coverage was lost. Thereafter, your payments are due on the first day of the month to which the premium applies.

Although periodic payments are due on the dates described above, you will be given a grace period of 30 days after the first day of the month to make each periodic payment. Your continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you make a payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month 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 month, you will lose all rights to continuation coverage under the Plan.

Your **first payment** for continuation coverage administered by the Plan should be made payable to the **NCBE Insurance Trust** and be sent to the **COBRA Administrator – North Coast Builders Exchange Insurance Trust, 1030 Apollo Way, Santa Rosa, CA 95407** or to the Carrier if it bills directly. **Subsequent payments must be mailed to 1030 Apollo Way, Santa Rosa, CA 95407**, or to the Carrier if it bills directly.

NEWBORNS AND ADOPTED CHILDREN

A child who is born to, adopted by, or placed for adoption with the covered employee (or former employee) during a period of COBRA continuation coverage will be eligible to become a qualified beneficiary if the child is enrolled within 30 days of the birth, adoption or placement for adoption. In accordance with the terms of the Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA continuation coverage

upon proper written notification to the COBRA Administrator, within 30 days of the birth, adoption or placement for adoption.

TERMINATION OF COBRA CONTINUATION COVERAGE

COBRA continuation coverage under this Plan may be terminated for any of the following reasons:

- The required COBRA premium payment is not paid when due.
- You or any other qualified beneficiary(ies) have exhausted the applicable maximum period of COBRA continuation coverage (i.e., 18 or 36 months; or, in the case of a disability extension, 29 months).
- You and your spouse or dependent child(ren), if any, become covered under another group health plan that does not contain any exclusion or limitation for any of your preexisting conditions. If you become covered by another group health plan and that plan contains a preexisting condition limitation that affects you, your COBRA continuation coverage cannot be terminated. However, if the other plan's preexisting condition rule does not apply to you by reason of HIPAA's restrictions on preexisting condition clauses, the Plan may terminate your COBRA continuation coverage.
- You, your spouse or dependent child(ren), if any, become eligible for and enrolled in Medicare after the date COBRA continuation coverage has been elected.
- Your Employer ceases to provide any group health plan coverage.
- If coverage is extended to 29 months due to disability, a determination during that extended period that the individual is no longer disabled. **NOTE:** As described above, federal law requires that you inform the COBRA Administrator of any final determination that you are no longer disabled within 30 days of such a determination.
- This Plan terminates.

The COBRA Administrator will provide the qualified beneficiary with a notice if COBRA coverage terminates prior to the end of the maximum COBRA continuation coverage period. This notice will be provided as soon as reasonably practicable after the COBRA Administrator's determination that COBRA coverage will terminate.

INELIGIBILITY FOR COBRA CONTINUATION COVERAGE

Continuation coverage under COBRA is provided subject to your eligibility. If the COBRA Administrator receives a notice from an individual who is not entitled to COBRA coverage, the COBRA Administrator will send the individual a notice that he or she is not eligible for COBRA coverage within 14 days of the COBRA Administrator receiving the notice. Further, the COBRA Administrator reserves the right to terminate your COBRA continuation coverage retroactively if you are determined to be ineligible for coverage.

IF YOU HAVE QUESTIONS AND WHERE TO PROVIDE NOTICES TO THE PLAN

All COBRA notices and questions concerning your Plan or your COBRA continuation coverage rights should be directed to the COBRA Administrator:

COBRA Administrator – North Coast Builders Exchange Insurance Trust
1030 Apollo Way
Santa Rosa, CA 95407
Phone number (707) 542-9502

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

KEEP THE PLAN INFORMED OF ADDRESS CHANGES

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

The information described below provides a summary of rights you may have under state law.

ADDITIONAL CONTINUATION COVERAGE UNDER STATE LAW

You may be entitled to extend your continuation coverage period under AB1401 in certain programs for a total of 36 months *under state law* if you were initially only entitled to 18 or 29 months of COBRA continuation coverage. The right to the extension only applies to medical benefits.

If you elect such additional continuation coverage, your benefits will be provided by the Carrier, not by the Plan, and your rights will be determined by that policy, not the rules of the Plan. *Refer to your program's Evidence of Coverage or contact the applicable Carrier for more information regarding this extension.*

CAL-COBRA COVERAGE

On January 1, 1998, CAL-COBRA became effective and offers certain legal rights for small employer plan members regarding continuation of group coverage following loss of coverage due to specified qualifying events. This is commonly referred to as CAL-COBRA coverage.

CAL-COBRA generally applies to small businesses that employ fewer than 20 (2 through 19) employees on payroll for 50% of its business days in the preceding calendar year.

CAL-COBRA allows you to continue certain medical, dental and vision benefits after you cease to be eligible for coverage by your employer. Coverage may be extended for up to 36 months following the loss of coverage.

The election form for coverage must be submitted within 60 days of termination from the group. Payment is required for any retroactive period, as coverage must be continuous from the qualifying date.

If you elect CAL-COBRA medical coverage, your benefits will be provided by the Carrier, not by the Plan, and your rights will be determined by that policy, not the rules of the Plan. *Contact the applicable Carrier for more information regarding CAL-COBRA.*

OTHER FEDERAL MANDATES

CONTINUATION COVERAGE DURING MILITARY LEAVE

If you take a leave of absence because of voluntary or involuntary service in the uniformed services for a period that is less than 31 days, you and your covered dependents' employer-paid Plan coverage will be continued. If your military leave of absence is between 31 days and five years, you may elect to continue group health program coverage for yourself and your eligible dependents for up to 24 months (18 months for elections made prior to December 10, 2004) or for the period ending on the day after the date you fail to apply for or return to employment with your employer as determined under § 4312(e) of the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), whichever is earlier. Coverage shall commence on the date of the military leave. You will be required to pay 102% of the cost of coverage for the duration of your coverage period. Because a right to continuation coverage under USERRA and COBRA are triggered simultaneously, an election of COBRA will be treated as an election of USERRA as well and the period of coverage available under USERRA will run concurrently with COBRA coverage.

This provision applies to:

- Eligible employees on active duty; and
- Eligible employees on active duty for training; and
- Eligible employees on initial active duty for training and inactive duty training in the Armed Forces (including the Reserve components), the Army or Air National Guard and the commissioned corps of the Public Health Services, and to full-time National Guard duty; and

- Absences needed to determine the employee's fitness for duty in the uniformed service.

To continue coverage under USERRA, you must provide your employer with advance notice of your military service. If you fail to provide advance notice to your employer, you will lose your right to continue coverage pursuant to USERRA unless the requirement to provide advance notice has been excused in accordance with USERRA because such notice was impossible, unreasonable or precluded by military necessity. If your requirement to provide advance notice has been properly excused, your health plan coverage will be reinstated retroactive to the date that your coverage was terminated upon your election to continue coverage and your payment of all unpaid premium payments.

You or your dependents may elect continuation coverage pursuant to USERRA by following the election procedure for COBRA coverage and electing COBRA coverage. An election of COBRA coverage will be treated as an election of continuation coverage pursuant to USERRA. If you do not elect coverage during the 60-day election period described in the COBRA election procedures, you will lose the right to continue coverage under both COBRA and USERRA (Even if you provided advance notice of your military service to your employer or if you failed to provide advance notice and such advanced notice was excused).

If you desire to elect USERRA continuation coverage, you must elect continuation coverage for yourself and all eligible family members who are currently covered. You may not make a separate election to continue coverage for some but not all of the persons who are currently covered. Continuation coverage under both COBRA and USERRA is available for qualified beneficiaries who are covered by the Plan and the benefits elected for continuation on the day before the event that qualifies them for COBRA and/or USERRA. Continuation coverage will be identical to the coverage provided under the plan to similarly situated employees or family members.

Paying for Continuation Coverage

The cost of continuing coverage pursuant to USERRA is the same as the cost of coverage under COBRA. This means that you will be required to pay the full cost of coverage (employer and employee share) plus a 2% administrative fee for the duration of your coverage period. The cost and payment schedule described in the section of the Summary Plan Description describing COBRA apply to continuation coverage pursuant to USERRA.

End of Continuation Coverage

Continuation coverage pursuant to USERRA ends on the earliest to occur of the following:

- The date you fail to return from protected military service or apply for a position of employment as provided under USERRA;
- The end of the 24-month period beginning the date your military leave of absence began;
- Your failure to make a timely payment for COBRA/USERRA coverage;
- The date you are discharged from military service under other than honorable conditions or if you are dismissed or dropped from military rolls under conditions that result in a loss of reemployment rights under USERRA;
- Any event that would terminate coverage of a participant not on COBRA/USERRA (e.g., fraud); or
- Termination of the Plan.

Returning From A Military Leave of Absence

If your Plan coverage terminated by reason of your service in the uniformed services, your employer-paid coverage will be reinstated upon your return from leave and reemployment in accordance with USERRA. Your coverage will be reinstated without the application of any preexisting condition exclusions or waiting periods unless you have an injury or illness that the Secretary of Veterans Affairs has determined to have been incurred in, or aggravated during, performance of service in the uniformed services.

FEDERAL FAMILY AND MEDICAL LEAVE

If your Employer is subject to the Family And Medical Leave Act of 1993 ("FMLA"), you may be entitled to continued group health plan coverage under this Plan if you are on leave for certain purposes, including:

- the birth or adoption of your child(ren); or

- the care of a spouse or relative; or
- any other purpose provided for by the FMLA.

Generally, companies that employ 50 or more employees are subject to FMLA. Coverage will be continued for the period of time allowed by FMLA. Your Employer will continue making Employer contributions to the Plan on your behalf during your approved leave; you must arrange to pay the employee contributions during your absence. The contribution rate shall be equivalent to your current cost of coverage at the time you go on leave in accordance with FMLA, subject to any increase or decrease resulting from any subsequent Open Enrollment and/or approved modification to the Plan. It will be your responsibility to notify your Employer that FMLA leave is being taken. Contact your Employer for more information.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)

Federal law may affect your health coverage if you are enrolled or become eligible to enroll in health coverage that excludes coverage for preexisting medical conditions. *Preexisting condition exclusions under a particular program are described in the Evidence of Coverage for that program.*

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) limits the circumstances under which coverage may be excluded for preexisting conditions. A preexisting condition is any physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received during the 6-month period ending on the enrollment date (or, if earlier, the 6-month period ending on the first day of any applicable waiting period). A preexisting condition exclusion generally may not be imposed for more than 12 months after coverage begins (18 months for a late enrollee). The 12-month (or 18-month) exclusion period is reduced by your prior creditable health coverage under HIPAA. To show evidence of your prior creditable health coverage, you are entitled to receive a Certificate of Creditable Coverage from your health plan.

CERTIFICATE OF CREDITABLE COVERAGE

When your coverage under the Plan terminates, you will automatically receive a Certificate of Creditable Coverage which will enable you to provide evidence of prior creditable coverage for purposes of reducing or eliminating preexisting condition exclusions imposed by subsequent health plan coverage. You may also request a Certificate of Creditable Coverage at any time while you are covered under the Plan and up to 24 months after your Plan coverage ceases. To request a Certificate of Creditable Coverage, you must send a written request to the Plan Administrator at the following address:

North Coast Builders Exchange Insurance Trust
1030 Apollo Way
Santa Rosa, CA 95407

You will receive the Certificate of Creditable Coverage within a reasonable period of time after the Administrative Office receives your written request.

HIPAA PORTABILITY

Special Enrollment: In certain circumstances, you and your eligible dependents may have rights to enroll outside the Open Enrollment period. To take advantage of special enrollment rights, you must request enrollment with the Plan Administrator (via your employer) within 30 days of the event triggering special enrollment. Special enrollment rights may be triggered by any of the following events:

- If you or any of your dependents declined enrollment under this Plan because of other health insurance coverage, other than COBRA coverage, but afterwards lost eligibility for that coverage for any of the following reasons other than the failure to pay timely premiums or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan):
 - Loss of eligibility for coverage as result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of the employee, termination of employment, and reduction in the number of hours of employment;
 - In the case of coverage through an individual HMO, a loss of eligibility for coverage under your individual HMO because you no longer reside, live or work in the HMO’s service area;

- In the case of coverage through a group HMO, a loss of eligibility for coverage under the group HMO because you no longer reside, live or work in the HMO's service area and no other benefit package is available to you;
- If you incur a claim under the other plan that would meet or exceed a lifetime limit on all benefits under the other plan; or
- The other plan ceases to offer any benefits to the class of similarly situated individuals that includes you or your dependent (e.g., your dependent is a part-time employee with employer A and employer A discontinues coverage for part-time employees);
- If you are covered under another plan for which an employer makes a contribution towards your premium and that contribution is terminated (such contributions must be completely terminated; a reduction in the value of the benefit or an increase in cost to the participant does not trigger a special enrollment right); or
- You exhaust COBRA coverage; or
- If you acquire a new dependent(s) as a result of marriage or domestic partnership, birth, adoption or placement for adoption, you may be able to add the new spouse or domestic partner or child(ren), or enroll yourself and your dependents.

If you are covered by a medical plan or HMO offered under the Plan and you enroll yourself and/or a new dependent(s) in accordance with the Plan's special enrollment procedures, you have the right to enroll in any other medical plan or HMO option for which you and your dependents are eligible.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

If you have or had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed; and
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the applicable medical plan.

If you would like more information on WHCRA benefits, contact your health insurance Carrier or refer to your Evidence of Coverage.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1997 (NMHPA)

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

The laws of your state related to hospital stays in connection with childbirth may differ from these federal requirements. For example, California law does not prohibit the treating physician from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable), after consulting with the mother and if the policy covers a post-discharge follow up visit for the mother and the newborn within 48 hours of the discharge.

For more information, please refer to you Carrier's Evidence of Coverage.

PRIVACY OF YOUR MEDICAL INFORMATION

The Plan is required to maintain the privacy of your protected health information (“PHI”). The Plan’s Notice of Privacy Practices describes the Plan’s obligations and your rights under the federal law called the HIPAA Privacy Rule. To obtain a copy of the Plan’s Notice of Privacy Practices, contact the Plan’s Privacy Official at:

North Coast Builders Exchange Insurance Trust
1030 Apollo Way
Santa Rosa, CA 95407
(707) 542-9502

The Plan’s current Notice of Privacy Practices is also available at ncbehealth.com.

Retaliation and Wavier

The Plan will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against you (or any other individual) for the exercise of any right established under the HIPAA Privacy Rule, including filing a complaint with the Plan or with the Secretary of the Department of Health and Human Services; testifying, assisting or participating in an investigation, compliance review, proceeding or hearing under the HIPAA Privacy Rule; or opposing any act or practice made unlawful by the HIPAA Privacy Rule, provided that you (or the individual) have a good faith belief that the practice opposed is unlawful and the manner of the opposition is reasonable and does not involve a disclosure of protected health information in violation of the HIPAA Privacy Rule.

The Plan will not require you to waive your privacy rights under the HIPAA Privacy Rule as a condition of treatment, payment, enrollment in a group health plan(s), or eligibility for benefits.

STATEMENT OF ERISA RIGHTS

The following Statement of ERISA Rights is required by federal law and regulation:

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”).

ERISA provides that all Plan participants are entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator’s office and at other specified locations all documents governing the plan, including insurance Carrier contracts and a copy of the latest Annual Report (Form 5500 Series) filed by the Plan, if applicable, with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance Carrier contracts and copies of the latest Annual Report (Form 5500 Series), if applicable, and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant a copy of this Annual Report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose

coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest Annual Report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrators to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator – NCBE Insurance Trust. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration, or at www.dol.gov/ebsa.

MISCELLANEOUS

STATEMENT REGARDING IMPACT OF ORAL COMMUNICATIONS

Any statement, representation or other oral communications made by your Employer, the Plan Administrator, or employees or staff members, that alters, modifies, amends, or is inconsistent with the written terms of the official Plan documents shall be invalid and unenforceable, and may not be relied upon by any employee, participant, beneficiary, service provider, insurance Carrier, or any other individual or entity.

NOT A CONTRACT FOR EMPLOYMENT

The Plan is not intended to be, and may not be construed as, constituting a contract for employment between you and your employer.

NO VESTED INTEREST

No individual shall have any rights under the Plan except as and only to the extent expressly provided in the Plan document and the applicable group insurance policy.

EXCESS BENEFIT PAYMENT

If any payment made under the Plan exceeds the amount that should have been paid, you or your beneficiary, if applicable, will be required to repay the amount of the overpayment to the Plan. The Contract Administrator or Insurance Carrier may make reasonable arrangements with you for repayment, including offsetting against future benefits.

GLOSSARY OF TERMS

CAL-COBRA – A California state law that allows certain employees who were covered under a group health plan to continue their health coverage (at their own expense) when they lose group health coverage under certain circumstances; for example, when they leave their jobs, either voluntarily or involuntarily. CAL-COBRA generally applies to employers with 2 to 19 employees for more than 50% of the prior calendar year.

CARRIER – An insurance risk taker such as MetLife, or a Health Maintenance Organization (HMO) such as Kaiser and Health Net. The Carriers insure and administer the programs offered under the Plan.

COBRA – The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, a federal law that allows employees who were covered under a group health plan to continue their health coverage (at their own expense) when they lose group health coverage under certain circumstances; for example, when they leave their jobs, either voluntarily or involuntarily. COBRA generally applies to employers with 20 or more employees more than 50% of the prior calendar year

CO-INSURANCE – Generally, the amount shared by the insured and the insurer. For example: PPO (70%), Non-PPO (50%), the Carrier pays 70% and the insured (individual) pays 30% for in-network PPO covered services; and the Carrier pays 50% and the insured pays 50% for out-of-network PPO covered services. Refer to the applicable Evidence of Coverage for further explanation.

CO-PAYMENTS – Generally, the amount the insured must pay for medical services, such as doctor visits, prescription drugs and hospitalization. Usually stated in dollars; e.g., a \$20 office visit co-pay or a \$20 prescription co-pay. Refer to the applicable Evidence of Coverage for further explanation.

COVERAGE – A choice of insurance coverage that can be selected to fit the needs of a family. There are usually four coverage elections available under a particular program: employee, employee/spouse (or domestic partner, if applicable), employee/child(ren), and employee/family. Refer to the applicable Evidence of Coverage for further explanation.

DEDUCTIBLE – Generally, the amount a participant must pay for services before benefits are payable under a particular program. Refer to the applicable Evidence of Coverage for further explanation.

ERISA – The Employee Retirement Income Security Act of 1974, as amended.

EVIDENCE OF COVERAGE – The booklet prepared by the Carrier of a particular program under this Plan that describes the benefits, limitations, and other terms and conditions of coverage under that program.

EXCHANGE MEMBER – A member in good standing with the North Coast Builders Exchange.

NCBE - The North Coast Builders Exchange, a non-profit mutual benefit association (under Internal Revenue Code § 501(c)(6)), located at 1030 Apollo Way, Santa Rosa, CA 95407.

OPEN ENROLLMENT – An annual “sign-up” period during which eligible employees can enroll in a group health program offered by their employer. In addition, employees already participating are allowed to change Carriers or enroll dependents not previously covered. Open Enrollment for the Plan is usually held February 1 through February 28, with an effective date of April 1.

PLAN ADMINISTRATOR – The North Coast Builders Exchange Insurance Trust, located at 1030 Apollo Way, Santa Rosa, CA 95407.

WAITING PERIOD – The length of continuous employment required by a participating employer (as set forth in that Employer’s Participation Agreement) in order for an employee who otherwise meets the eligibility requirements to obtain coverage.

SUMMARY OF PROGRAMS OFFERED

Your Employer’s Plan may include medical, dental, vision, chiropractic, chiropractic/acupuncture, life and accidental death and dismemberment (AD&D) coverage to the eligible employees. The following comparisons are only summaries of programs that may be offered during the current plan year, and should not be relied upon. Consult the applicable Evidence of Coverage for the exact terms of coverage, including information about the benefits and limitations on eligibility or benefits under a particular program. The Evidence of Coverage booklets are available at no charge to any participant on request.

Not all of the programs described in the following comparisons may be available to you. You will be provided with information about which programs you may be eligible to participate in when you first become eligible to participate and during the annual Open Enrollment periods. Contact your Employer for more information.

In the event any of the information contained in the following comparisons conflicts with the information contained in the Evidence of Coverage for a particular program, the terms of the Evidence of Coverage shall govern.

KAISER PERMANENTE PLAN COMPARISONS

NOT ALL PLANS ARE AVAILABLE TO FIRMS WITH 1 OR 2 MEDICAL ENROLLEES

Enrollee must live or work in a Kaiser Permanente zip code area

CALENDAR YEAR BENEFITS	PLAN 15 [◀]	PLAN 20	PLAN 30	PLAN 50
Medical Deductible (calendar year)	\$0	\$0	\$0	\$0
Pharmacy Deductible (calendar year)	\$0	\$0	\$250 brand name	\$250 brand name
Out-of-Pocket Maximum¹ (calendar year)	\$3,000 individual \$6,000 family	\$3,000 individual \$6,000 family	\$3,500 individual \$7,000 family	\$3,500 individual \$7,000 family
In the Medical Office				
Office visit	\$15 per visit	\$20 per visit	\$30 per visit	\$50 per visit
Maternity/prenatal care	\$0	\$0	\$0	\$15
Well-child preventive care ²	\$0	\$0	\$0	\$15
Allergy injections	\$5	\$5	\$5	\$5
Occupational, physical, speech therapy	\$15	\$20	\$30	\$50
Lab & imaging	\$10	\$10	\$10	\$10
MRI/CT/PET	\$50	\$50	\$50	\$50
Outpatient surgery	\$100 per procedure	\$150 per procedure	\$200 per procedure	\$250 per procedure
Emergency Services				
Emergency Room (waived if admitted)	\$100 per visit	\$100 per visit	\$100 per visit	\$150 per visit
Ambulance	\$75	\$75	\$75	\$300
Prescription Drugs				
Medicare D	Up to a 30 day supply Creditable	Up to a 30 day supply Creditable	Up to a 100 day supply Creditable	Up to a 100 day supply Creditable
Generic	\$10	\$10	\$10	\$10
Brand name	\$25	\$30	\$35 (after \$250 pharmacy deductible)	\$35 (after \$250 pharmacy deductible)
Hospital Care				
Physicians' services, room, tests, medications, therapies	\$200 per day	\$300 per day	\$400 per day	\$500 per day
Skilled nursing facility care (up to 100 days)	\$0	\$0	\$0	\$0
Mental Health Services				
In the medical office 20 visits per calendar year	\$15 individual \$7 group	\$20 individual \$10 group	\$30 individual \$15 group	\$50 individual \$25 group
In the hospital 30 days per calendar year	\$200 per day	\$300 per day	\$400 per day	\$500 per day
Chemical Dependency				
In the medical office	\$15 individual	\$20 individual	\$30 individual	\$50 individual
In the hospital (detox only)	\$200 per day	\$300 per day	\$400 per day	\$500 per day
Other				
Chiropractic care	Not covered	Not covered	Not covered	Not covered
Certain durable medical equipment (DME) ³	20% (\$2,000 maximum)	20% (\$2,000 maximum)	Not covered	Not covered
Vision exam	\$15	\$20	\$30	\$50
Optical ⁴ (every 24 months)	\$150 allowance	Not covered	Not covered	Not covered
Hospice care	\$0	\$0	\$0	\$0

◀ Not available to firms with 1 or 2 enrollees in medical

¹ Co-payments for most services and all deductible payments (except prescription drugs) count toward this maximum as described in the Evidence of Coverage

² 23 months or younger

³ Most DME for home use is not covered. Refer to your Evidence of Coverage for a description of limited covered items.

⁴ All members are entitled to a 20% discount on eyeglasses and contact lenses purchased at KP optical centers. These discounts may not be coordinated with any plan vision benefit. The discounts do not apply to any sale, promotional or package eyewear program, contact lenses extended purchase agreement or to low-vision aids.

**This is only a summary and there may be details not included,
the Kaiser Permanente Evidence of Coverage document supersedes any omissions or discrepancies in these plan descriptions.**

KAISER PERMANENTE PLAN COMPARISONS

Enrollee must live or work in a Kaiser Permanente zip code area

CALENDAR YEAR BENEFITS	HSA COMPATIBLE PLAN \$0/\$1,500	HSA COMPATIBLE PLAN \$0/\$2,700	HIGH DEDUCTIBLE (NON-HSA) PLAN \$30/\$1,000
Medical Deductible (calendar year)	\$1,500 individual \$3,000 family ¹	\$2,700 individual \$5,450 family ²	\$1,000 individual \$2,000 family
Pharmacy Deductible (calendar year)	N/A	N/A	\$250 brand name
Out-of-Pocket Maximum³ (calendar year)	\$1,500 individual enrollment \$3,000 family enrollment	\$2,700 individual enrollment \$5,450 family enrollment	\$3,500 individual \$7,000 family
In the Medical Office			
Office visit	\$0 (after deductible)	\$0 (after deductible)	\$30 (deductible waived)
Maternity/prenatal care	\$0	\$0	\$0
Well-child preventive care ⁴	\$0	\$0	\$0
Allergy injections	\$0 (after deductible)	\$0 (after deductible)	\$5 (after deductible)
Occupational, physical, speech therapy	\$0 (after deductible)	\$0 (after deductible)	\$30 (after deductible)
Lab & imaging	\$0 (after deductible)	\$0 (after deductible)	\$10 (after deductible)
MRI/CT/PET	\$0 (after deductible)	\$0 (after deductible)	\$50 (after deductible)
Outpatient surgery	\$0 (after deductible)	\$0 (after deductible)	\$250 (after deductible)
Emergency Services			
Emergency Room (waived if admitted)	\$0 (after deductible)	\$0 (after deductible)	\$100 per visit (after deductible)
Ambulance	\$0 (after deductible)	\$0 (after deductible)	\$75 (after deductible)
Prescription Drugs			
Medicare D	Up to a 100 day supply Non-Creditable	Up to a 100 day supply Non-Creditable	Up to a 100 day supply Creditable
Generic	\$0 (after deductible)	\$0 (after deductible)	\$10
Brand name	\$0 (after deductible)	\$0 (after deductible)	\$35 (after \$250 pharmacy deductible)
Hospital Care			
Physicians' services, room, tests, medications, therapies	\$0 per admission (after deductible)	\$0 per admission (after deductible)	\$500 per day (after deductible)
Skilled nursing facility care	\$0 per admission (after deductible)	\$0 per admission (after deductible)	\$50 per day (after deductible) (Up to 60 days)
Mental Health Services			
In the medical office 20 visits per calendar year	\$0 individual (after deductible) \$0 group (after deductible)	\$0 individual (after deductible) \$0 group (after deductible)	\$30 individual (after deductible) \$15 group (after deductible)
In the hospital 30 days per calendar year	\$0 per admission (after deductible)	\$0 per admission (after deductible)	\$500 per day (after deductible)
Chemical Dependency			
In the medical office	\$0 individual (after deductible)	\$0 individual (after deductible)	\$30 individual (after deductible)
In the hospital (detox only)	\$0 per admission (after deductible)	\$0 per admission (after deductible)	\$500 per day (after deductible)
Other			
Chiropractic care	Not covered	Not covered	Not covered
Certain durable medical equipment (DME) ⁵	Not covered	Not covered	Not covered
Vision exam	\$0 (after deductible)	\$0 (after deductible)	\$30
Optical ⁶ (every 24 months)	Not covered	Not covered	Not covered
Hospice care	\$0 (after deductible)	\$0 (after deductible)	\$0

¹ The entire family deductible must be met before copayments apply for individual family members (Aggregate Deductible).

² Each family member becomes eligible for copayments after meeting his or her individual deductible (Embedded Deductible).

³ Co-payments for most services and all deductible payments (except prescription drugs) count toward this max. as described in the Evidence of Coverage.

⁴ 23 months or younger

⁵ Most DME for home use is not covered. Refer to your Evidence of Coverage for a description of limited covered items.

⁶ All members are entitled to a 20% discount on eyeglasses and contact lenses purchased at KP optical centers. These discounts may not be coordinated with any plan vision benefit. The discounts do not apply to any sale, promotional or package eyewear program, contact lenses extended purchase agreement or to low-vision aids.

**This is only a summary and there may be details not included,
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CHIROPRACTIC AND ACUPUNCTURE PLANS

100% PARTICIPATION IS REQUIRED

AMERICAN SPECIALTY HEALTH PLANS OF CALIFORNIA, INC. (ASH)

Medical enrollment is required

American Specialty Health was the first “specialized healthcare service plan” in the nation to offer Chiropractic Benefits (1994) and Acupuncture Benefits (1997). You must use the chiropractic and acupuncture networks in California. There are over 2,200 chiropractic providers and over 800 acupuncture providers in the network. Coverage is available for firms with 2 or more enrolled owners and employees. Enrollment must match the medical enrollment including dependents.

Please call the contact person listed on the front cover of this booklet for rates and additional information.

THESE PLANS COVER THE FOLLOWING SERVICES WHEN THEY ARE PROVIDED BY AN ASH PROVIDER.

CALENDAR YEAR BENEFITS	CHIROPRACTIC	CHIROPRACTIC & ACUPUNCTURE
Office Visits Visits per calendar year No claim forms, no deductibles No medical referral required Initial and subsequent examinations Adjunctive therapy with or without adjustment (considered as one visit)	\$15 20 Covered Covered	\$15 20 combined Chiropractic/Acupuncture Covered Covered
Chiropractic Appliance Braces & supports Orthotics Cervical collars	\$50 per calendar year	\$50 per calendar year
Diagnostic Services Radiology Clinical laboratory	Covered Covered	Covered Covered
ASH Provider	Obtains authorization for all services based on clinical necessity	Obtains authorization for all services based on clinical necessity
Flexible Choice	Service area includes all California counties Over 2,200 ASH Chiropractic providers 250 Ancillary radiology & clinical laboratory providers ASH provider chosen at point-of-service & no pre-designation required Change ASH provider at any time	Service area includes all California counties Over 2,200 ASH Chiropractic providers Over 800 ASH Acupuncture providers 250 Ancillary radiology & clinical laboratory providers ASH provider chosen at point-of-service & no pre-designation required Change ASH provider at any time

To find an ASH provider, visit www.ashcompanies.com or call (800) 848-3555.

This is only a summary and there may be details not included, the American Specialty Health Evidence of Coverage document supersedes any omissions or discrepancies in these plan descriptions.

Enrollees must select a Primary Care Physician in their area

CALENDAR YEAR BENEFITS	HMO 20 VALUE◀	HMO 30 VALUE◀	HMO 40 VALUE
Lifetime Maximum	No maximum	No maximum	No maximum
Annual Deductible (calendar year)	\$0	\$0	\$0
Pharmacy Deductible (calendar year)	\$150 brand name	\$200 brand name	\$250 brand name
Annual Out-of-Pocket Maximum (calendar year)	\$2,500 individual \$5,000 family	\$3,500 individual \$7,000 family	\$4,500 individual \$9,000 family
In the Medical Office			
Office visit	\$20	\$30	\$40
Annual routine physical	Not covered	Not covered	Not covered
Maternity/prenatal care	\$20	\$30	\$40
Well-child preventive care ¹	\$20	\$30	\$40
Allergy injections (serum not included)	\$20	\$30	\$40
Rehabilitation therapy ² physical, speech	\$20	\$30	\$40
Lab & imaging	\$0	\$0	\$0
MRI/CT/PET/SPECT	\$100	\$100	\$100
Emergency Services			
Emergency room (waived if admitted)	\$100	\$100	\$100
Urgent care center	\$50	\$50	\$50
Ambulance	\$100	\$100	\$100
Prescription Drugs			
Medicare D	\$150 brand name deductible Creditable	\$200 brand name deductible Non-Creditable	\$250 brand name deductible Non-Creditable
Level I (30 day supply)	\$15	\$15	\$15
Level II (30 day supply)	\$30	\$30	\$30
Level III (30 day supply)	\$50	\$50	\$50
Mail-In-Service (90 days)	2 co-pays	2 co-pays	2 co-pays
Hospital Care³			
In-patient	20%	30%	40%
Out-patient	20%	30%	40%
Skilled nursing facility	\$0 (day 1-10) \$25 per day (day 11-100)	\$0 (day 1-10) \$25 per day (day 11-100)	\$0 (day 1-10) \$25 per day (day 11-100)
Nonsevere Mental Health			
Out-patient 20 visits per year	\$30 individual \$15 group	\$35 individual \$17.50 group	\$40 individual \$20 group
In the hospital 30 days per year	20%	30%	40%
Chemical Dependency			
Acute care detoxification	20%	30%	40%
Other			
Chiropractic care	Not covered	Not covered	Not covered
Diabetic equipment	20%	20%	20%
Durable medical equipment	50%	50%	50%
DME calendar year max	\$2,000	\$2,000	\$2,000
Orthotics & prosthetics	\$0	\$0	\$0
Vision exam	\$20	\$30	\$40
Optical eyewear	Not covered	Not covered	Not covered
Hospice care	\$0	\$0	\$0

◀ Not available to firms with 1 or 2 enrollees in medical

¹ Birth through age 2 covered in full

² Provided as long as significant improvement is expected

³ Excluding care for Mental Disorders, confinement for Infertility Services

This is only a summary and there may be details not included, the Health Net Evidence of Coverage document supersedes any omissions or discrepancies in these plan descriptions.

HEALTH NET PPO PLAN COMPARISONS

THESE PLANS ARE NOT AVAILABLE TO FIRMS WITH 1 OR 2 MEDICAL ENROLLEES

These plans are available to out-of-state employees¹

CALENDAR YEAR BENEFITS	PPO 40 STANDARD ⁴		PPO 40 VALUE ⁴	
	IN-NETWORK	OUT-OF-NETWORK (LFS) ²	IN-NETWORK	OUT-OF-NETWORK (LFS) ²
Lifetime Maximum	\$5,000,000 combined		\$5,000,000 combined	
Annual Deductible (calendar year)	\$500 individual \$1,000 family	\$1,000 individual \$2,000 family	\$1,500 individual \$3,000 family	\$3,000 individual \$6,000 family
Prescription Drug Deductible (calendar year)	\$0	\$100	\$250 brand name	\$100
Annual Out-of-Pocket Maximum (calendar year)	\$5,000 individual \$10,000 family ³	\$10,000 individual \$20,000 family ³	\$5,000 individual \$10,000 family ³	\$10,000 individual \$20,000 family ³
In the Medical Office				
Office visit	\$40	50%	\$40	50%
Annual routine physical	\$40 (\$250 max)	Not covered	\$40 (\$250 max)	Not covered
Maternity/prenatal care	40%	50%	50%	50%
Well-child preventive ⁴	\$40	Not covered	\$40	Not covered
Allergy injections (serum not included)	\$40	50%	\$40	50%
Rehabilitation therapy physical, speech	40%	50%	50%	50%
	12 visits per year combined		12 visits per year combined	
Lab & imaging ⁵ MRI/CT/PET/SPECT	40%	50%	50%	50%
Emergency Room				
Professional services	\$40		\$40	
Emergency facility (waived if admitted)	\$100 copay + 40%		\$100 copay + 50%	
Urgent care center	\$50 copay + 40%	\$50 copay + 50%	\$50 copay + 50%	
Ambulance ⁵	\$50 copay + 40%	\$50 copay + 50%	\$50 copay + 50%	
Prescription Drugs⁷	\$0	\$100 deductible	\$250 brand name	\$100
Medicare D		Creditable	Non-Creditable	
Level I (30 day supply)	\$15	50%	\$15	50%
Level II (30 day supply)	\$30	50%	\$30	50%
Level III (30 day supply)	\$50	50%	\$50	50%
Mail-In-Service (90 days)	2 co-pays	Not covered	2 co-pays	Not covered
Hospital Care⁵	\$500 deductible per year combined ⁶		\$500 deductible per year combined ⁶	
In-patient				
Professional services	40%	50%	50%	50%
Facility charges	40%	50% (\$600 per day max)	50%	50% (\$600 per day max)
Out-patient surgery	\$250 deductible per year combined ⁷		\$250 deductible per year combined ⁷	
Facility charges	40%	50%	50%	50%
Skilled nursing facility	\$500 deductible per year combined ⁶ (50 days max per year)		\$500 deductible per year combined ⁶ (50 days max per year)	
	40%	50% (\$250 per day max)	50%	50% (\$250 per day max)
Nonsevere Mental Health				
Out-patient	40% (\$25 per visit max)	50% (\$25 per visit max)	50% (\$25 per visit max)	
	30 visits per year combined		30 visits per year combined	
In the hospital⁵	40% (\$250 per day max)	50% (\$250 per day max)	50% (\$250 per day max)	
	30 days per year combined		30 days per year combined	
Chemical Dependency				
In-patient⁵	40%	50%	50%	
	30 days per year combined, \$250 per day max		30 days per year combined, \$250 per day max	
Other				
Chiropractic	\$40 (12 visits per year)	Not covered	\$40 (12 visits per year)	Not covered
Acupuncture	40%	50%	50%	50%
	12 visits per year, \$25 per visit max		12 visits per year, \$25 per visit max	
Diabetic equipment	40%	50%	50%	50%
Durable medical equip(DME)⁵	40%	50%	50%	50%
DME calendar year max	\$1,000 per year combined		\$1,000 per year combined	
Vision exam	\$40 (to age 16)	Not covered	\$40 (to age 16)	Not covered

◀ Not available to firms with 1 or 2 enrollees in medical

¹ Subject to restrictions and limitations; contact your Benefits Consultant for plan benefits & rates

² Out-of network based on a Limited Fee Schedule (LFS), enrollee is responsible for excess of covered services

³ Two family members must satisfy their individual OOPM to satisfy the family OOPM

⁴ Birth through age 16

⁵ These services require prior certification. If prior certification is not acquired benefits are reduced to 50%.

⁶ This deductible is only required for the first in-patient hospital or skilled nursing facility admission each calendar year. This is in addition to the plan year deductible.

⁷ This deductible is in addition to the plan calendar year deductible.

This is only a summary and there may be details not included, the Health Net Evidence of Coverage document supersedes any omissions or discrepancies in these plan descriptions.

HEALTH NET HSA PPO PLAN COMPARISONS

These plans are available to out-of-state employees¹

CALENDAR YEAR BENEFITS	HSA COMPATIBLE PPO HSA 10 ¹		HSA COMPATIBLE PPO HSA 30	
	IN-NETWORK	OUT-OF-NETWORK (LFS) ²	IN-NETWORK	OUT-OF-NETWORK (LFS) ²
Lifetime Maximum	\$5,000,000 combined		\$5,000,000 combined	
Annual Deductible (calendar year)	\$1,500 individual \$3,000 family		\$3,500 individual \$7,000 family	
Prescription Drug Deductible (calendar year)	Subject to annual deductible		Subject to annual deductible	
Annual Out-of-Pocket Maximum (calendar year)	\$2,500 individual \$5,000 family		\$4,500 individual \$9,000 family	
In the Medical Office				
Office visit	\$10	40%	\$30	50%
Annual routine physical	\$10 (\$250 max) deductible waived	Not covered	\$30 (\$250 max) deductible waived	Not covered
Maternity/prenatal care	20%	40%	30%	50%
Well-child preventive ³	\$10 (deductible waived)	Not covered	\$30 (deductible waived)	Not covered
Allergy injections (serum not included)	\$10	40%	\$30	50%
Rehabilitation therapy physical, speech	20%	40%	30%	50%
Lab & imaging ⁴ MRI/CT/PET/SPECT	20%	40%	30%	50%
	12 visits per year combined		12 visits per year combined	
Emergency Room				
Professional services	\$10	40%	\$30	50%
Emergency facility (waived if admitted)	\$100 copay + 20%	\$100 copay + 40%	\$100 copay + 30%	\$100 copay + 50%
Urgent care center	\$50 copay + 20%	\$50 copay + 40%	\$50 copay + 30%	\$50 copay + 50%
Ambulance ⁴	\$50 copay + 20%	\$50 copay + 40%	\$50 copay + 30%	\$50 copay + 50%
Prescription Drugs⁶	Subject to annual deductible		Subject to annual deductible	
Medicare D	Creditable		Non-Creditable	
Level I (30 day supply)	\$10	50%	\$15	50%
Level II (30 day supply)	\$25	50%	\$30	50%
Level III (30 day supply)	\$50	50%	\$50	50%
Mail-In-Service (90 days)	2 co-pays	Not covered	2 co-pays	Not covered
Hospital Care⁴	Subject to annual deductible		\$250 deductible per year combined ⁵	
In-patient				
Professional services	20%	40%	30%	50%
Facility charges	20%	40%	30%	50% (\$600 per day max)
Out-patient surgery	Subject to annual deductible		\$250 deductible per year combined ⁶	
Facility charges	20%	40%	30%	50%
Skilled nursing facility	Subject to annual deductible		\$250 deductible per year combined ⁵	
	20%	40% (\$250 max per day)	30%	50% (\$250 max per day)
	100 days per year		60 days per year	
Nonsevere Mental Health				
Out-patient				
30 visits (per year max)	20% (\$25 per visit max)	40% (\$25 per visit max)	30% (\$25 per visit max)	50% (\$25 per visit max)
	30 visits per year combined		30 visits per year combined	
In the hospital⁴				
30 days per year combined	20% (\$250 max per day)	40% (\$250 max per day)	30% (\$250 max per day)	50% (\$250 max per day)
	30 days per year combined		30 days per year combined	
Chemical Dependency				
In-patient⁴				
	20%	40%	30%	50%
	30 days per year combined, \$250 per day max		30 days per year combined, \$250 per day max	
Other				
Chiropractic				
Acupuncture	\$10 (12 visits per year) 20%	Not covered 40%	\$30 (12 visits per year) 30%	Not covered 50%
	12 visits per year, \$25 per visit max		12 visits per year, \$25 per visit max	
Diabetic equipment	20%	40%	30%	50%
Durable medical equip(DME)⁴	20%	40%	30%	50%
DME calendar year max	\$3,000 per year combined		\$1,000 per year combined	
Vision exam	\$10 (to age 16)	Not covered	\$30 (to age 16)	Not covered

¹ Not available to firms with 1 or 2 enrollees in medical

² Subject to restrictions and limitations; contact your Benefits Consultant for plan benefits & rates

³ Out-of network based on a Limited Fee Schedule (LFS), enrollee is responsible for excess of covered services

⁴ Birth through age 16

⁵ These services require prior certification. If prior certification is not acquired benefits are reduced to 50%.

⁶ This deductible is only required for the first in-patient hospital or skilled nursing facility admission each calendar year. This is in addition to the plan year deductible.

⁷ This deductible is in addition to the plan calendar year deductible.

This is only a summary and there may be details not included, the Health Net Evidence of Coverage document supersedes any omissions or discrepancies in these plan descriptions.

HEALTH NET OPTIONS[®]

PLAN COMPARISONS

THESE PLANS ARE ONLY AVAILABLE TO FIRMS WITH 5 OR MORE MEDICAL ENROLLEES

If Options is offered by the employer, all owners and employees must enroll in one of these plans

CALENDAR YEAR BENEFITS	OPTIONS HMO 35	OPTIONS PPO 500		OPTIONS PPO 1750	
		IN-NETWORK	OUT-OF-NETWORK (LFS) ²	IN-NETWORK	OUT-OF-NETWORK (LFS) ²
Lifetime Maximum	None	\$5,000,000 combined		\$5,000,000 combined	
Annual Deductible (calendar year)	None	\$500 individual \$1,000 family	\$1,000 individual \$2,000 family	\$1,750 individual \$3,500 family	\$3,500 individual \$7,000 family
Prescription Drug Deductible (calendar year)	\$200 brand name	\$200 brand name	\$100	\$200 brand name	\$100
Annual Out-of-Pocket Maximum (calendar year)	\$4,000 individual \$8,000 family	\$4,000 individual \$8,000 family	\$8,000 individual \$16,000 family	\$5,000 individual \$10,000 family	\$10,000 individual \$20,000 family
In the Medical Office					
Office visit	\$35	\$35	50%	\$35	50%
Annual routine physical	Not covered	\$35 (\$250 max)	Not covered	\$35 (\$250 max)	Not covered
Maternity/prenatal care	\$35	30%	50%	40%	50%
Well-child preventive ³	\$35 (\$0 birth to age 2)	\$35	Not covered	\$35	Not covered
Allergy injections (serum not included)	\$35	\$35	50%	\$35	50%
Rehabilitation therapy, Physical, speech	\$35	30%	50%	40%	50%
Lab & imaging ⁴ MRI/CT/PET	\$0 \$100	30%	50%	40%	50%
Emergency Room					
Professional services	\$0	\$35		\$35	
Emergency facility (waived if admitted)	\$100	\$100 copay + 30%		\$100 copay + 40%	
Urgent care center	\$50	\$50 copay + 30%		\$50 copay + 40%	
Ambulance ⁴	\$100 deductible	\$50 + 30%	\$50 + 50%	\$50 + 40%	\$50 + 50%
Prescription Drugs	\$200 brand name	\$200 brand name	\$100 deductible	\$200 brand name	\$100 deductible
Medicare D	Creditable	Creditable		Creditable	
Level I (30 day supply)	\$15	\$15	50%	\$15	50%
Level II (30 day supply)	\$30	\$30	50%	\$30	50%
Level III (30 day supply)	\$50	\$50	50%	\$50	50%
Mail-In-Service (90 day)	2 co-pays	2 co-pays	Not covered	2 co-pays	Not covered
Hospital Care⁴					
In-patient		\$250 deductible ⁵		\$250 deductible ⁵	
Professional services	\$0	30%	50%	40%	50%
Facility services	30%	30%	50% (\$600 per day)	40%	50% (\$600 per day)
Out-patient Surgery	30%	\$250 deductible ⁶		\$250 deductible ⁶	
Facility charges	30%	30%	50%	40%	50%
Skilled nursing facility	\$0 (day 1-10) \$25 per day (day 11-100)	\$250 deductible ⁵		\$250 deductible ⁵	
		30%	50% (\$250 per day)	40%	50% (\$250 per day)
		60 days per year		60 days per year	
Nonsevere Mental Health					
Out-patient	\$40 individual, \$20 group 20 visits per year	30% (\$25 per visit)	50% (\$25 per visit)	40% (\$25 per visit)	50% (\$25 per visit)
		30 visits per year		30 visits per year	
In the hospital⁴	30%	30%	50%	40%	50%
	30 days per year	30 days per year, \$250 per day		30 days per year, \$250 per day	
Chemical Dependency					
In-patient⁴	30% (acute care)	30%	50%	40%	50%
		30 days per year, \$250 per day		30 days per year, \$250 per day	
Other					
Chiropractic	Not covered	\$35 (12 visits year)	Not covered	\$35 (12 visits year)	Not covered
Acupuncture	Not covered	30%	50%	40%	50%
		12 visits per year, \$25 per visit		12 visits per year, \$25 per visit	
Diabetic equipment	20%	30%	50%	40%	50%
Durable medical equip⁴	50%	30%	50%	40%	50%
DME calendar year max	\$2,000	\$1,000 per year		\$1,000 per year	
Vision exam	\$35	\$35 (to age 16)	Not covered	\$35 (to age 16)	Not covered

² These plans are only available to firms enrolling 5 or more owners/employees in Health Net. When Options is offered, no other Health Net plans can be offered.

¹ Subject to restrictions and limitations; contact your Benefits Consultant for plan benefits & rates

² Out-of-network (OON) based on a Limited Fee Schedule (LFS), enrollee is responsible for excess of covered services

³ Birth through age 16

⁴ These services require prior certification. If prior certification is not acquired benefits are reduced to 50%.

⁵ This deductible is only required for the first in-patient hospital or skilled nursing facility admission each calendar year. This is in addition to the plan year deductible.

⁶ This deductible is in addition to the plan calendar year deductible.

This is only a summary and there may be details not included, the Health Net Evidence of Coverage document supersedes any omissions or discrepancies in these plan descriptions.

If Options is offered by the employer, all owners and employees must enroll in one of these plans

CALENDAR YEAR BENEFITS	OPTIONS HSA COMPATIBLE PPO 3000		OPTIONS HSA COMPATIBLE PPO 4000	
	IN-NETWORK	OUT-OF-NETWORK (LFS) ²	IN-NETWORK	OUT-OF-NETWORK (LFS) ²
Lifetime Maximum	\$5,000,000 combined		\$5,000,000 combined	
Annual Deductible (calendar year)	\$3,000 employee only coverage \$6,000 employee/dependent(s)		\$4,000 employee only coverage \$8,000 employee/dependent(s)	
Prescription Drug Deductible (calendar year)	Subject to annual deductible		Subject to annual deductible	
Annual Out-of-Pocket Maximum (calendar year)	\$4,000 employee only coverage \$8,000 employee/dependent(s)		\$5,000 employee only coverage \$10,000 employee/dependent(s)	
In the Medical Office				
Office visit	\$25	50%	\$35	50%
Annual routine physical	\$25 (deductible waived/\$250 max)	Not covered	\$35 (deductible waived/\$250 max)	Not covered
Maternity/prenatal care	30%	50%	40%	50%
Well-child preventive ³	\$25 (deductible waived)	Not covered	\$35 (deductible waived)	Not covered
Allergy injections (serum not included)	\$25	50%	\$35	50%
Rehabilitation therapy, Physical, speech	30%	50%	40%	50%
	12 visits per year		12 visits per year	
Lab & imaging ⁴ MRI/CT/PET	30%	50%	40%	50%
Emergency Room				
Professional services	\$25	50%	\$35	50%
Emergency facility (waived if admitted)	\$100 copay + 30%	\$100 copay + 50%	\$100 copay + 40%	\$100 copay + 50%
Urgent care center	\$50 copay + 30%	\$50 copay + 50%	\$50 copay + 40%	\$50 copay + 50%
Ambulance ⁴	\$50 + 30%	\$50 + 50%	\$50 + 40%	\$50 + 50%
Prescription Drugs	Subject to annual deductible		Subject to annual deductible	
Medicare D	Non-Creditable		Non-Creditable	
Level I (30 day supply)	\$15	50%	\$15	50%
Level II (30 day supply)	\$30	50%	\$30	50%
Level III (30 day supply)	\$50	50%	\$50	50%
Mail-In-Service (90 day)	2 co-pays	Not covered	2 co-pays	Not covered
Hospital Care⁴	\$250 deductible ⁵		\$250 deductible ⁵	
In-patient				
Professional services	30%	50%	40%	50%
Facility services	30%	50% (\$600 per day)	40%	50% (\$600 per day)
Out-patient Surgery	\$250 deductible ⁶		\$250 deductible ⁶	
Facility charges	30%	50%	40%	50%
Skilled nursing facility	\$250 deductible ⁵		\$250 deductible ⁵	
	30%	50% (\$250 per day)	40%	50% (\$250 per day)
	90 days per year		60 days per year	
Nonsevere Mental Health				
Out-patient	30% (\$25 per visit)	50% (\$25 per visit)	40% (\$25 per visit)	50% (\$25 per visit)
	30 visits per year		30 visits per year	
In the hospital ⁴	30%	50%	40%	50%
	30 days per year, \$250 per day		30 days per year, \$250 per day	
Chemical Dependency				
In-patient ⁴	30%	50%	40%	50%
	30 days per year, \$250 per day		30 days per year, \$250 per day	
Other				
Chiropractic	\$25 (12 visits year)	Not covered	\$35 (12 visits year)	Not covered
Acupuncture	30%	50%	40%	50%
	12 visits per year, \$25 per visit		12 visits per year, \$25 per visit	
Diabetic equipment	30%	50%	40%	50%
Durable medical equip ⁴	30%	50%	40%	50%
DME calendar year max	\$2,000 per year		\$1,000 per year	
Vision exam	\$25 (to age 16)	Not covered	\$35 (to age 16)	Not covered

➤ These plans are only available to firms enrolling 5 or more owners/employees in Health Net. When Options is offered, no other Health Net plans can be offered.

¹ Subject to restrictions and limitations; contact your Benefits Consultant for plan benefits & rates

² Out-of-network (OON) based on a Limited Fee Schedule (LFS), enrollee is responsible for excess of covered services

³ Birth through age 16

⁴ These services require prior certification. If prior certification is not acquired benefits are reduced to 50%.

⁵ This deductible is only required for the first in-patient hospital or skilled nursing facility admission each calendar year. This is in addition to the plan year deductible.

⁶ This deductible is in addition to the plan calendar year deductible.

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DENTAL PLANS

PREMIER ACCESS

100% PARTICIPATION FOR FIRMS OF 1 - 9 OWNERS/EMPLOYEES

75% Participation for Firms of 10+ Owners/Employees

Unique to Premier Access is their PCN network which is available to members with the lowest out-of-pocket expenses; PCN Dentists fees average 50% off of those typically charged by Non Network Providers. This provides members with the most coverage available from any carrier. Premier Access Dental plans are available on a “stand alone” basis. This program is a valuable addition to your firms benefit package. The plans cover the following services when they are provided by a licensed dentist and when necessary and customary, as determined by the standards of generally accepted dental practices. This chart identifies the primary covered services.

Please call the contact person listed on the front cover of this booklet for rates and additional information.

CALENDAR YEAR	ELITE + ORTHO ⁴		ELITE		FREEDOM 1500		FREEDOM 1000	
	Preferred Dentist ¹	Any Dentist ²	Preferred Dentist ¹	Any Dentist ²	Preferred Dentist ¹	Any Dentist ²	Preferred Dentist ¹	Any Dentist ²
Annual Maximum (calendar year)	\$2,000	\$1,500	\$2,000	\$1,500	\$1,500	\$1,500	\$1,000	\$1,000
Deductible (calendar year)								
Basic & Major Services								
Individual	Waived	\$50	Waived	\$50	\$50	\$50	\$50	\$50
Family	Waived	\$150	Waived	\$150	\$150	\$150	\$150	\$150
Preventive Care	100%	100%	100%	100%	100%	100%	100%	100%
Oral evaluations & cleanings (every 6 months)								
X-Rays ³								
Topical fluoride applications (children under age 14)								
Basic Care	90%	80%	90%	80%	80%	80%	80%	80%
Fillings, extractions, anesthesia								
Endodontics								
Space maintainers								
Oral surgery								
Periodontics								
Emergency pain relief treatment								
Major Care (Subject to a 12 month wait)⁴	60%	50%	60%	50%	50%	50%	50%	50%
Repair of bridges & crowns ³								
Inlays, onlays								
Crowns								
Bridges								
Dentures								
Implants								
Orthodontics (Children to age 19 only)								
Lifetime Maximum	\$2,000	\$2,000	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Co-Insurance	50%	50%						
Deductible	\$0	\$0						

To find a Premier Access provider, visit www.premierppo.com or call (888) 715-0760.

⁴Not available to firms with less than 10 owners/employees enrolling

¹Reimbursement based on PDP (Preferred Dentist Program) fees

²Reimbursement based on Reasonable & Customary Charges

³There are some restrictions to this benefit, see the Premier Access Evidence of Coverage for complete details

⁴May be waived with proof of prior group dental coverage. Please call your administrator if you have any questions.

GENERAL EXCLUSIONS - PLEASE SEE THE PREMIER ACCESS EVIDENCE OF COVERAGE FOR A COMPLETE DETAILED LIST

- TMJ expenses
- Services not listed and services begun before the enrollee and/or dependents became covered
- Services and supplies provided primarily for cosmetic purposes, or treatment to correct congenital defects
- Replacements of a crown, bridge or denture within five years
- Initial placement of a denture or fixed bridge which involved the replacement of one or more natural teeth, missing before the enrollee and or dependents became covered, unless it also replaces a natural tooth extracted while covered

This is only a summary and there may be details not included, the Premier Access Evidence of Coverage document supersedes any omissions or discrepancies in these plan descriptions.

DENTAL PLANS

METLIFE PREMIER & STANDARD PLANS

MetLife Dental plans are available on a “stand alone” basis. The plans cover the following services when they are provided by a licensed dentist and when necessary and customary, as determined by the standards of generally accepted dental practices. This chart identifies the primary covered services.

Please call the contact person listed on the front cover of this booklet for rates and additional information.

BENEFITS	PREMIER + ORTHO [†]		PREMIER		STANDARD	
	PREFERRED DENTIST*	ANY DENTIST**	PREFERRED DENTIST*	ANY DENTIST**	PREFERRED DENTIST*	ANY DENTIST**
Annual Maximum (calendar year)	\$2,000	\$1,500	\$2,000	\$1,500	\$1,500	\$1,000
Deductible (calendar year)						
Basic & Major Services						
Individual	Waived	\$50	Waived	\$50	\$50	\$50
Family	Waived	\$150	Waived	\$150	\$150	\$150
Preventive Care	100%	100%	100%	100%	100%	80%
Oral evaluations						
Cleanings & X-Rays						
Space maintainers						
Emergency pain relief treatment						
Topical fluoride applications (child only)						
Basic Care	90%	80%	90%	80%	80%	80%
Fillings, extractions, anesthesia						
Endodontics, oral surgery						
Periodontics						
Repair of bridges & crowns						
Injections of antibiotic drugs						
Major Care (Subject to a 12 month wait)¹	60%	50%	60%	50%	50%	50%
Inlays, onlays						
Crowns						
Bridgework						
Dentures						
Implants						
Orthodontics			Not covered	Not covered	Not covered	Not covered
Lifetime Maximum	\$2,000	\$1,500				
Co-Insurance	50%	50%				
Deductible	\$0	\$0				

To find a MetLife provider, visit www.metlife.com or call (800) 942-0854.

[†] Not available to firms with less than 6 owners/employees enrolling

* Reimbursement based on PDP (Preferred Dentist Program) fees

** Reimbursement based on Reasonable & Customary Charges

¹ Subject to a 12 month waiting period, which may be waived with proof of prior GROUP dental coverage

EXCLUSIONS

- TMJ expenses
- Services not listed and services begun before the enrollee became covered
- Cosmetic treatment or treatment to correct congenital defects
- Initial placement of a denture or fixed bridge which includes the replacement of one or more natural teeth, missing before the enrollee became covered, unless it also replaces a natural tooth extracted while covered
- Replacement of a crown within five years and replacement of bridges or dentures within ten years

This is only a summary and there may be details not included, the MetLife Evidence of Coverage document supersedes any omissions or discrepancies in these plan descriptions.

DENTAL PLANS

METLIFE SAVINGS PLUS PLAN

100% PARTICIPATION FOR FIRMS OF 1 - 5 OWNERS/EMPLOYEES

75% Participation for Firms of 6 + Owners/Employees

MetLife Dental plans are available on a “stand alone” basis. The MetLife Savings Plus plan is designed to provide the features of a PPO at a price comparable to other lower-cost dental benefit programs. The plan covers a full range of services and provides the greatest value when members receive services from a participating PDP dentist.

Please call the contact person listed on the front cover of this booklet for rates and additional information.

IMPORTANT: THIS PLAN PROVIDES VERY LIMITED BENEFITS WHEN NOT USING A PREFERRED PROVIDER

BENEFITS	SAVINGS PLUS PLAN	
	PREFERRED DENTIST	ANY DENTIST*
Annual Maximum (calendar year)	\$1,000 combined	
Deductible (calendar year) Basic & Major Services		
Individual	\$50	\$50
Family	\$150	\$150
Preventive Care Oral evaluations Cleanings & X-Rays Space maintainers Emergency pain relief treatment Topical fluoride applications (child only)	100% \$10 co-pay for cleaning	Paid at a set Non-Provider reimbursement schedule*
Basic Care Fillings, extractions, anesthesia Oral surgery Repair of bridges & crowns Injections of antibiotic drugs	70%	Paid at a set Non-Provider reimbursement schedule*
Major Care (Subject to a 12 month wait)¹ Inlays, onlays Crowns Periodontics Endodontics Bridgework Dentures	40%	Paid at a set Non-Provider reimbursement schedule*
Orthodontics	Not covered	Not covered

To find a MetLife provider, visit www.metlife.com or call (800) 942-0854.

¹ Subject to a 12 month waiting period, which may be waived with proof of prior GROUP dental coverage

* Savings Plus is designed to provide significant savings to its members through its extensive network of providers. Any services received by a Non-Provider will be paid at a set reimbursement schedule. Please refer to the MetLife Employee Benefit Plan booklet for this schedule of fees

EXCLUSIONS

- TMJ expenses
- Orthodontia
- Services not listed and services begun before the enrollee became covered
- Cosmetic treatment or treatment to correct congenital defects
- Initial placement of a denture or fixed bridge which included the replacement of one or more natural teeth, missing before the enroll became covered, unless it also replaces a natural tooth extracted while covered
- Replacement of a crown within five years and replacement of bridges or dentures within ten years

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VISION PLAN

BLUE VIEW VISION

100% PARTICIPATION AS A "STAND ALONE" PLAN
or Vision Enrollment matches Medical

Blue View Vision, a division of Blue Cross, has an extensive nationwide network of private practice doctors and retail optical specialists who provide exceptional care and eyewear to persons covered under this plan. The plan is designed to encourage you to maintain your vision through eye exams and to help with vision care expenses for required glasses or contact lenses.

Blue View Vision is available as a "stand alone" plan with 100% participation or in conjunction with medical plan coverage. If written in conjunction with medical coverage, the vision enrollment must match the medical enrollment, including dependents, regardless of the medical plan chosen.

Please call the contact person listed on the front cover of this booklet for rates and additional information.

BENEFITS	CO-PAY	FREQUENCY	OUT-OF-NETWORK REIMBURSEMENT
Exam	\$10	Once every 12 months *	Up to \$45
Lenses Single Vision Lenses Lined Bifocal Lenses Lined Trifocal Lenses Progressive Lenses	\$25 \$25 + \$65	Once every 12 months *	Up to \$45 Up to \$65 Up to \$85 Up to \$49
<i>This \$25 material co-pay is applied once per service year toward you lenses or contacts.</i>			
Frame	No co-pay applies	Once every 24 months *	Up to \$47
<i>Frame of your choice covered up to \$120. Plus, 20% off any out-of-pocket costs.</i>			
Contacts (in lieu of frame and lens benefit)	No co-pay applies	Once every 12 months *	Up to \$105
<i>Contacts may be chosen instead of prescription glasses. An allowance of \$120 will be provided towards the cost of your contact lens fitting, evaluation and materials. Any costs exceeding the allowance are the responsibility of the patient.</i>			
<i>Contact lens frequency is the same as lenses. Under this plan, if you choose, you will be eligible for a frame 24 months after the last date of obtaining contacts.</i>			

* From last date of service

LENSES FOR CHILDREN UNDER THE AGE OF 18

In addition to the standard lens allowance, Blue View Vision covers polycarbonate lenses for children under the age of 18. Polycarbonate lenses are now becoming the industry standard for children due to safety reasons.

SERVICES FROM A BLUE VIEW NETWORK DOCTOR OR RETAIL SPECIALIST

Blue View Vision offers you additional savings of up to 40% on extra eyewear, certain non-prescription sunglasses and other popular accessories. There is no limit to the number of purchases you can make using this great savings opportunity - even after you've exhausted your covered vision benefits.

Extra eyeglasses	40% off retail
Conventional contact lenses	15% off retail (applied to materials only)
Eyewear accessories	20% off retail
Includes certain non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	

To find a Blue View Vision provider, visit www.eyewearspecialoffers.com or call (866) 723-0515.

This is only a summary and there may be details not included, the Blue View Vision Evidence of Coverage document supersedes any omissions or discrepancies in these plan descriptions.

Vision Service Plan has an extensive nationwide network of private practice doctors who provide exceptional care and eyewear to persons covered under this plan. The plan is designed to encourage you to maintain your vision through eye exams and to help with vision care expenses for required glasses or contact lenses. Once enrolled, VSP has an exceptional interactive website to help enrollees determine when and if they are eligible for benefits.

VSP coverage is available as a “stand alone” plan with 100% participation or in conjunction with medical plan coverage. If written in conjunction with medical coverage, the vision enrollment must match the medical enrollment, including dependents, regardless of the medical plan chosen.

Please call the contact person listed on the front cover of this booklet for rates and additional information.

BENEFITS	CO-PAY	FREQUENCY	NON-VSP DOCTOR REIMBURSEMENT
Exam	\$10	Once every 12 months *	Up to \$45
Lenses¹ Single Vision Lenses Lined Bifocal Lenses Lined Trifocal Lenses	\$25 \$25 \$25	Once every 12 months *	Up to \$45 Up to \$65 Up to \$85
<i>¹ All lenses include a \$25 material co-pay that is applied once per service year toward your lenses or contacts.</i>			
Frame	No co-pay applies	Once every 24 months *	Up to \$47
<i>Frame of your choice covered up to \$120. Plus, 20% off the amount exceeding their retail costs</i>			
Contacts (in lieu of frame and lens benefit)	No co-pay applies	Once every 12 months *	Up to \$105
<i>Contacts may be chosen instead of prescription glasses. An allowance of \$120 will be provided towards the cost of your contact lens fitting, evaluation and materials. Any costs exceeding the allowance are the responsibility of the patient.</i>			
<i>Contact lens frequency is the same as lenses. Under this plan, if you choose, you will be eligible for a frame 24 months after the last date of obtaining contacts.</i>			

* From last date of service

LENSES FOR CHILDREN UNDER THE AGE OF 18

In addition to the standard lens allowance, VSP covers polycarbonate lenses for children under the age of 18. Polycarbonate lenses are now becoming the industry standard for children due to safety reasons.

SERVICES FROM A VSP NETWORK DOCTOR

When you select a doctor from the VSP network, members will receive a 20 percent discount on additional pairs of prescription and non-prescription glasses, including sunglasses.

To find a VSP provider, visit www.vsp.com or call (800) 877-7195.

This is only a summary and there may be details not included, the Vision Service Plan Evidence of Coverage document supersedes any omissions or discrepancies in these plan descriptions.

BASIC LIFE METLIFE GROUP LIFE AND AD&D PLANS

100% PARTICIPATION REQUIRED

100% Employer Paid

MetLife Insurance Company provides a basic term life and AD&D plan that is available as a “stand alone” plan or in conjunction with health plan coverage. **Insured participants must be actively at work to participate in the plan.**

Please call the contact person listed on the front cover of this booklet for rates and additional information.

	PLAN I All Owners & Employees	PLAN II All Owners & Employees	PLAN III All Owners & Employees	PLAN IV All Owners & Employees	PLAN V Scheduled ¹ for firms of 6 or more ²
Benefit Level	\$5,000	\$10,000	\$25,000	\$50,000 ²	\$10,000 \$25,000 \$50,000

¹ “Scheduled” allows for different amounts based on position, title, salary or other non-discriminatory elections. When offering the scheduled plan, at least one owner/employee must be in each of the three levels

² Only available for member firms with 6 or more enrolled owners/employees

BENEFITS

LIFE BENEFIT	Payable to the beneficiary named by the insured. If multiple beneficiaries are named, benefit will be paid in equal shares to all. The insured may change the beneficiary at any time by providing written notice.				
AGE REDUCTION ADEA graded age reductions apply for insureds over age 65	Age	% of pre-age 65 benefit paid		Age	% of pre-age 65 benefit paid
	65-69	60%		80-84	15%
	70-74	35%		85-89	10%
	75-79	25%		90 +	5%
PREMIUM WAIVER	Premiums are waived for insureds who become disabled before age 60. If an insured becomes disabled between ages 60-69, coverage is extended without change for one year beyond the termination of insurance. All benefits for disabled employees terminate at age 70.				
CONVERSION PRIVILEGE	Within 31 days upon termination of employment, an insured may convert this coverage, without a medical examination, to any Individual Life insurance policy offered by MetLife Insurance Company.				
ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)	Benefits are payable for a loss due to occupational or non-occupational accident, within 12 months of the accident, as follows:				
	One-half the full benefit amount for loss of one hand, one foot, or sight of one eye.		Full benefit amount for loss of any combination of hands, feet, eye sight or the loss of life.		
AD&D COMMON CARRIER BENEFIT	This benefit covers accidental loss of life due to riding in a public conveyance as a fare-paying passenger. This benefit pays an <i>additional</i> 100% of the face amount.				
AD&D EXCLUSIONS	AD&D benefits are not payable for loss resulting from:				
	<ul style="list-style-type: none"> ◆ Medical, surgical or dental treatment ◆ Poisons, drugs, medicines, sedatives or gas ◆ Air travel as crew or for training & military 	<ul style="list-style-type: none"> ◆ War, riot or military service ◆ Disease or illness ◆ Driving while intoxicated 	<ul style="list-style-type: none"> ◆ Commission of a crime ◆ Intentionally self-inflicted injury while sane or insane 		

This is only a summary and there may be details not included, the MetLife Evidence of Coverage document supersedes any omissions or discrepancies in these plan descriptions.

OPTIONAL LIFE METLIFE OPTIONAL TERM LIFE AND AD&D PLAN

The Optional Group Term Life Insurance Plan is available for all active full-time owners and active full-time employees, under the age of 70, working 20 hours or more per week. Coverage is also available to the spouse and dependent children of an approved and covered owner/employee. This coverage is subject to medical underwriting and is a 100% employee paid benefit.

Please call the contact person listed on the front cover of this booklet for rates and additional information.

BENEFITS	
LIFE BENEFIT	Payable to the beneficiary named by the insured. If multiple beneficiaries are named, benefit will be paid in equal shares to all. The insured may change the beneficiary at any time by providing written notice.
EMPLOYEE	An owner/employee may apply for insurance in \$ 10,000 units up to a maximum of \$ 300,000 not to exceed 5 times the owner/employee's basic annual earnings. When Optional Life is approved, the applicant is automatically enrolled in Optional Accidental Death and Dismemberment (AD&D) benefits equal to the amount of Optional Life benefits elected.
SPOUSE	An owner/employee's spouse may apply for insurance in \$ 10,000 units up to a maximum of \$ 100,000 not to exceed 50% of the owner/employee's coverage amount. When Optional Life is approved, an owner/employee's spouse is automatically enrolled in Dependent Accidental Death and Dismemberment (AD&D) benefits equal to the amount of Dependent Life benefits elected. The owner/employee must be insured in order for the spouse to be eligible for coverage. Insurance benefits will terminate at age 70.
CHILDREN¹	Dependent children can be insured for \$ 2,500 units up to a maximum of \$ 10,000. When Optional Life is approved, a dependent child is automatically enrolled in Dependent Accidental Death (AD&D) benefits equal to the amount of Dependent Life benefits elected. The owner/employee must be insured in order for dependent children to be eligible for coverage. Insurance benefits will terminate at age 19, when the dependent is no longer an eligible student, or reaches a maximum age of 25.
EVIDENCE OF INSURABILITY REQUIREMENTS	An owner/employee must complete the Medical Questionnaire on all amounts. If the response is "yes" to any of the questions or if this is not the Initial Offering of optional life coverage by the company to the owners/employees, MetLife requires a full statement of health approval before coverage can take effect. An owner/employee's spouse must submit a Statement of Health form to MetLife, and MetLife must approve it before a spouse can be covered for amounts above \$10,000.
CONVERSION PRIVILEGE (PORTABILITY)	Should your employment terminate for any reason, you can continue your optional life insurance coverage without a medical examination. Competitive rates apply, but the premium may differ. MetLife will bill you directly.
EXCLUSIONS	Suicide is excluded during the first two years of coverage.

¹ Dependent children are eligible if they are between the ages of 15 days and 25 years. However, children must be attending an accredited college or university on a full-time basis from ages 21 - 25 and be wholly dependent on the owner/employee for support in order to remain eligible for this coverage.

This is only a summary and there may be details not included, the MetLife Evidence of Coverage document supersedes any omissions or discrepancies in these plan descriptions.