

North Coast Builders Exchange
Insurance Trust

SUMMARY PLAN DESCRIPTION

Effective April 1, 2005

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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 is composed of health care benefits such as medical, chiropractic, dental and vision benefits, and group life and accidental death and dismemberment (AD&D) benefits. The benefits are provided through contracts and policies entered into with insurance Carriers by the North Bay Builders Exchanges, Inc. on behalf of the North Coast Builders Exchange Insurance Trust. Those contracts and policies are part of the official plan documents of the North Coast Builders Exchange Health Plan.

The insurance Carriers have prepared booklets 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 a federal law, the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), to appear in a Summary Plan Description. Therefore, 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 North Coast Builders Exchange Health Plan. The provisions of those Evidence(s) of Coverage are incorporated into this document by reference. Any reference to the “Summary Plan Description” therefore 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.

An eligible employee may not be eligible to choose from all of the programs offered by the Plan—a participating employer may choose only certain programs to offer to its eligible employees, and eligibility to participate in certain programs may depend on certain variables, such as where you live.

If you have any questions about which programs you are eligible for or enrolled in, or if you have any other questions about this document or about the North Coast Builders Exchange Health Plan, contact the Insurance Trust Administrator, 1030 Apollo Way, Santa Rosa, CA 95407; phone 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 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 benefit plan which is composed of health care benefits such as medical, chiropractic, dental and vision benefits, and group life and accidental death and 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 for the North Coast Builders Exchange 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 nine members of the Board of Trustees of the NCBE Insurance Trust (the “Trustees”) are appointed by the Board of Directors of North Coast Builders Exchange for a four-year term. Each Trustee must be either the owner, partner or an officer of a firm participating in one of the insurance programs offered by the Trust and there shall be a least one Trustee who is a participant in each of said programs. The NCBE Executive Director shall be an additional Trustee with full voting authority.

Responsibilities of the Trustees include determining the group insurance programs to be offered under the Plan, negotiating 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 program(s) they insure.

PLAN ADMINISTRATOR

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.

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

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

The Insurance Trust Administrator is responsible for the administration of the Trust on a day to day basis. This includes premium billing, Carrier statement reconciliation, payments of premium to Carriers, enrollments, changes, termination of employer units and/or employees and termination notification to Carriers.

PLAN TRUSTEES

The Trustees of the NCBE Insurance Trust, effective as of January 1, 2005, are:

Rick Anderson, R L A Sheet Metal, Inc., PO Box 1366, Healdsburg, CA 95448

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

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

David Elie, Elie Development, 1370 Industrial Ave Ste F, Petaluma, CA 94952

Mark Jordan, Jordan & AQui, 1612 4th St, Santa Rosa, CA 95404

John McLarty, McLarty Remodeling, 4193 Sonoma Mountain Rd,
Santa Rosa, CA 95404

Lee Morton, Morton Building Solutions, 1387 San Miguel Rd, Santa Rosa, CA 95403

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

Keith Woods, North Coast Builders Exchange, 1030 Apollo Way,
Santa Rosa, CA 95407

SOURCE OF CONTRIBUTIONS

The Plan is funded by contributions made by Exchange Members, which are deposited into a trust operated for the sole benefit of participants. The employee rate of contribution to the Exchange Member, if any, is set by the Exchange Member (within guidelines established by the Carriers) as set forth in the Exchange Member's participation agreement, and may be adjusted from time to time.

FUNDING MEDIUM

Plan contributions are deposited into the NCBE Insurance Trust which is maintained by the Trustees.

PLAN YEAR

The Plan documents and records of the Plan are kept on a calendar year basis. Carrier contracts are generally negotiated annually, usually with an effective date of April 1. Open Enrollment is generally held during the month of February and March, with an effective date of April 1.

EFFECTIVE DATE OF THE PLAN

The Plan was originally effective as of March 1, 1981.

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. Legal service may also be made upon a Plan Trustee or the Plan Administrator.

INSURANCE CARRIERS

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," which are provided automatically at no charge by the applicable Carrier. If you do not have a copy of any of these Evidence of Coverage booklets, contact the Insurance Trust 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 Elect Open Access (Medical/Prescription Drug)
PO Box 10348
Van Nuys, CA 91410-0348
(800) 676-6976

Health Net PPO (Medical/Prescription Drug)
PO Box 10348
Van Nuys, CA 91410-0348
(800) 361-3366

American Specialty Health Plan (ASHP) (Chiropractic/Acupuncture)
PO Box 509002
San Diego, CA 92150-9002
(800) 678-9133

Vision Service Plan (VSP) (Vision)
3333 Quality Dr
Rancho Cordova, CA 95670
(800) 877-7195

MetLife (Dental)
PO Box 981282
El Paso, TX 79998-1282
(800) 942-0854 or (877) 942-3379

MetLife (Group Life and AD&D)
PO Box 14069
Lexington, KY 40512
(800) 638-5433

MetLife (Optional Term Life and AD&D)
PO Box 14069
Lexington, KY 40512
(800) 638-5433

PARTICIPATING EMPLOYERS

Participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer is a participating employer in the Plan.

AMENDMENT/TERMINATION PROVISION

The Trustees reserve the right to amend or modify the Trust Document and/or the Plan at any time, and from time to time, by a majority vote of the Trustees, provided that 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 Trust to any person, including

any Exchange Member. Likewise, the Plan may be terminated at any time upon the majority vote of the Trustees. Any amendment or termination of the Plan will not affect the payment of benefits incurred prior to the date of the amendment or termination.

CLAIMS REVIEW PROCEDURES

The Carriers are responsible for evaluating all benefit claims under the programs of the Plan. 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 its 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 appeals. 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.

While the Insurance Trust Administrator may assist with claims issues (to the extent permitted by law), neither the Insurance Trust Administrator nor the Trustees have authority over claim disputes. Claim resolution is at the sole discretion of the Carrier.

If any Participant has a dispute with the Trustees as to eligibility or any other dispute which is under the control of the Trustees, such dispute shall be resolved by the Trustees in their sole discretion and any decision of the Trustees 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”) for at least ninety (90) calendar days 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 NCBEIT 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 50% of all eligible employees not covered by other health insurance must enroll. If a participating employer contributes 100% of the employee cost, all of that participating employer’s eligible employees 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 (your employer’s initial eligibility Waiting Period may be a period, for example, of 30, 60, 90, 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**), or
- d. Under certain circumstances, if your employer is an Exchange Member whose coverage under another group insurance program is not renewed, provided the employer meets specific requirements for participation in the Plan.

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 Exchange Member becomes a participating employer. 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 their participating 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 spouse and unmarried child(ren) under age 19 (or other such age as specified by the Carrier). Unmarried children 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, primarily supported by you and incapable of self-sustaining employment may be considered an eligible dependent). 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) at any time.

Special Enrollment Rights

In certain circumstances, enrollment may occur outside the Open Enrollment period, as explained in the Evidence of Coverage.

If, upon your initial eligibility, you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other health coverage ends. 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, as long as you file a written application with the Insurance Trust Administrator (via your employer) within 30 days of the marriage, birth, adoption or placement for adoption.

Domestic Partner Eligibility

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 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 either the requirements of California Family Code Section 297 (see paragraph A below) or the Plan's domestic partner eligibility criteria (see paragraph B below). If an employee has not registered his or her domestic partnership with the Secretary of the State of California and, therefore, does not satisfy the requirements of California Family Code Section 297, the employee and his or her domestic partner must satisfy the Plan's domestic partner eligibility criteria to enroll the employee's domestic partner.

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 complete, sign and file with the Carrier from whom they desire coverage an affidavit or declaration 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 Insurance Trust Administrator.

- B. **Alternate Domestic Partner Eligibility Requirements:** If an employee's domestic partnership does not meet the requirements of California Family Code Section 297, the employee's domestic partner will be eligible for enrollment only if the requirements described in the Plan's Affidavit for Enrollment of Domestic Partners ("Affidavit") and Declaration for Domestic Partnership ("Declaration") are met. The requirements include the following. :
1. Both the employee and the domestic partner have reached at least the age 18.
 2. Neither would be prevented under California law from marrying the other as a result of blood relationship.
 3. Neither is married or has had another domestic partner within the previous six months, unless that domestic partnership terminated by death.
 4. All statements made at the time that the Declaration was entered into remain true and both members intend them to remain true indefinitely.
 5. Both members maintain the same principal place of residence and intend to continue to do so indefinitely.
 6. Both members are economically responsible to third parties for each other's expenses for food, shelter and medical care and this shall remain the case for at least as long as the non-employee domestic partner is covered by the Plan and the Carrier.

You may be required to provide a copy the Affidavit and Declaration with the Carrier from whom the domestic partner desires coverage.

Employees intending to cover domestic partners under any of the programs under the Plan should understand that as a result of applicable federal and state law, coverage of the domestic partner (or the domestic partner's child(ren)) may have tax consequences. (If you are covering a domestic partner (or the domestic partner's children), you should consult your employer and your tax advisor.)

While continuation coverage is not required to be available to domestic partners under COBRA, the domestic partner may be eligible to continue coverage under a particular program under certain circumstances if coverage in a group health insurance program is lost. Contact the Insurance Trust Administrator or the health insurance Carrier for more information.

Domestic partners are generally eligible to be enrolled only during the employee's initial enrollment period or during the annual Open Enrollment period. Children of enrolled domestic partners may be eligible for coverage from Carriers under conditions similar to those governing children of employees.

ENROLLING IN THE PLAN

To enroll in the Plan, you must complete and submit the application(s) prescribed by the Plan Administrator and the Carrier(s) to your employer (who will provide them to the Insurance Trust Administrator) within 30 days of becoming eligible. All applications will be reviewed by the Insurance Trust Administrator for completeness.

If you are enrolling your domestic partner, you must obtain a Carrier enrollment application, and an Affidavit and Declaration from the Plan Administrator. These forms must be completed and timely returned to the Insurance Trust Administrator during any Open Enrollment period or at your commencement of initial eligibility.

REQUIRED PREMIUM PAYMENTS

Employees are generally required to contribute to their employer a percentage of the premium for coverage under a particular program. Coverage for your dependents is voluntary and requires a payment of an additional contribution to your employer. 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 Insurance Trust Administrator. All correspondence and questions concerning a Qualified Medical Child Support Order should be directed to the Insurance Trust 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 governing the Plan. 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 automatically, 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.*

DISQUALIFICATION, INELIGIBILITY, DENIAL/LOSS OF BENEFITS

Participation in the Plan and the program(s) will terminate if an Exchange Member fails to make the monthly premium payment, or fails to keep a membership in good standing in North Coast Builders Exchange. Disqualification and/or ineligibility could be determined if false statements are made on any application to the Trust 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 agreement between the employer covered under this Plan and the Plan Sponsor ends;
- The employer covered under this plan 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 programs 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 Insurance Trust, and your rights will be determined by that policy, not the rules of the NCBE Insurance Trust or the Plan. *Refer to the applicable Evidence of Coverage for information about conversion privileges under a particular program.*

COBRA INFORMATION

In 1985, Congress enacted health care continuation coverage requirements in Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly referred to as COBRA. COBRA requires that most employers with at least 20 employees offer employees and their families the opportunity for a temporary extension of health coverage at their own expense at group rates in certain instances where coverage under a plan would otherwise end. (If there are changes to this law or other laws concerning continuation coverage, those laws, and not these Plan rules, will govern.) *Questions about COBRA continuation coverage should be directed to the Insurance Trust Administrator.*

You can elect COBRA continuation coverage if you lose your coverage because of:

- a reduction in your hours of employment; or
- the termination of your employment (except for gross misconduct).

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.

Your eligible spouse can elect COBRA continuation coverage if he or she loses coverage for one of the following reasons:

- you die;
- you get divorced or are legally separated;
- you lose coverage because you become entitled to and enroll in Medicare; or
- your employment is terminated (except for gross misconduct) or your hours of employment are reduced such that you are no longer eligible for coverage under the Plan.

Your eligible dependent child can elect COBRA continuation coverage if he or she loses coverage for one of the following reasons:

- you die;
- your employment is terminated (except for gross misconduct) or your hours of employment are reduced such that you are no longer eligible for coverage under the Plan;
- you get divorced or are legally separated;
- you lose coverage because you become entitled to and enroll in Medicare; or
- the child ceases to be a “dependent child” as defined under the Plan.

In addition, any child born to or placed for adoption with the employee covered by the Plan during the period of COBRA continuation coverage also has the right to COBRA continuation coverage.

Each of the reasons described above which cause a loss of coverage are called “qualifying events.” If you and/or your dependents experience a qualifying event described above (and therefore become a “qualified beneficiary”), health coverage under the Plan may end unless COBRA continuation coverage is elected.

If you lose eligibility because your employer no longer contributes to the Plan, COBRA continuation coverage is not available under this Plan.

NOTIFICATION TO THE INSURANCE TRUST ADMINISTRATOR OF QUALIFYING EVENTS

You (or your dependent) must notify the Insurance Trust Administrator in writing of the occurrence of a qualifying event that is either your divorce or legal separation, or a dependent child ceasing to be a “dependent child” under the terms of the Plan. *The notification must be sent to the Insurance Administrator within 60 days after the date of the qualifying event, otherwise your spouse’s and/or dependent’s right to COBRA continuation coverage will be lost.* You must include in your notification the following:

- 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.

The address of the Insurance Trust Administrator is 1030 Apollo Way, Santa Rosa, CA 95407; phone number (707) 542-9502.

Your employer will provide the Insurance Trust Administrator with notice of your termination of employment or reduction of hours of employment by submitting to the Insurance Trust Administrator a Termination of Health Coverage Notice. The Insurance Trust Administrator will treat this as notice that an employee has been terminated or worked insufficient hours and will send the required COBRA notice. If you want to be sure the Insurance Trust Administrator has notice that you have been terminated and you want to elect COBRA continuation coverage as soon as possible, you should notify the Insurance Trust Administrator that you have terminated or worked insufficient hours to make you eligible for coverage and apply for COBRA continuation coverage.

If you die, are terminated, had a reduction in hours, or become entitled to Medicare, your employer must notify the Insurance Trust Administrator.

HOW TO ELECT COBRA COVERAGE

To have COBRA continuation coverage, you must timely elect it.

The Insurance Trust Administrator, upon notification from the employer, employee, and/or dependent that a qualifying event has occurred, will send a COBRA notice and COBRA election form to the qualified beneficiary(ies) within 30 days. *To continue coverage, a qualified beneficiary must complete and submit the election form to the Insurance Trust Administrator within sixty (60) days from the later of the date of notice or the date of the qualifying event.*

Note that each qualified beneficiary may make an independent COBRA election, although a parent or legal guardian may make an election on behalf of a minor child. However, if an employee or an employee's spouse makes an election to provide any other eligible person with COBRA continuation coverage, that election will be binding on the other person. 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.

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 pre-existing 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.

PAYMENT OF COBRA PREMIUMS

The current amount of the premium and the due date for payment are explained in the COBRA election notice and form. The premiums for COBRA coverage may change in the future.

You must self-pay for COBRA continuation coverage. COBRA continuation coverage may generally require payment of up to 102% of the applicable group premium. Each month you must send your payment to the Insurance Trust Administrator. The Insurance Trust Administrator may send you monthly notices of premiums due. *These are provided only as a courtesy—your 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 the COBRA election—you have sixty-days to notify the Insurance Trust Administrator that you are electing COBRA coverage. 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 of coverage and are considered

delinquent if not received within 30 days of the due date. If you have any questions, please contact the Insurance Trust Administrator.

PERIOD OF COBRA COVERAGE

The length of time you will have COBRA continuation coverage depends on the reason that your health plan coverage was lost.

If group health coverage was lost because of a termination of employment or reduction in hours of employment, you and/or your dependents may elect continuation of coverage for a period of 18 months. That period may be extended for an additional 11 months for a total of 29 months if a qualified beneficiary (you or your dependents) was determined by the Social Security Administration to have been disabled at any time during the first 60 days of COBRA continuation coverage. You or your dependent must notify the Insurance Trust Administrator of your qualification for Social Security disability benefits before the end of the initial 18 month period and within 60 days of a Social Security determination of your disabled status and pay the additional premium; otherwise you will lose the right to the extension. The notification to the Insurance Trust Administrator must include a copy of the Social Security award determination. Send the notification to the Insurance Trust Administrator at 1030 Apollo Way, Santa Rosa, CA 95407.

This extended period of COBRA continuation coverage applies to the person who has been determined to be disabled by the Social Security Administration and all covered family members then covered by COBRA. If the disabled individual elects the disability extension, COBRA continuation coverage after the 18th month 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. You or your dependent must also notify the Insurance Trust 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 you have coverage under an HMO program, you may wish to refer to the section about extended COBRA coverage under state law before making an election for extended COBRA coverage due to a disability.

Your dependents may elect coverage for up to 36 months if you divorce, become legally separated, die, or your dependent no longer meets the definition of an eligible dependent while covered under the Plan. If your qualifying event entitles your eligible dependent child to only 18 months of COBRA continuation coverage, COBRA continuation coverage is elected for your dependent, and during that COBRA continuation coverage your child ceases to be a qualified dependent, then COBRA continuation coverage may be continued for up to 36 months from the date of the first qualifying event. This also applies to any 18 month original qualifying event which subsequently turns into a 36 month event, i.e., termination, then your death, separation or divorce. *You must notify the Insurance Trust Administrator within 60 days of the occurrence of a second qualifying event to extend coverage; otherwise you will lose the right to the 36-month COBRA continuation coverage period.*

If you are entitled to Medicare and, within 18 months after your Medicare entitlement, lose coverage as a result of a termination of employment or reduction in hours of employment, your dependents who elect COBRA continuation coverage will be entitled to 36 months of such coverage measured from the date of your Medicare entitlement. Medicare entitlement means actual enrollment in Medicare Part A and Part B.

If the employer files for bankruptcy reorganization and retiree health coverage is lost within one year before or after the bankruptcy filing, COBRA coverage could continue until the death of a retiree (or a surviving spouse of a deceased retiree) or for 36 months from the retiree's death (after the bankruptcy filing) in the case of the spouse and dependent child(ren).

NEWBORNS AND ADOPTEES

A child who is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the NCBE Health Insurance Trust and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Insurance Trust Plan Administrator of the birth or adoption.

EARLY TERMINATION OF COBRA COVERAGE

COBRA coverage 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 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 NCBE Insurance Trust may terminate your COBRA 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.
- All of your employer's group health plans are terminated.
- If coverage is extended to 29 months due to disability, a determination during that extended period that the individual is no longer disabled. **NOTE:** Federal law requires that you inform the Plan Administrator of any final determination that you are no longer disabled within 30 days of such a determination.
- This Plan terminates.

Continuation coverage under COBRA is provided subject to your eligibility. The Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible for coverage.

During Open Enrollment COBRA participants can add spouse and/or children or within 30 days of marriage. Newborn and/or adopted children may be added within 30 days of the event.

This is only a summary of your COBRA rights. For answers to specific questions, please contact the Insurance Trust Administrator.

Keep the Plan Informed of Address Changes

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

ADDITIONAL CONTINUATION COVERAGE UNDER STATE LAW

You may be entitled to extend your COBRA continuation coverage period 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.

If you elect such additional continuation coverage, your benefits will be provided by the Carrier, not by the NCBE Insurance Trust or the Plan, and your rights will be determined by that policy, not the rules of the NCBE Insurance Trust or 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 less than 20 (2 through 19) employees eligible to enroll in the health plan for half 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 loss of employment.

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 coverage, your benefits will be provided by the Carrier, not by the NCBE Insurance Trust or the Plan, and your rights will be determined by that policy, not the rules of the NCBE Insurance Trust or the Plan. *Refer to your program's Evidence of Coverage or contact the applicable Carrier for more information regarding CAL-COBRA.*

OTHER FEDERAL MANDATES

UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT OF 1994 (“USERRA”)

All employers must offer to continue group health plan coverage for up to 18 months while you are on a military leave of 31 days or more, at your expense. Continued coverage must also be offered for spouses and dependents insured under the plan when the military leave began. Any coverage taken pursuant to USERRA will be counted concurrently with your maximum COBRA continuation period coverage. If you do not continue your coverage during a military leave, it will be reinstated at the same benefit level you received before your leave if you meet the eligibility criteria established under USERRA.

Under USERRA, if your military leave is 31 days or less, the Plan Administrator may not charge you a higher premium than would be charged to active employees with similar coverage. If the leave exceeds 31 days, the Plan Administrator may charge you up to 102 percent of the applicable premium.

For more information about continuing or reinstating your group health plan coverage under USERRA, contact your employer or the Insurance Trust Administrator.

FEDERAL FAMILY AND MEDICAL LEAVE

You may be entitled to continued group health plan coverage under this Plan if you are on leave from your employment for the purposes set forth in the Family and Medical Leave Act of 1993 (“FMLA”), including:

- the birth or adoption of your child
- the care of a Spouse or relative; or
- any other purpose provided for by the FMLA.

Coverage will be continued for the period of time allowed by FMLA. It will be the responsibility of your employer to maintain the required contributions to the Plan on your behalf. 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 medical conditions present before you enroll. Under the law, a preexisting exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). Due to HIPAA, the 12-month (or 18-month) exclusion period is reduced by your prior health coverage. To show evidence of your prior health coverage, you are entitled to receive a certificate of creditable coverage from your health plan.

A certificate of creditable coverage will be provided when your coverage under a program that is a group health plan ends. You may also request a certificate of creditable coverage at any time while you are enrolled in a program that is a group health plan, or within 24 months from the date coverage under that program ends.

To obtain a certificate for you or a dependent included under your coverage, contact your Carrier and request a certificate of creditable coverage. The certificate must be provided to you in a reasonable time from date of your request. (The health insurance Carrier will generally provide a certificate of creditable coverage to an individual at the last known mailing address.) Keep a copy of the certificate for your records.

The Insurance Trust Administrator will also help you obtain a certificate of creditable coverage from any prior plan or issuer, if necessary.

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 lymph edemas.

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 for prescribing 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 your 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:

Insurance Trust Administrator
1030 Apollo Way
Santa Rosa, CA 95407
(707) 542-9502

Retaliation and Waiver

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 North Coast Builders Exchange Health Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”).

ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the plan administrator’s office and at other specified locations all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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

CONTINUE GROUP HEALTH PLAN COVERAGE

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

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 administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about the plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, 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 the Plan Administrator, staff members and or Trustees, that alters, modifies, amends, or is inconsistent with the written terms of the official plan documents of the Plan shall be invalid and unenforceable, and may not be relied upon by any employee, participant, beneficiary, service provide, 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.

GLOSSARY OF TERMS

CAL-COBRA – A California state 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. CAL-COBRA generally applies to employers with 2 to 19 employees.

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.

CO-INSURANCE – Generally, the amount shared by the insured and the insurer. For example: PPO (90%), Non-PPO (70%), the Carrier pays 90% and the insured (individual) pays 10% for in-network PPO covered services; and, the Carrier pays 70% and the insured pays 30% 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 \$10 office visit co-pay or a \$10 prescription co-pay. Refer to the applicable Evidence of Coverage for further explanation.

COVERAGE – A choice of 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), 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 of 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 NCBE Insurance Trust is usually held February 1 through March 31, with an effective date of April 1.

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

The Plan provides medical, chiropractic, dental, vision, life and accidental death and dismemberment (AD&D) coverage to the eligible employees of participating employers. The following Plan 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 Plan 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 Plan Comparisons conflicts with the information contained in the Evidence of Coverage for a particular program, the terms of the Evidence of Coverage shall govern.