

North Coast Builders Exchange
Insurance Trust

SUMMARY PLAN DESCRIPTION

Effective April 1, 2006

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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 eight 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: the 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, 2006, are:

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

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

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

John McLarty, McLarty Remodeling, 4193 Sonoma Mtn. Rd, Santa Rosa, CA 95404

Jerry Minton, 7796 Bell Rd, Windsor, CA 95492

Lee Morton, Morton Building Solutions, 200 Clear ridge Dr, Healdsburg, CA 95448

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

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

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 70% 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 the requirements of California Family Code Section 297 (see paragraph A below). If an employee has not registered his or her domestic partnership with the Secretary of the State of California, he or she does not satisfy the requirements of California Family Code Section 297.

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.

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 may require 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 14 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
- Protheses; 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.

GROUP HEALTH INSURANCE PROGRAM

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The following comparisons of coverage are intended as a general description of the principal features of the plan benefits. **Each plan's Evidence of Coverage may be consulted for more detailed information.**

Group plans are arranged by Q & A Insurance Marketing, Inc., licensed insurance brokers available to assist your firm in selecting insurance programs that best fit your company's needs.

For more information contact:
Q & A Insurance Marketing, Inc.
696 San Ramon Valley Blvd., #348
Danville, CA 94526

(800) 585-2392 • 0B17048 • www.qaim.com

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KAISER HMO

PLAN COMPARISONS

◀ **NOT ALL PLANS ARE AVAILABLE TO FIRMS WITH 2 OR FEWER ENROLLING SUBSCRIBERS.**
(EMPLOYEE MUST LIVE OR WORK IN KAISER ZIP CODE AREA)

BENEFITS	PLAN 5◀	PLAN 15◀	PLAN 20	PLAN 30	\$30/\$1,000 PLAN
Annual Deductible	None	None	None	None (\$250 for brand drugs)	\$1,000 individual / \$2,000 family (\$250 for brand drugs)
Out-of-Pocket Maximum[^]	\$1,500 individual \$3,000 family	\$1,500 individual \$3,000 family	\$1,500 individual \$3,000 family	\$3,000 individual \$6,000 family	\$3,500 individual \$7,000 family
Physician Office Visit[^]	\$5 per visit	\$15 per visit	\$20 per visit	\$30 per visit	\$30 after deductible*
Prescription Drugs	Up to a 100-day supply	Up to a 30/100-day supply	Up to a 30-day supply	Up to a 100-day supply	Up to a 100-day supply
Generic	\$5	\$10 for 30/\$30 for 100	\$10 for 30/\$30 for 100	\$10	\$10
Brand	\$15	\$25 for 30/\$75 for 100	\$30 for 30/\$90 for 100	\$35 after \$250 ded.	\$35 after \$250 deductible
Non-Formulary Drugs	Member Rate	Member Rate	Member Rate	Member Rate	Member Rate
Mail-in Service	1 co-pay	2 co-pays; 100-day supply	2 co-pays; 100-day supply	1 co-pay	1 co-pay
Brand Name Deductible - (Calendar Year)	None	None	None	\$250 calendar year	\$250 calendar year
Self-Injectables	Covered under prescription drugs				
X-Ray & Lab[^] (MRI, CAT, PET)	\$10 co-pay \$50 co-pay	\$10 co-pay \$50 co-pay	\$10 co-pay \$50 co-pay	\$10 co-pay \$50 co-pay	\$10 after deductible \$50 after deductible
Hospital In-patient[^] (Professional /Institutional)	No charge	\$100 per day, to OOP max.	\$100 per day, to OOP max.	\$200 per day, to OOP max.	\$500 per day after deductible, to OOP max.
Out-patient Surgery[^]	\$5 per procedure	\$50 per procedure	\$50 per procedure	\$100 per procedure	\$100 after deductible
Emergency Room[^] Ambulance [^] (waived if admitted)	\$100 per visit \$75	\$100 per visit \$75	\$100 per visit \$75	\$100 per visit \$75	\$100 after deductible \$75 after deductible
Allergy Testing Injections	\$5 co-pay No charge	\$15 co-pay \$5 co-pay	\$20 co-pay \$5 co-pay	\$30 co-pay \$5 co-pay	\$30 co-pay after deductible \$5 after deductible
Physical Therapy	\$5 per visit	\$15 per visit	\$20 per visit	\$30 per visit	\$30 after deductible
Durable Medical Equipment (Hospital / Home)	No charge / 20% home use (\$2,000 maximum)	No charge / 20% home use (\$2,000 maximum)	No charge / 20% home use (\$2,000 maximum)	No charge / Not covered	No charge / 30% home use (\$2,000 maximum)*
Vision / Hearing Exams Lenses & Frames	\$5 per visit \$150 every 24 months	\$15 per visit \$150 every 24 months	\$20 per visit Not covered	\$30 per visit Not covered	\$30 per visit* Not covered
Mental Health Care					
In-patient [^] (30 days per year max.)	No charge	\$100 per day, to OOP max.	\$100 day, to OOP max.	\$200 per day, to OOP max.	\$500 per day after ded., to OOP max.
Out-patient (20 visits per year max.)	\$5 per visit (individual) \$2 per visit (group)	\$15 per visit (individual) \$7 per visit (group)	\$20 per visit (individual) \$10 per visit (group)	\$30 per visit (individual) \$15 per visit (group)	\$30 after ded. (individual) \$15 after ded. (group)
Chiropractic Care	Not covered	Not covered	Not covered	Not covered	Not covered

◀ **Not available to member firms with two (2) or fewer enrolling subscribers.**

* These services are not subject to a deductible: preventive physical exams, durable medical equipment, vision and hearing exams, maternity/prenatal care, well-child preventive visits.

^ Amounts paid by insured apply toward the Annual Out-of-Pocket maximum.

This is only a summary; Carrier's Evidence of Coverage document supersedes any discrepancies in these plan descriptions.

KAISER ZIP CODE LIST - NORTHERN AND SOUTHERN CALIFORNIA

(EMPLOYEE MUST LIVE OR WORK IN KAISER ZIP CODE AREA)

AREA 1 - Includes all or portions of Alameda, Contra Costa, San Francisco, Santa Clara, San Mateo & Santa Cruz Counties by the zip codes below:

94002-03	94070-71	94101-12	94301-06	94550-52	94586-88	94666	94875	95030-33	95106
94005	94074	94114-47	94307-08	94555	94601-15	94701-10	95002	95035-38	95108-42
94010-21	94080	94150-72	94401-09	94557	94617-25	94712	95008-09	95042	95148
94025-31	94022-24	94175	94497	94560	94627	94720	95011	95044	95150-61
94037-38	94035	94177	94309-10	94566	94643	94801-08	95013-15	95046	95164
64044-45	94039-43	94188	94501-02	94568	94649	94820	95020-21	95050-56	95170-73
94059-67	94085-90	94199	94536-46	94577-80	94659-62	94850	95026	95070-71	95190-94
								95101-03	95196

AREA 2 - Includes all or portions of Amador, Contra Costa, El Dorado, Fresno, Kings, Madera, Marin, Mariposa, Napa, Placer, Sacramento, San Joaquin, Solano, Sonoma, Stanislaus, Sutter, Tulare, Yolo & Yuba Counties by the zip codes below:

93230	93662	93786	94267-69	94585	95219-20	95433	95328-30	95350-58	95741-43
93232	93666-69	93790-94	94271	94589-92	95227	95436	95336-37	95360-61	95746-47
93242	93673	93844	94273-74	94595-99	95230-31	95439	95465	95363	95757-59
93601-02	93675	93888	94277-80	94901	95234	95441-42	95471-73	95366-68	95762-63
93604	93701-12	94083	94282-91	94903-04	95236-37	95444	95476	95376-78	95765
93606-07	93714-18	94096	94293-99	94912-15	95240-42	95446	95486-87	95380-82	95776
93609	93720-22	94098-99	94503	94920	95253	95448	95492	95385-87	95798-99
93611-14	93724-29	94203-09	94506-31	94922-31	95258	95450	95602-05	95391	95812-38
93616	93740-41	94211	94533-35	94933	95267	95452	95607-21	95397	95840-43
93618-19	93744-45	94229-30	94547-49	94937-42	95269	95462	95623-26	95658-64	95851-53
93623-27	93747	94232	94553	94945-57	95296-97	95304	95628	95667-74	95857
93630-31	93750	94234-37	94556	94960	95401-09	95307	95630	95676-78	95860
93637-39	93755	94239-40	94558-59	94963-66	95416	95313	95632-35	95680-83	95864-67
93643-46	93760-62	94243-50	94561-65	94970-79	95419	95316	95638-41	95686-88	95887
93648-54	93764-65	94252-54	94567	94998-99	95421	95319-20	95645	95690-98	95894
93656-57	93771-80	94256-59	94569-76	95201-13	95425	95323	95648	95703	95899
93660	93784	94261-63	94581-83	95215	95430-31	95326	95650-52	95722	95903
							95655	95736	95961

AREA 3 - Includes portions of Kern, San Bernardino & Tulare Counties by the zip codes below:

91701	91761-64	92324-26	92352	92391-95	92427	93238	93276	93501-02	
91708-10	91784-86	92329	92354	92397	93203	93240-41	93280	93504-05	
91729-30	91798	92333-37	92357-59	92399	93205-06	93243	93285	93518-19	
91737	92305	92339-41	92369	92401-08	93215-16	93250-52	93287	93531	
91739	92307-08	92344-46	92371-78	92410-15	93220	93261	93301-09	93560-61	
91743	92313-18	92345-46	92382	92418	93222	93263	93311-14	93581	
91758	92321-22	92350	92385-86	92423-24	93224-26	93268	93380-90		

AREA 4 - Includes portions of Los Angeles, Riverside & Ventura Counties by the zip codes below:

91301-13	91350-65	91399	91482	92501-09	92562-64	92877-83	93060-66	93543-44	
91316	91367	91401-13	91495-97	92513-19	92567	93001-07	93093-94	93550-53	
91319-22	91371-72	91416	91499	92521-22	92570-72	93009-12	93099	93563	
91324-31	91376-77	91423	91601-12	92530-32	92581-87	93015-16	93510	93584	
91333-35	91380-88	91426	91614-18	92543-46	92595-96	93020-22	93532	93586	
91337	91390	91436	91752	92548	92599	93030-36	93534-36	93590-91	
91340-46	91392-96	91470	92320	92551-57	92860	93040-44	93539	93599	

AREA 5 - Includes portions of Imperial, Los Angeles, Orange & San Diego Counties by the zip codes below:

90001-84	90272	90701-03	91001	91182	91754-56	91941-47	92064-65	92190-99	92799
90086-89	90274-75	90706-07	91003	91184-89	91759	91950-51	92067-69	92275	92801-09
90091	90277-78	90710-17	91006-07	91191	91765-73	91962-63	92071-72	92602-07	92811-12
90093-97	90280	90720-21	91009-12	91201-10	91775-76	91976-80	92074-75	92609-10	92814-17
90099	90290-96	90723	91016-17	91214	91778	91987	92078-79	92612	92821-23
90101-03	90301-13	90731-34	91020-21	91221-22	91780	91990	92081-85	92614-20	92825
90174	90397-98	90740	91023-25	91224-26	91788-93	92007-11	92090-93	92623-30	92831-38
90185	90401-11	90742-49	91030-31	91501-08	91795	92007-09	92096	92637	92840-46
90189	90501-10	90755	91040-43	91510	91797	92010	92101-24	92646-63	92850
90201-02	90601-10	90801-10	91046	91521-23	91799	92011	92126-40	92672-79	92856-57
90209-13	90612	90813-15	91066	91526	91801-04	92013-14	92142-43	92683-85	92859
90220-24	90620-24	90822	91077	91702	91841	92018-27	92145	92688	92861-71
90230-33	90630-33	90831-35	91101-10	91706	91896	92029-30	92147	92690-94	92885-87
90239-42	90637-40	90840	91114-18	91711	91899	92033	92149-50	92697-98	92899
90245	90650-52	90842	91121	91714-16	91901-03	92037-40	92152-55	92701-12	
90247-51	90659-62	90844-48	91123-26	91722-24	91908-17	92046	92158-79	92725	
90254-55	90665	90853	91129	91731-35	91921	92049	92182	92728	
90260-67	90670-71	90888	91131	91740-41	91931-33	92051-52	92184	92735	
90270	90680	90899	91175	91744-50	91935	92054-58	92186-87	92780-82	

AREA 6 - Includes portions of Riverside & San Bernardino Counties by the zip codes below:

92201-03	92220	92230	92240-41	92252-56	92260-64	92270	92276-78	92284-86	
92210-11	92223	92234-36	92247-48	92258	92268	92274	92282	92292	

**HEALTH NET HMO
PLAN COMPARISONS**

◀ *NOT ALL PLANS ARE AVAILABLE TO FIRMS WITH 2 OR FEWER ENROLLING SUBSCRIBERS.*

BENEFITS	HMO 15 ◀	HMO 20 ◀	HMO 35 ◀	HMO 40
Annual Deductible	None	None	None	None
Annual Out-of-Pocket Maximum	\$1,500 individual \$3,000 family	\$2,500 individual \$5,000 family	\$3,000 individual \$6,000 family	\$3,500 individual \$7,000 family
Physician Office Visit	\$15 per visit	\$20 per visit	\$35 per visit	\$40 per visit
Prescription Drugs Generic (30 day supply) Brand (30 day supply) Non-Formulary Drugs Mail-in Service (90 days) Brand Name Deductible - (Calendar Year)	\$15 \$25 \$50 2 co-pays Not applicable	\$15 \$30 \$50 2 co-pays Not applicable	\$15 \$30 \$50 2 co-pays \$150 (combined with RX by mail)	\$15 \$30 \$50 2 co-pays \$150 (combined with RX by mail)
Self-Injectables #	30%	30%	30%	30%
X-Ray & Lab	No charge	No charge	No charge	No charge
Hospital In-patient (Professional / Institutional)	No charge / 20%; max. \$1,500	No charge / \$1,000 per admit	No charge / \$1,500 per admit	No charge / \$750 per day to 3-day max of \$2,250
Out-patient Surgery (Professional / Institutional)	No charge / 20%; max. \$1,500	No charge / \$1,000 co-pay	No charge / \$1,500 co-pay	No charge / \$1,500 co-pay
Emergency Room Co-pay waived if admitted (Professional / Institutional)	No charge / \$100 per visit	No charge / \$100 per visit	No charge / \$100 per visit	No charge / \$100 per visit
Allergy Testing Injections (serum not included)	\$15 per visit \$15	\$20 per visit \$20	\$35 per visit \$35	\$40 per visit \$40
Physical Therapy	\$15 per visit	\$20 per visit	\$35 per visit	\$40 per visit
Durable Medical Equipment	50%	50%	50%	50%
Vision / Hearing Exams Lenses & Frames	\$15 per visit Not covered	\$20 per visit Not covered	\$35 per visit Not covered	\$40 per visit Not covered
Mental Health Care In-patient Severe	No charge	\$1,000 per admit	\$1,500 per admit	\$750 per day to 3-day max of \$2,250
In-patient Non-Severe (30 days per year max.)	No charge	\$1,000 per admit	\$1,500 per admit	\$750 per day to 3-day max of \$2,250
Out-patient Severe	\$15 per visit	\$20 per visit	\$35 per visit	\$40 per visit
Out-patient Non-Severe (20 visits per year max.)	\$30 per visit	\$30 per visit	\$35 per visit	\$40 per visit
Chiropractic Care	Not covered	Not covered	Not covered	Not covered

◀ Not available to member firms with two (2) or fewer enrolling subscribers.

Applies to the Annual Out-of-Pocket maximum.

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HEALTH NET ELECT OPEN ACCESS

◀THESE PLANS ARE NOT AVAILABLE TO FIRMS WITH 2 OR FEWER ENROLLING SUBSCRIBERS. PLAN COMPARISONS

BENEFITS	EOA 10 [◀]	EOA 20 [◀]	EOA 30 [◀]
Annual Deductible	None	None	None
Out-of-Pocket Maximum	\$1,500 individual \$3,000 2-party \$4,000 family	\$2,000 individual \$4,000 2-party \$5,000 family	\$2,500 individual \$5,000 2-party \$6,000 family
Physician Office Visit	\$10 HMO; \$30 PPO self-referral	\$20 HMO; \$35 PPO self-referral	\$30 HMO; \$40 PPO self-referral
Prescription Drugs			
Generic (30 day supply)	\$10	\$15	\$15
Brand (30 day supply)	\$25	\$30	\$30
Non-Formulary Drugs	\$50	\$50	\$50
Mail-in Service (90 days)	2 co-pays	2 co-pays	2 co-pays
Brand Name Deductible – (Calendar Year)	Not applicable	Not applicable	\$150 (combined with RX by mail)
Self-Injectables #	30%	30%	30%
X-Ray & Lab	No charge	No charge	No charge
Hospital In-patient* (Professional / Institutional)	No charge / \$250 per admit	No charge / \$500 per admit	No charge / \$1,000 per admit
Out-patient Surgery* (Professional / Institutional)	No charge / \$250 co-pay	No charge / \$500 co-pay	No charge / \$1,000 co-pay
Emergency Room Co-pay waived if admitted (Professional / Institutional)	No charge / \$100 per visit	No charge / \$100 per visit	No charge / \$100 per visit
Allergy Testing Injections (serum not included)	\$10 HMO or \$30 PPO \$10 HMO or \$30 PPO	\$20 HMO or \$35 PPO \$20 HMO or \$35 PPO	\$30 HMO or \$40 PPO \$30 HMO or \$40 PPO
Physical Therapy	\$10 HMO or \$30 PPO (12 visit max. PPO)	\$20 HMO or \$35 PPO (12 visit max. PPO)	\$30 HMO or \$40 PPO (12 visit max. PPO)
Durable Medical Equipment*	50% (HMO only)	50% (HMO only)	50% (HMO only)
Vision / Hearing Exams Lenses & Frames	\$10 HMO or \$30 PPO Not covered	\$20 HMO or \$35 PPO Not covered	\$30 HMO or \$40 PPO Not covered
Mental Health Care			
In-patient Severe	\$250 per admit	\$500 per admit	\$1,000 per admit
In-patient Non-Severe (30 days per year max.)	\$250 per admit	\$500 per admit	\$1,000 per admit
Out-patient Severe	\$10 per visit	\$20 per visit	\$30 per visit
Out-patient Non-Severe (20 visits per year max.)	\$30 per visit	\$30 per visit	\$30 per visit
Chiropractic Care	Not covered	Not covered	Not covered

◀ Not available to member firms with two (2) or fewer enrolling subscribers.

Applies to the Annual Out-of-Pocket maximum.

* Only covered when provided or coordinated by the Primary Care Physician and approved by the PPG/IPA. In-patient care and out-patient services are not covered at the PPO level.

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⚠️ **THESE PLANS ARE NOT AVAILABLE TO FIRMS WITH 2 OR FEWER ENROLLING SUBSCRIBERS.**

HEALTH NET PPO 20⚠️ & PPO 30⚠️

(PPO PLANS ARE AVAILABLE TO OUT-OF-STATE EMPLOYEES)¹

PLAN COMPARISONS

BENEFITS	PPO 20 (80/60) ^{*⚠️}		PPO 30 (80/50) ^{*⚠️}	
	In-Network	Out-of-Network (LFS) ²	In-Network	Out-of-Network (LFS) ²
Lifetime Maximum	\$5,000,000		\$5,000,000	
Annual Deductible	\$250 single / two per family	\$500 single / two per family	\$500 single / three per family	\$1,000 single / three per family
Out-of-Pocket Maximum	\$3,500 single / two per family	\$7,000 single / two per family	\$4,000 per member	\$8,000 per member
Physician Office Visit	\$20	40%*	\$30	50%*
Prescription Drugs Generic (30 day supply) Brand (30 day supply) Non-Formulary Drugs Mail-in Service (90 days) ⁴ Brand Name Deductible (Calendar Year)	\$15 \$30 \$50 2 co-pays Not applicable	50%* after deductible 50%* after deductible 50%* after deductible Not covered \$100 deductible for Brand, Generic, NF	\$15 \$30 \$50 2 co-pays \$150 Brand deductible only, combined with RX by mail	50%* after deductible 50%* after deductible 50%* after deductible Not covered \$100 deductible for Brand, Generic, NF
Self-Injectables[#]	30%	40%	30%	50%
X-Ray & Lab	20%	40%*	20%	50%*
Hospital In-patient³ (Professional /Institutional)	20% / \$250 deductible per calendar year then 20%	(\$600 max per day) 40%* / \$250 deductible per calendar year then 40%	20% / \$250 deductible per calendar year then 20%	(\$600 max per day) 50%* / \$250 deductible per calendar yr. then 50%
Out-patient Surgery³ (Professional /Institutional)	20% / \$250 deductible per calendar year then 20%	40%* / \$250 deductible per calendar year then 40%	20% / \$250 deductible per calendar year then 20%	50%* / \$250 deductible per calendar year then 50%
Emergency Room (waived if admitted) (Professional /Institutional)	\$20/ \$100 deductible, then 20%	20% / \$100 deductible, then 20%*	\$30 / \$100 deductible, then 20%	20%* / \$100 deductible, then 20%*
Allergy Testing Injections (serum not incl.)	\$20 \$20	40%* 40%*	\$30 \$30	50%* 50%*
Physical Therapy (12 visits per yr PPO/OON)	20%	40%*	20%	50%*
Durable Medical Equipment⁴	20% (\$2,000 max. combined with OON)	40%* (\$2,000 max. combined with PPO)	20% (\$1,000 max. combined with OON)	50%* (\$1,000 max. combined with PPO)
Vision / Hearing Exams Lenses & Frames	\$20 per visit (to age 17) Not covered	Not covered In-Network benefit only	\$30 per visit (to age 17) Not covered	Not covered In-Network benefit only
Mental Health Care³ In-patient Severe	\$250 deductible PPO/OON 20%	\$250 deductible PPO/OON 40%*; \$600 max. / day	\$250 deductible PPO/OON 20%	\$250 deductible PPO/OON 50%*; \$600 max. / day
In-patient Non-Severe (30 days per year max.)	20%; \$175 max. / day	40%*; \$175 max. / day	20%; \$175 max. / day	50%*; \$175 max. / day
Out-patient Severe	\$20 per visit	40%*	\$30 per visit	50%*
Out-patient Non-Severe (20 visits per year max.)	20%*; member pays all charges in excess of \$25 per visit.	40%*; member pays all charges in excess of \$25 per visit.	20%*; member pays all charges in excess of \$25 per visit.	50%*; member pays all charges in excess of \$25 per visit.
Chiropractic Care	\$20 co-payment 12 visits per year	Not covered In-Network benefit only	Not covered	Not covered

⚠️ **Not available to member firms with two (2) or fewer enrolling subscribers.**

⁴ Prior Certification required when an item amount is greater than \$500.

* Plus excess of covered expenses.

[#] Applies to the Annual Out-of-Pocket maximum.

¹ Subject to restrictions and limitations; see Program Manager for plan benefits & rates.

² Out-of-network based on a Limited Fee Schedule (LFS).

³ This is in addition to the annual deductible.

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HEALTH NET PPO \$2,000 (HSA - COMPATIBLE)**PLAN SUMMARY****(PPO PLANS ARE AVAILABLE TO OUT-OF-STATE EMPLOYEES)****

BENEFITS	PPO \$2,000 (HSA - COMPATIBLE, 70/50)	
	In-Network	Out-of-Network (LFS) ¹
Lifetime Maximum	\$5,000,000	
Annual Deductible²	\$2,000 individual / \$4,000 family ³	\$2,000 individual / \$4,000 family ³
Out-of-Pocket Maximum	\$4,000 individual / \$8,000 family ³	\$4,000 individual / \$8,000 family ³
Physician Office Visit	30%	50%* of LFS
Preventive Care	\$30; deductible waived	Not covered
Prescription Drugs²		
Generic (30 day supply)	\$15 after deductible	50%* after deductible
Brand (30 day supply)	\$30 after deductible	50%* after deductible
Non-Formulary Drugs	\$50 after deductible	50%* after deductible
Mail-in Service (90 days)*	2 co-pays	Not covered
Prescription Deductible	All Prescriptions Subject to Annual Deductible	All Prescriptions Subject to Annual Deductible
Self- Injectables[#]	30%	50%
X-Ray & Lab	30%	50%* of LFS
Hospital In-patient⁴ (Professional/Institutional)	30% / 30%	50% / 50%*, \$600 max. day
Out-patient Surgery⁴ (Professional/Institutional)	30% / 30%	50%* / 50%*
Penalties for Non-Certification⁴	\$50 per out-patient visit. Payment reduced to 50%.	
In-patient	\$250 per admit. Payment reduced to 50%.	
Emergency Room	30%	50%*
Allergy Testing	30%	50%*
Injections (Serum not included)	30%	50%*
Physical Therapy (out-patient)	12 visits max. combined PPO/OON 30%	12 visits max. combined PPO/OON 50%*
Durable Medical Equipment⁴ (Certification required for billed amount greater than \$500)	30% ⁵ \$1,000 max. combined PPO & OON	50%* \$1,000 max. combined PPO & OON
Vision / Hearing Exams (Preventative Only) Lenses & Frames	\$30 per visit (through age 16) Not Covered	Not covered
Mental Health Care⁴		
In-patient Severe	30%	50%*; \$600 max. per day
In-patient Non-Severe	Not covered	Not covered
Out-patient Severe	30%	50%*
Out-patient Non-Severe	Not covered	Not covered
Chiropractic Care	Not covered	Not covered

* Plus excess of covered expenses.

** Subject to restrictions and limitations; see Program Manager for plan benefits and rates.

¹ Out-of-network based on a Limited Fee Schedule (LFS).² All benefits including pharmacy are subject to deductible, except preventive care.³ For family coverage, there is no per member deductible or OOPM accumulation/accrual. It is a single comprehensive family deductible or OOPM.⁴ Services subject to Pre-certification: in-patient admits, out-patient surgery, home health services, hospice care, pregnancy, transplant services, out-patient diagnostic procedures, rehabilitation therapy, DME, prosthetics & orthotics, air ambulance, tocolytic services, orthognathic procedures.⁵ Diabetic supplies covered at 80%.

• Subject to limitations.

Applies to the Annual Out-of-Pocket maximum.

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HEALTH NET PPO CATASTROPHIC SAVER

(PPO PLANS ARE AVAILABLE TO OUT-OF-STATE EMPLOYEES)**

PLAN SUMMARY

BENEFITS ⁶	CATASTROPHIC SAVER (50/50) ¹		<p>This plan is primarily for Major Catastrophic coverage. First dollar benefits are <u>very limited</u>.</p> <p>† The following professional services are subject to the In-Network co-insurance of 50% and the Out-of-Network co-insurance of 50%:</p> <ul style="list-style-type: none"> ◆ Physician visit to hospital or skilled nursing facility ◆ Surgeon ◆ Assistant surgeon ◆ Anesthesiologist ◆ Chemotherapy ◆ Nuclear medicine ◆ X-ray ◆ Laboratory procedures ◆ Normal delivery ◆ C-section ◆ Pregnancy complications ◆ Elective abortion ◆ Genetic testing of fetus ◆ Circumcision of newborn ◆ Fitting of contraceptive devices ◆ Sterilization ◆ Allergy testing
	In-Network	Out-of-Network (LFS)	
Lifetime Maximum	\$5,000,000		
Annual Deductible	\$500 member / two per family combined PPO / OON (The annual deductible does not apply to the OOPM)		
Out-of-Pocket Maximum	\$5,000 individual PPO / \$10,000 OON		
Physician Office Visit²†	\$40	50%*	
Prescription Drugs	Recommended drug list only		
Generic (30 day supply)	30%	50%*	
Brand (30 day supply)	30%	50%*	
Non-Formulary Drugs	Not Covered	Not Covered	
Mail-in Service (90 days) ⁴	30%	Not Covered	
Annual Maximum	\$500 combined PPO / OON		
Self-Injectables[#]	50%	50%	
X-Ray & Lab†	50% ³	50%*	
Hospital In-patient	\$500 deductible PPO / OON ⁵		
(Professional / Institutional)	50% / 50%	50%* / 50%*; \$600 max./day	
Out-patient Surgery (Professional / Institutional)	50% / 50%	50%* / 50%*; \$600 max./day	
Emergency Room Co-pay waived if admitted (Professional / Institutional)	50% / \$100 deductible, then 50%	50%* / \$100 deductible, then 50%	
Allergy Testing† Injections†	50% \$40 ³	50%* 50%*	
Physical Therapy	Not covered	Not covered	
Durable Medical Equipment (\$1,000 max. combined PPO & OON)	50%	50%*	
Vision / Hearing Exams Lenses & Frames	\$40 co-pay (to age 17) ³ Not covered	Not covered	
Mental Health Care	\$500 deductible PPO / OON ⁵		
In-patient Severe	50%	50%*: \$600 max. per day	
In-patient Non-Severe (20 days per year max.)	50%; \$175 max. per day	50%*: \$175 max. per day	
Out-patient Severe ²	50%	50%*	
Out-patient Non-Severe ²	\$40 co-pay ² ; member pays all charges in excess of \$25 per visit	50%* ² ; member pays all charges in excess of \$25 per visit	
Chiropractic Care	Not covered	Not covered	

* Plus excess of covered expenses.

** Subject to restrictions and limitations; see Program Manager for plan benefits and rates.

¹ Out-of-network based on a Limited Fee Schedule (LFS).

² 4 visits per year, combined for subscriber & spouse; 8 visits per year for dependents.

³ Deductible is waived for these services.

⁴ Subject to limitations.

⁵ This is in addition to the annual deductible.

⁶ Many services require prior certification before being provided or received. If prior certification is not acquired, benefits are reduced by 50%. In addition, for each **uncertified in-patient admission**, a \$250 deductible is required.

[#] Applies to the Annual Out-of-Pocket maximum.

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DENTAL PLANS

METLIFE PREMIER & STANDARD PLANS

100% REQUIRED PARTICIPATION 1-9 ENROLLED EMPLOYEES; 75% REQUIRED PARTICIPATION 10+ ENROLLED EMPLOYEES

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.

SUMMARY OF BENEFITS	PREMIER + ORTHO PLAN		PREMIER PLAN		STANDARD PLAN	
	Preferred Dentist*	Any Dentist**	Preferred Dentist*	Any Dentist**	Preferred Dentist*	Any Dentist**
Preventive Care	100%	100%	100%	100%	80%	80%
Basic Care	90%	80%	90%	80%	80%	80%
Major Care [#]	60%	50%	60%	50%	50%	50%
Deductible - Individual/Family For Basic & Major Services	Waived	\$50 / \$150	Waived	\$50 / \$150	\$50 / \$150	\$50 / \$150
Annual Maximum	\$2,000	\$1,500	\$2,000	\$1,500	\$1,500	\$1,000
Ortho Lifetime Maximum (Children to age 19 only)	\$2,000	\$1,500	Orthodontia coverage is not available on this plan.		Orthodontia coverage is not available on this plan.	
Ortho Co-Insurance	50%	50%				
Ortho Deductible	\$0	\$0				

* Reimbursement based on PDP (Preferred Dentist Program) fees

** Reimbursement based on Reasonable & Customary Charges

PRIMARY COVERED SERVICES

PREVENTIVE CARE

Oral Evaluations	Prophylaxis (cleanings)	Topical Fluoride Applications
Space Maintainers	X-Rays	Emergency Treatment to Relieve Pain

BASIC

Fillings	Endodontics	Repair of Bridges
Extractions	Oral Surgery	Repair of Crowns
Anesthesia	Periodontics	Injections of Antibiotic Drugs

MAJOR[#]

Bridgework	Inlays	Crowns
Dentures	Onlays	

[#] Subject to a 12-month waiting period. May be waived with proof of prior GROUP dental coverage.

ORTHODONTIA

The Exchange/Association Premier and Standard Dental plans do not cover Orthodontia. If you use a participating PDP Orthodontist for orthodontia services, you will receive the full course of treatment at the scheduled PDP fee. In other words, MetLife is pleased to pass their discount along to Exchange/Association members.

The Premier Plus Ortho plan does cover orthodontia as shown, for children only to age 19.

EXCLUSIONS

- ◆ Orthodontia - see “Orthodontia” above
- ◆ TMJ expenses
- ◆ Services not listed and services begun before the member became covered.
- ◆ Cosmetic treatment or treatment to correct congenital defects.
- ◆ Initial placement of a denture or fixed bridge which involved the replacement of one or more natural teeth, missing before the member became covered, unless it also replaces a natural tooth extracted while covered.
- ◆ Replacements of a prosthetic appliance, crown or bridge within five years, and a replacement of lost or stolen appliances.

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DENTAL PLANS

METLIFE SAVINGS PLUS PLAN (75% REQUIRED PARTICIPATION)

Savings Plus 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 note: The Savings Plus Plan provides very limited benefits when utilizing Out-of-Network providers.

SUMMARY OF BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Preventive Care	100%; \$10 co-pay for prophylaxis service	Paid at a set Out-of-Network Reimbursement Schedule*
Basic Care	70%	
Major Care [#]	40%	
Deductible (Individual/Family) For Basic & Major Services	\$50 / \$150	\$50 / \$150
Annual Maximum	\$1,000 Combined In & Out-of-Network	

* Savings Plus is designed to provide significant savings to its members through its extensive network of providers. Any services received Out-of-Network will be paid at a set reimbursement schedule. To obtain the reimbursement schedule, please call (800) 585-2392.

PRIMARY COVERED SERVICES

PREVENTIVE CARE

Oral Evaluations	Prophylaxis (cleanings)	Topical Fluoride Applications
Space Maintainers	X-Rays	Emergency Treatment to Relieve Pain

BASIC

Fillings	Repair of Bridges	Injections of Antibiotic Drugs
Extractions	Repair of Crowns	
Anesthesia	Oral Surgery	

MAJOR[#]

Inlays	Bridgework & Dentures	Crowns
Onlays	Periodontics	Endodontics

[#] **Subject to a 12-month waiting period. May be waived with proof of prior GROUP dental coverage.**

ORTHODONTIA

The Exchange/Association Savings Plus Dental plan does not cover Orthodontia, however if you use a participating PDP Orthodontist for orthodontia services, you will receive the full course of treatment at the scheduled PDP fee. In other words, MetLife is pleased to pass their discount along to Exchange/Association members.

EXCLUSIONS

- ◆ Orthodontia - see "Orthodontia" above
- ◆ TMJ expenses
- ◆ Services not listed and services begun before the member became covered.
- ◆ Cosmetic treatment or treatment to correct congenital defects.
- ◆ Initial placement of a denture or fixed bridge which involved the replacement of one or more natural teeth, missing before the member became covered, unless it also replaces a natural tooth extracted while covered.
- ◆ Replacements of a prosthetic appliance, crown or bridge within five years, and a replacement of lost or stolen appliances.

This is only a summary; Carrier's Evidence of Coverage document supersedes any discrepancies in these plan descriptions.

VISION PLANS

UNDERWRITTEN & ADMINISTERED BY VISION SERVICE PLAN (VSP)

VSP has an extensive nationwide network of private practice doctors who provide exceptional care and eyewear to persons covered under the 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. It is available as a “stand-alone” plan 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.

EXAM AND PRESCRIPTION GLASSES

Exam	\$10 copay	Once each 12 months*
Lenses	\$25 copay	Once each 12 months*
Frame	\$25 copay	Once each 24 months*
<i>The \$25 material copay is applied once per service year</i>		
Contacts	No copay applies	Once each 12 months*

*From last date of service

FRAMES

Frame of your choice covered up to \$120.00. Plus, 20% off any out-of-pocket costs.

CONTACT LENSES

Contacts may be chosen instead of prescription glasses. An allowance of \$105.00 will be provided towards the cost of your contact lens fitting and evaluation and materials. Any costs exceeding the allowance are the responsibility of the patient.

Contact lens frequency is the same for lenses. Under this plan, if you choose, you will be eligible for a frame 24 months after the last date of obtaining contacts.

SERVICES FROM A VSP NETWORK DOCTOR

When you select a doctor from the VSP network, the above services are covered. There will be a \$10 charge for the examination. There is a \$25 copay for eyewear (lenses and frame). You'll receive extra discounts and savings on additional care, services and/or eyewear not covered by this plan when you visit a VSP network doctor.

Services from a Non-VSP Provider

EXAM Reimbursed up to \$45

EYEWEAR

Single Vision Lenses	Reimbursed up to \$45
Lined Bifocal Lenses	Reimbursed up to \$65
Lined Trifocal Lenses	Reimbursed up to \$85
Frame	Reimbursed up to \$47
Contact Lenses	Reimbursed up to \$105

This is only a summary; Carrier's Evidence of Coverage document supersedes any discrepancies in these plan descriptions.

CHIROPRACTIC AND ACUPUNCTURE PLANS

UNDERWRITTEN & ADMINISTERED BY AMERICAN SPECIALTY HEALTH PLANS OF CALIFORNIA, INC. (ASH)

Chiropractic and Acupuncture plans are provided by American Specialty Health (ASH). To participate, an insured must be enrolled in an employer-sponsored medical plan and 100% of medical enrollees, **including dependents**. The program covers the following services when they are provided by an ASH provider.

CHIROPRACTIC ONLY PLAN \$15 / 20 VISITS

BENEFITS

- ◆ Office visit \$15 co-pay
- ◆ 20 visits per calendar year
- ◆ No claim forms, no deductibles
- ◆ No medical referral required
- ◆ Initial and subsequent examinations (annual limits apply)
- ◆ Office visits and adjustments (annual limits apply)
- ◆ Adjunctive therapy (annual limits apply)
- ◆ \$50 annual chiropractic appliance benefit
- ◆ Diagnostic services, including radiology and clinical laboratory services
- ◆ ASH provider obtains authorization for all services based on clinical necessity (other services not covered)

FLEXIBLE CHOICE

- ◆ Service area includes all California counties
- ◆ Over 2,200 ASH chiropractic providers, over 250 ancillary radiology and clinical laboratory providers
- ◆ ASH Plan provider chosen at point of service, no pre-designation required
- ◆ Change ASH provider at any time

CHIROPRACTIC & ACUPUNCTURE PLAN \$15 / 20 VISITS

BENEFITS

- ◆ Office visit \$15 co-pay
- ◆ 20 visits per year (combined Chiropractic & Acupuncture)
- ◆ No claim forms, no deductibles
- ◆ No medical referral required
- ◆ Chiropractic benefits same as on the Chiropractic Only Plan
- ◆ Over 800 participating acupuncturists

This is only a summary; Carrier's Evidence of Coverage document supersedes any discrepancies in these plan descriptions.

METLIFE BASIC GROUP LIFE AND AD&D PLANS

GUARANTEED ISSUE (100% EMPLOYER PAID / 100% REQUIRED PARTICIPATION)

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.**

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.

BENEFIT AGE REDUCTION - ADEA graded age reductions apply for insureds over age 65

Age 65-69	60% of pre-age 65 benefit	Age 80-84	15% of pre-age 65 benefit
Age 70-74	35% of pre-age 65 benefit	Age 85-89	10% of pre-age 65 benefit
Age 75-79	25% of pre-age 65 benefit	Age 90+	5% of pre-age 65 benefit

PREMIUM WAIVER

Premiums are waived for insureds who became disabled before age 60. If an insured becomes disabled between ages 60-69, coverage is extended without charge 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 the carrier, except term life. A spouse may also convert if the employee terminates employment or if the employee dies.

ACCIDENTAL DEATH & DISMEMBERMENT - 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 above or 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 **additional** 100% of the face amount.

EXCLUSIONS – AD&D benefits are not payable for loss resulting from:

- ◆ Medical, surgical or dental treatment
- ◆ Poisons, drugs, medicines, sedatives or gas
- ◆ Air travel as crew, or for training & military
- ◆ War, riot or military service
- ◆ Disease or illness
- ◆ Driving while intoxicated
- ◆ Commission of a crime
- ◆ Intentionally self-inflicted injury while sane or insane

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

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

METLIFE OPTIONAL TERM LIFE AND AD&D

SUBJECT TO MEDICAL UNDERWRITING (100% EMPLOYEE PAID)

COVERAGE

An **Employee** may apply for insurance in **\$10,000** units up to a maximum of **\$300,000**, not to exceed 5 times the employee's basic annual earnings. An **Employee** is automatically enrolled in Optional Accidental Death or Dismemberment benefits equal to the amount of Optional Life benefits elected.

An **Employee's Spouse** may apply for insurance in **\$10,000** units up to a maximum of **\$100,000**, not to exceed 50% of the Employee's coverage amount. An **Employee's Spouse** is automatically enrolled in Dependent Accidental Death or Dismemberment benefits equal to the amount of Dependent Life benefits elected. The employee must be insured in order for the spouse and dependent children to be eligible for coverage. Insurance benefits will terminate at age 70.

Dependent children can be insured for \$2,500 units up to a maximum of \$10,000. A **Dependent child** is automatically enrolled in Dependent Accidental Death or Dismemberment benefits equal to the amount of Dependent Life benefits elected.

EVIDENCE OF INSURABILITY REQUIREMENTS

An **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 employees, MetLife requires full statement of health approval before coverage can take effect. An Employee's spouse must submit a Statement of Health form to MetLife, and MetLife must approve before a spouse can be covered for amount above \$10,000.

OPTION TO CONTINUE YOUR COVERAGE (PORTABILITY)

Should your employment terminate for any reason, you can continue your optional life insurance coverage without a medical examination. Competitive rates apply, but will differ from these rates. MetLife will bill you directly.

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.

**** NOTE: As the insured enters the next age bracket, the rate will increase on the first of the month following their birthday, or their birthday if it is on the first of the month.**

* 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 employee for support in order to remain eligible for this coverage.

EXCLUSIONS

- ◆ Suicide is excluded during the first two years of coverage.
- ◆ The Optional Group Term Life Insurance Plan is available for all active full-time employees, under the age of 70, working 20 hours or more per week, including spouse under the age of 70, and dependent children.