SUMMARY PLAN DESCRIPTION

FOR THE

CALIFORNIA CONSTRUCTION INSURANCE TRUST WELFARE BENEFIT PLAN

Effective 01/01/2019

INTRODUCTION

This document, along with the benefit information furnished by your insurance provider(s), is your Summary Plan Description for purposes of the Employee Retirement Income Security Act of 1974 (ERISA). This summary highlights your rights and obligations under the CALIFORNIA CONSTRUCTION INSURANCE TRUST WELFARE BENEFIT PLAN ("Plan"). Benefits under the Plan are provided by certain insurance providers contracting with the Trust, and are subject to the provisions of the Plan, the Trust Agreement, your employer's Adoption Agreement, and the determination of the Plan Administrator or health insurance issuer(s).

Since this is only a summary, all of the details of the Plan are not covered, and you should contact the Plan Administrator or health insurance issuer(s) if you still have questions about your coverage. The Plan Sponsor reserves the right to change or discontinue the Plan at any time. This Summary Plan Description does not create a contract of employment.

Noticia de Asistencia de Lenguaje Extranjero: Este folleto contiene un sumario en ingles de sus derechos del Plan y los beneficios del California Construction Insurance Trust Welfare Benefit Plan. Si tiene alguna dificultad entendiendo cualquier parte de este folleto communiquese con el Administrador del Plan a su oficina en 3444 Camino del Rio North, Suite 101, San Diego, CA 92108. Horas de oficina son de 8:30 a.m. a 4:30 p.m. de Lunes a Viernes. Tambien se puede comunicar con el Administrador por telefono al (619) 280-2009 or (800) 886-7559 para asistencia.

SUMMARY PLAN DESCRIPTION

A. Basic Plan Information

1. Name of Plan.

CALIFORNIA CONSTRUCTION INSURANCE TRUST WELFARE BENEFIT PLAN ("Plan")

2. Name and Address of Plan Sponsor.

California Professional Association of Specialty Contractors
520 Capitol Mall, Suite 630
Sacramento, CA 95814

3. Participating Employer.

The employer identified at the top of page one. The Plan allows participation of more than one employer. You may receive upon written request of the Plan Administrator information as to whether a particular employer participates in the Plan.

4. Plan Employer Identification Number (EIN): 33-6296719.

5. Plan Number (PN): 501.

6. Type of Plan and Funding.

This is a welfare benefit plan that provides group medical benefits through a multiple employer trust fund established under section 501(c)(9) of the Internal Revenue Code. All benefits are fully insured. The Plan is not collectively bargained and does not apply to employees covered by collective bargaining agreements. The Plan covers work performed throughout California. Contributions are paid by Participating Employers to the Trust Fund.

The trust name is the CALIFORNIA CONSTRUCTION INSURANCE TRUST.

7. Plan Administrator and Type of Administration.

The Plan is administered by a professional Plan Administrator. If you have questions about the Plan, please contact:

Coast Benefits, Inc.
3444 Camino del Rio North, Suite 101
San Diego, CA 92108
Telephone: (619) 280-2009; Toll Free: (800) 886-7559

8. Agent for Service of Legal Process.

The name and address of the Plan's agent for service of legal process are:

Melissa W. Cook, Esq.
Melissa W. Cook & Associates
3444 Camino Del Rio North, Ste. 106
San Diego, California 92108

Service of legal process may also be made on the plan administrator identified in the preceding section or on any plan trustee identified in the following section.

9. Plan Trustees.

The names and addresses of the Plan Trustees are:

Mary Kathawa (Chairperson)
California Construction Insurance Trust
c/o Coast Benefits, Inc.
3444 Camino del Rio North, Suite 101
San Diego, California 92108

Daniel F. Schaldach (Secretary)
California Construction Insurance Trust
c/o Coast Benefits, Inc.
3444 Camino del Rio North, Suite 101
San Diego, California 92108

Gregory B. Minor
California Construction Insurance Trust
c/o Coast Benefits, Inc.
3444 Camino del Rio North, Suite 101
San Diego, California 92108

10. Source of Plan Contributions.

Contributions are made by Participating Employers for their employee participants covered under the group term life insurance and group health insurance plans. Depending upon the Participating Employer's election, a portion of contributions for group term life insurance and health coverage may be paid by the employee. If dental or vision benefits are provided, contributions for dental and vision insurance are paid by either the Participating Employer or the employee, depending upon the election of the Participating Employer. Contributions are set at amounts needed to pay premiums for coverage and to pay for plan expenses.

11. Plan Year.

The Plan Year is January 1 through December 31.

12. Role of Health Insurance Issuer.

The medical benefits provided under the United Healthcare Group HMO Plan are insured and underwritten by United Healthcare Group. United Healthcare Group is also responsible for performing various administrative services in connection with the Plan, including payment of claims. Should you have any questions for the insurer, you may direct inquiries to:

HMO
United Healthcare
Attn: Claims Department
P.O. Box 30968
Salt Lake City, Utah 84130-0968
Telephone:
Website:

The medical benefits provided under the United Healthcare Group PPO Plan are insured and underwritten by United Healthcare Group. United Healthcare Group is also responsible for performing various administrative services in connection with the Plan, including payment of claims. Should you have any questions for the insurer, you may direct inquiries to:

PPO
United Healthcare
Attn: Claims Department
PO Box 30555
Salt Lake City, UT 84130
Telephone:
Website:

The medical benefits provided under the MediExcel HMO Plan are insured and underwritten by MediExcel. MediExcel is also responsible for performing various administrative services in connection with the Plan, including payment of claims. Should you have any questions for the insurer, you may direct inquiries to:

MediExcel
750 Medical Center Ct., Suite 1
Chula Vista CA 91911
Telephone:
Website:

The Dental benefits are insured and underwritten by United Healthcare Group. Administrative services in connection with the United Healthcare Group plan, including the payment of claims, are performed by United Healthcare Group. Should you have any questions for the insurer, you may direct inquiries to:

HMO and PPO
United Healthcare
PO Box 30567
Salt Lake City, UT 84130-0567
MS QM600
Telephone:
Website:

The Vision benefits are insured and underwritten by United Healthcare, a UnitedHealth Group Company. Administrative services in connection with the United Healthcare Group, including the payment of claims, are performed by United Healthcare Group. Should you have any questions for the insurer, you may direct inquiries to:

United Healthcare Vision Claims Department
Out-of-Network Claims
PO Box 30978
Salt Lake City, UT 84130
Telephone:
Website:

Life insurance benefits provided under the Unimerica group term life insurance plan are insured and underwritten by UnitedHealth Group Company. Administrative services in connection with the life insurance plan, including the payment of claims, are performed by Unimerica Workplace Benefits, a UnitedHealth Group Company. Should you have any questions for the insurer, you may direct inquiries to:

Unimerica Workplace Benefits
PO Box 30759
Salt Lake City, UT 84130
(866) 293-1794
Website:

13. Filing a Claim.

Procedures for submitting claims and obtaining benefits are outlined in the insurance provider's benefits information materials. Plan Participants and beneficiaries can obtain a copy of these procedures, without charge, from the Plan Administrator.

14. Appealing a Claim Denial.

The following describes the process to appeal actions of the Plan Administrator with regard to the Plan's eligibility provisions and any action of the Board of Trustees. The Appeals Procedure does not apply to benefits obtained through HMOs, PPOs or any insured benefits.

a. No employee, dependent, beneficiary or other person shall have any right or claim to benefits under the Plan other than as specified in policies or contract procured by the Board of Trustees or in the rules and regulations of the Board, or any right to claim to payments from the fund, other than as specified herein.

Any dispute as to eligibility shall be resolved by the Board under and pursuant to the Plan and the Trust Agreement except that any dispute as to type or amount of benefits which are provided pursuant to a contract of insurance or service contract entered into by the Board of Trustees shall be resolved under the terms of such contract.

The Board shall have full discretionary authority to decide all other matters and its decision of the dispute, right or claim shall be final and binding upon all parties thereto, subject only to such judicial review. No action may be brought to enforce any right under the Plan until a claim therefore has been submitted to and determined by the Board of Trustees and thereafter the only action which may be brought is one to enforce the decision of the Board or to clarify the rights of the claimant under such decision.

b. Any person whose application has been denied in whole or in part by the Board of Trustees shall be notified of such decision in writing by the Board of Trustees and may petition the Board of Trustees to reconsider its decision. A petition for reconsideration shall be in writing, shall state in clear and concise terms the reason for disagreement with the decision of the Board of Trustees and shall be filed with or received by the Plan Administrator within 60 days after the date shown on the notice to the petitioner of the decision of the Board of Trustees.

c. Upon good cause shown, the Board of Trustees may permit the petition to be amended or supplemented. The failure to file a petition for reconsideration within such 60- day period shall constitute a waiver of the claimant's right to reconsideration of the decision. Such failure shall not, however, preclude the applicant or claimant from establishing his or her entitlement at a later date based on additional information and evidence, which was not available to him or her at the time of the decision of the Board of Trustees.

d. Upon receipt of a petition for reconsideration, the Board of Trustees, a committee or an Agent appointed by the Board and authorized to act on such petitions shall grant a hearing on the petition and receive and hear any evidence or argument which cannot be presented satisfactorily by correspondence.

A decision by the Board of Trustees shall be made no later than the date of the quarterly meeting of the Board that immediately follows the Plan Administrator's receipt of the request for reconsideration unless the request for reconsideration is filed within thirty (30) days preceding the date of such meeting. In such case, a benefit determination will be made no later than the date of the second meeting following the Plan Administrator's receipt of the request for reconsideration. If special circumstances require a further extension of time for processing, a benefit determination will be rendered no later than the third meeting following the Plan Administrator's receipt of the request for reconsideration and the Plan Administrator will provide you with a written notice of the extension, describing the special circumstances and the date by which the benefit determination will be made, prior to the commencement of the extension. The Plan Administrator will notify you of the benefit determination as soon as possible but not later than 5 days after the benefit determination is made.

e. The decision of the Board of Trustees with respect to petition for reconsideration shall be final and binding upon all parties, including the petitioner and any person claiming under the petitioner.

f. No action may be brought to enforce any rights under the Trust or the Plan until after the claim therefore has been submitted and determined by the Board of Trustees and, thereafter, the only action that may be brought is one to enforce the decision of the Board of Trustees.

g. Any dispute as to the type or level of benefits provided under a contract of insurance or a service contract entered into by the Board of Trustees shall be resolved in accordance with the terms of such contract including any appeals provisions of such contract.

Finality of Decision on Claim – Right to File Lawsuit

The denial of an application or claim after the right to review has been waived or the decision of the Trustees on appeal has been issued is final and binding upon all parties, including the claimant.

No lawsuit may be filed without first exhausting the above appeals procedure. No legal action may be commenced or maintained against the Plan or any Trustee or legal fiduciary, person or entity involved in the decision more than two years after a claim has been denied on appeal.

No lawsuit may be filed (started) more than two years after services were provided or benefits partially of totally denied or an otherwise adverse determination was made against you. The provisions of this Section shall apply to and include any and every claim to benefits from the Trust, and any claim or right asserted under the Plan or against the Trust, regardless of the basis asserted for the claim, and regardless of when the act or omission upon which the claim is based

occurred, and regardless of whether or not the claimant is a "Participant" or "Beneficiary" of the Plan with the meaning of those terms as defined in ERISA. Such claim shall be limited to benefits due to him under the terms of the Plan, or to clarify his rights to future benefits under the terms of the Plan, and shall not include any claim or right to damages, either compensatory or punitive.

15. No Vested Benefits.

Benefits under this Plan are NOT vested. The Board of Trustees may amend, reduce, eliminate or otherwise change the Plan at any time and may change, reduce, or discontinue any Plan benefits, in whole or in part, at any time. Moreover, the Board of Trustees may require new or greater premiums, co-payments, or deductibles at any time. The Board of Trustees may change the eligibility requirements and any other Plan rules at any time.

16 Termination of the Plan.

The Plan Sponsor and Participating Employers do not promise the continuation of any benefits nor do they promise any benefit at or during retirement. The Plan may be terminated at any time by the Trustees. Benefits may be terminated also by the Participating Employer's failure to make contributions or by the termination or expiration of the Participating Employer's agreement adopting the Plan.

Upon termination of the Trust Fund, the Trustees will wind up the affairs of the Trust Fund, and any remaining funds will be used to continue payment of benefits to Participants and their beneficiaries under the Plan.

17. Statement of ERISA Rights.

As a Plan Participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants will be entitled to:

a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.

b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator shall make a charge of twenty-five (.25) cents per page for the copies.

c. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

d. 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.

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

No one including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied 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 up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan 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 domestic relations order or 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.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration U.S. Department of Labor, 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 publication hotline of the Employee Benefits Security Administration.

18. Maternity Benefits.

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 not in excess of 48 hours (or 96 hours).

19. Women's Health and Cancer Rights Act of 1998

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

1. Reconstruction of the breast on which the mastectomy was performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; or

3. Prosthesis and physical complications of all stages of mastectomy, including lymphedemas.

The coverage is subject to the Plan's annual deductibles and coinsurance provisions.

20. Qualified Medical Child Support Order.

A Qualified Medical Child Support Order ("QMCSO") issued by a court or a state agency requires the Plan to provide health coverage to the child(ren) of a Plan participant. The Plan has adopted Qualified Medical Child Support Order Procedures to determine whether a particular order qualifies as a QMCSO. Plan participants and beneficiaries can obtain, without charge, a copy of these procedures from the Plan Administrator.

B. Eligibility Rules

The following information describes the conditions pertaining to your eligibility to receive benefits. A detailed summary of medical benefits is furnished by your insurance provider and certain limits on participation may be included in your employer's adoption agreement. Please contact the Plan Administrator if you have any questions regarding your coverage.

COVERAGE

1. Coverage of Employees.

Medical Benefits

Medical, dental, vision and life insurance benefits are provided to eligible Employees and their eligible dependents through this Trust pursuant to the plan of benefits selected by the Employer.

1. Eligibility of Hourly Field Construction Employees for Medical Benefits. Becoming Insured.

Monthly Eligibility – An hourly construction trade employee is eligible for benefits on the first day of the month following the eligibility-waiting period elected by the employer.

Hourly Eligibility – If an hourly construction trade employee works for an employer who elects the hour eligibility option, contributions are made for employees following expiration of the eligibility waiting period elected by the employer. Under this option, the employee is eligible for benefits on the first day of the second month following two consecutive months in which the employer makes required contributions. For example, if any employee works in January and February, and required contributions are paid to the Trust Fund in both January and February, the employee will become eligible for benefits on April 1 (March is called a "lag" month). This coverage will continue on a month to month basis assuming that the Participating Employee is credited with the required contributions each month thereafter. Monthly employer contribution amounts will change periodically. In addition, if an employer contributes more than is required to provide medical benefit coverage, the excess will be held in a dollar bank reserve, up to an amount sufficient to provide three (3) months of coverage. The reserves will be available for application in months in which insufficient contributions are received to cover the participant for another month of eligibility. The Plan Administrator is authorized to forfeit, on a quarterly basis, contributions over the maximum dollar bank reserve, plus amounts related to employees who never acquired eligibility and those who terminated coverage without sufficient amounts to purchase additional coverage.

b. Termination of Your Insurance.

Unless you are entitled to coverage under the Family and Medical Leave Act of 1993 ("FMLA"), your insurance will end on the earliest date shown below:

(1) Monthly Eligibility – The last day of the calendar month you cease to qualify as an eligible employee. The Plan deems the employee-employer relationship to end on the date the employee stops full-time work for a Participating Employer.

Hour Bank Eligibility – The last day of the month in which the total amount included in the participant's dollar bank reserve are insufficient to cover the participant for another month of eligibility.

(2) The last day for which premiums are paid by your employer for your insurance.

(3) The date the group policy terminates.

(4) The date upon which you were advised of termination of eligibility because of work for non-Participating Employers in accordance with policies and procedures adopted by the Trustees.

c. Reinstatement.

If for any reason your insurance ends, reinstatement will be as described under the previous section entitled "Becoming Insured."

2. Eligibility of Salaried and Hourly Office and Staff Employees for Medical Benefits.

a. Becoming Insured.

Reported Employees will become eligible for coverage on the first day of the month following the eligibility-waiting period elected by their employer. You must be actively employed at work on the effective date of your insurance. The field employees of your Employer must be participants in this Plan in order for salaried and office staff to receive coverage through this Trust. Employees who are covered by a collective bargaining agreement are not eligible to participate.

b. Termination of Your Insurance.

Unless you are entitled to coverage under the Family and Medical Leave Act of 1993 ("FMLA"), your insurance will end on the earliest date shown below:

(1) The last day of the calendar month in which you cease to qualify as an eligible employee. The Plan deems the employee-employer relationship to end on the date the employee stops full-time active work for a Participating Employer.

(2) The last day of the month in which your employer ceases to be a Participating Employer.

(3) The last day of the month in which your Participating Employer has paid premiums for your insurance.

(4) The date the group policy terminates.

3. Eligibility of Plan Dependents for Medical Benefits.

a. Insuring Dependents.

Only a person who meets the definition of dependent may become insured for dependents' insurance under the group policy. To become insured, the person must:

(1) Qualify as a dependent;

(2) Be enrolled for the dependents' insurance through your Participating Employer;

(3) Reach an eligibility date.

Eligible Dependent – The term "dependent" means only your spouse or domestic partner and children of an age within the Age Limits for Dependent Children shown below. The term "dependent" does not include a spouse with whom you are legally separated. The definitions of "child" and "dependent" are outlined in the insurance providers' benefit information materials and includes any child covered pursuant to a QMCSO.

Age Limits for Dependent Children – Dependent health coverage is available for both married and unmarried children until the end of the month in which the child reaches the age of 26.

Exception to Age Limits - If an unmarried dependent child, when he or she reaches the age limit shown above, is insured under the group policy, chiefly depends on you for support and maintenance, and is continuously unable to get self-sustaining work due to a physical or mental handicap, the child will continue to qualify as a dependent for coverage until the earlier of the following dates: (a) the date he or she recovers from the handicap; and (b) the date he or she no longer chiefly depends on you for support and maintenance.

Eligibility Date - A dependent's eligibility date is the later of: (a) your eligibility date;or (b) the date the person qualifies as your dependent.

b. Termination of a Dependent's Insurance.

A dependent's insurance will end on the earliest date shown below:

(1) The last day for which premiums are paid for your dependents' insurance;

(2) The last day of the month in which the person no longer qualifies as a dependent; or

(3) The date your employees' insurance ends.

5. Insuring Domestic Partners.

Your employer has elected to recognize domestic partners as eligible for dependent coverage. To be eligible, an employee requesting domestic partner coverage, and his or her domestic partner must meet certain criteria. In addition, only a person who meets the definition of domestic partner may be insured for domestic partner coverage under a group and the domestic policy. To become insured, the employee partner, among other things must:

(1) Have a common residence;

(2) Be capable of consenting to the domestic partnership;

(3) Not be married to someone else, or a member of another domestic partnership that has not been terminated, dissolved or adjudged a nullity;

(4) Not be related by blood in a way that would prohibit marriage; and

(5) Both be at least the minimum age of consent in the state in which they reside.

6. Coverage of Former Medicaid or State Children's Health Insurance Program Participants.

The Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") provides new enrollment rights of eligible individuals. The Plan provides the following special enrollment rights for individuals who are eligible for coverage under the Plan but are not enrolled for coverage:

(1) An employee or eligible dependent who is covered under Medicaid or the State Children's Health Insurance Program ("SCHIP") and loses coverage under Medicaid or SCHIP because the employee or dependent is no longer eligible for such coverage may request coverage under the Plan within sixty (60) days of the loss of Medicaid or SCHIP coverage.

Like other special enrollment rights under the Plan, qualified individuals may enroll in the Plan outside of the regular open enrollment period; and

(2) An employee or eligible dependent who becomes eligible for a premium assistance subsidy in the Plan under Medicaid or SCHIP may request coverage under the Plan within sixty (60) days after such eligibility is determined. State-specific notices will be provided to employees regarding the state-provided subsidy after they have been issued by the Department of Labor and Division of Health and Human Services.

7. Continuing Coverage (COBRA).

You, your spouse and/or your covered dependents may elect to continue your coverage under the Plan through federal legislation called COBRA. You will be required to pay premiums for this continued coverage.

If you are a Participating Employee, you have a right to elect continuation coverage if you lose coverage for one of the following qualifying events:

(a) Termination of your employment (for reasons other than gross misconduct), or:
(b) Reduction in the hours of your employment, if the reduction causes you to no longer be eligible for coverage under the Plan.

If you are the spouse of a Participating Employee, you have the right to elect continuation coverage if you lose coverage for one of the following qualifying events:

(a) The death of your spouse;
(b) Termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment which cause
a loss or reduction of Plan coverage;
(c) Divorce or legal separation from your spouse; or
(d) Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both).

A dependent child, including a child covered pursuant to a QMCSO, of a Participating Employee has the right to elect continuation coverage if health coverage under the Plan is lost for one of the following qualifying events:

(a) The death of the employee parent;
(b) The termination of the employee parent's employment (for reasons other than gross misconduct) or reduction in the employee parent's hours of employment causing the loss of coverage;
(c) The parents' divorce or legal separation;

(d) The employee parent becomes entitled to Medicare benefits (Part A, Part B, or both);
or

(e) You cease to be a "dependent child" under the Plan.

Under the law, the Participating Employee or a family member has the responsibility to notify the Plan Administrator of a divorce, legal separation or a child losing dependent coverage under the Plan. You or your family member must provide written notice no later than 60 days after the date of the event, or after the day coverage is lost because of the qualifying event, whichever is later. You must provide this notice to the Plan Administrator, failure to provide timely notice will result in the waiver of your COBRA continuation coverage rights. The Plan Administrator will notify you of your rights to elect continuation coverage. Under the law, you must elect continuation coverage within 60 days after Plan coverage ends, or if later, 60 days after the date of the notice of your right to elect continuation coverage.

A Participating Employee, or the spouse of the Participating Employee, may elect continuation coverage for all family members, including a new spouse or new dependent child born, adopted or placed for adoption during the COBRA continuation coverage period. If a covered employee or spouse of a covered employee elects COBRA without specifying whether the election is for self-only coverage, the election will be considered to be on behalf of all other qualified beneficiaries with respect to that qualifying event. The Participating Employee, his or her spouse and the dependent children, however, each have an independent right to elect continuation coverage. To ensure that you, your spouse and/or dependents receive notice of the right to continuation coverage pursuant to COBRA, you should keep the plan administrator informed of the current addresses of family members. A spouse or dependent child may elect coverage even if the Participating Employee does not elect it.

If you elect continuation coverage, you will receive coverage identical to coverage provided under the Plan at that time to similarly situated active employees or family members. You must pay the entire premium for your continuation coverage, and the rate may include an additional 2 percent to cover administrative expenses. If you are entitled to a COBRA continuation coverage extension due to disability, you may be required to pay up to 150% of the premium costs during the extension period.

If you lose group health coverage because of the employee's death, divorce, legal separation, employee's entitlement to Medicare benefits, or loss of status as dependent under the Plan, coverage may be extended for 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. Otherwise if, you lose group health coverage because of a termination or reduction in hours of employment, coverage may be extended for 18 months, and an additional 18 months under CAL-COBRA. If coverage is lost due to termination of

employment or a reduction in hours at a date later than the date of the qualifying event, the maximum coverage period will be 18 months from the date of coverage loss, as well as the additional 18 months under CAL-COBRA.

If a second qualifying event occurs, continuation coverage for your spouse and the dependent children in your family may be extended up to a total of 36 months. The extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

If the Social Security Administration determines that you (or your spouse or dependent child, if applicable) are disabled during the first 60 days of the continuation period, then your continuation coverage period as well as your spouse's and any dependent's continuation coverage periods may be extended from 18 months to 29 months.

The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period. To qualify, you (or your spouse or dependent child, if applicable) must notify the Plan Administrator during the initial 18 month continuation coverage period and within 60 days after the latest of (a) the date the qualifying event occurs, (b) the date of the SSA determination, or (c) the date of loss of coverage because of the qualifying event. If there is a final determination that the qualified beneficiary is no longer disabled, the Plan Administrator must be notified within 30 days of the determination by the qualified beneficiary, and any coverage extended beyond the maximum that would otherwise apply will be terminated for all qualified beneficiaries.

Continuation coverage terminates (even before the end of the maximum coverage period) when any one of the following events occurs:

(a) The Participating Employer or the Plan no longer provides group health coverage to any employees;

(b) The premium for continuation coverage is not timely paid;

(c) You, or your spouse or dependent child, become covered as an employee or dependent under another employer's plan;

(d) You, or your spouse or dependent child, become entitled to Medicare benefits;

(e) You, or your spouse or dependent child, have extended continuation coverage due to a disability and then the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled;

(f) The maximum required COBRA or CAL-COBRA continuation period expires; or

(g) For such cause, as fraudulent claim submission, that would result in termination of coverage for similarly situated active employees.

Questions concerning this Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator.

8. HIPAA *Special Enrollment Rights*

Under HIPAA you are entitled to special enrollment rights if you acquire a new dependent or you and your dependents were covered under your spouse's plan and you lose coverage under your spouse's plan. However, you must request enrollment within 31 days after you acquire a new dependent or your coverage under your spouse's plan ends.

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act ("HIPAA"), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") or visit the EBSA website at www.dol.gov/ebsa. Addresses and telephone numbers of Regional and District EBSA offices are available through EBSA's website.

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. In addition, even if your dependent children are covered under a ("QMCSO"), you and/or your spouse should notify this office immediately of his, her or their address(es). You should also keep a copy, for your records, of any notices you send to the Plan Administration

9. Privacy of Protected Health Information

This Plan will use and disclose protected health information ("PHI") in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

PHI is defined as individually identifiable health information that is maintained or transmitted by this Plan in any form or medium (oral, written, or electronic). Individually identifiable health information is health information, including demographic information, that is created or received by a health care provider, employer, health care clearinghouse or this Plan and relates to the past, present or future physical or mental health condition of you or your eligible dependents, including payment information for

the provision of health care. When held by this Plan, it also means information that either identifies you or your eligible dependents directly or indirectly, in that one has a reasonable belief that you or your eligible dependents can be identified using the information. For example, your name, address, birth date, marital status, Social Security Number, and choice of health plan would be considered PHI. Other examples are the amount of contributions paid by your employer for your coverage, or whether you are an active employee, retiree, or Medicare enrollee.

THE FOLLOWING USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI) AND CORRESPONDING RIGHTS AND DUTIES APPLY TO YOU AND YOUR ELIGIBLE DEPENDENTS:

a. Permitted Uses and Disclosures of PHI

This Plan and its Business Associates will use and disclose PHI without your authorization for purposes of treatment, payment and health care operations, but only the minimum amount of PHI necessary to accomplish these activities. Treatment includes but is not limited to the provision, coordination or management of health care among health care providers or the referral of a patient from one health care provider to another. Payment includes but is not limited to actions concerning eligibility, coverage determinations, coordination of benefits, adjudication of health benefit claims (including appeals), determinations of cost-sharing amounts, utilization reviews, medical necessity reviews, preauthorization reviews, and billing and collection activities. Health care operations include but are not limited to performing quality assessment reviews, implementing disease management programs, reviewing the competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes legal services and auditing functions for the purpose of creating and maintaining fraud and abuse programs, compliance programs, business planning programs, and other related administrative activities.

b. Required Uses and Disclosures of PHI

This Plan must disclose PHI to you upon request to access your own PHI, with limited exceptions, or to request an accounting of PHI disclosures. Use and disclosure of PHI may be required by the Secretary of U.S. Department of Health and Human Services ("HHS") and its Office of Civil Rights ("OCR") or other authorized government organizations to investigate or determine this Plan's compliance with the Privacy Rule.

c. Agreed to Uses and Disclosures of PHI by You after an Opportunity to Agree or Disagree to the Disclosure

This Plan will disclose PHI to family members, other relatives or close personal friends if the information is directly relevant to the family or friend's involvement with

your health care or payment for such care and you have either agreed to the disclosure or been given an opportunity to object and have not objected.

d. Allowed Uses and Disclosures of PHI For Which Authorization or Opportunity to Object is Not Required

This Plan will use or disclose PHI without your authorization or opportunity to object when required by law, or to law enforcement officials, public health agencies, research facilities, coroners, funeral directors and organ procurement organizations, judicial and administrative agencies, military and national security agencies, worker's compensation programs and correctional facilities. These uses and disclosures are more fully described in this Plan's Privacy Policy Statement and Notice of Privacy Practices for Protected Health Information. Additional copies of these documents may be obtained from the Administration Office.

e. Your Individual Rights

HIPAA and the Privacy Rule afford you the following rights:

- You (or your personal representative) have the right to request restrictions on how this Plan will use and/or disclose PHI for treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified who are involved in your health care or payment for such care. However, this Plan is not required to agree to such a request. If this Plan agrees, it is bound by the restriction except when otherwise required by law, in emergencies, or when the restricted information is necessary for treatment. You will be required to complete a form requesting any restriction.

- You (or your personal representative) have the right to request to receive communications of PHI from this Plan either by alternative means or at alternative locations. This Plan may agree to accommodate any such request if it is reasonable. This Plan, however, must accommodate such a request if you clearly state that the disclosure of all or a part of the PHI could endanger you. You will be required to complete a request form to receive communications of PHI by alternative means or at alternative locations.
- You (or your personal representative) have the right to request access to your PHI contained in a Designated Record Set, for inspection and copying, for as long as this Plan maintains the PHI. A Designated Record Set includes the medical billing records about you maintained by or for a covered health care provider, enrollment, payment, billing, claims adjudication, and case or medical management record systems maintained by or for this Plan or other information used in whole or in part by or for this Plan to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you are not in the Designated Record Set and therefore not subject to access. The right

to access does not apply to psychotherapy notes or information compiled in anticipation of litigation. You must complete a request form to access PHI in a Designated Record Set. If access to inspect and copy PHI is granted, the requested information will be provided within 30 days if the information is maintained onsite or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if this Plan is unable to comply with the deadline. This Plan may charge a reasonable fee for the costs of copying. If access to inspect and copy your PHI is denied, a written denial will be provided setting forth the basis for the denial, a description of how you may have the denial reviewed, if applicable, and a description of how you may file a complaint with this Plan or the HHS or its OCR.

- You (or your personal representative) have the right to request an amendment to your PHI in a Designated Record Set for as long as the PHI is maintained in a Designated Record Set. You will be required to complete a request form to amend PHI in a Designated Record Set. This Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if this Plan is unable to comply with the deadline. If the request is denied in whole or in part, the Plan must provide a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

- You (or your personal representative) have the right to request an accounting of disclosures of PHI by this Plan. This Plan will provide such an accounting only for the six-year period preceding the date of the request. However, such accounting will not include PHI disclosures made to carry out treatment, payment or health care operations or made to you about your own PHI. Also, this Plan is not required to provide an accounting of disclosures pursuant to an authorization request or disclosures made prior to the compliance date of the Privacy Rule. You will be required to complete a request form to obtain an accounting of PHI disclosures within 60 days of the request. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if you are given a written statement of the reasons for the delay and the date by which the account will be provided. If more than one request for an accounting is made within a 12-month period, this Plan will charge a reasonable, cost-based fee for each subsequent accounting.

f. Access by Personal Representatives to PHI

This Plan will treat your personal representative as you with respect to uses and disclosures of PHI, and all the rights afforded you by the Privacy Rule, under certain circumstances, but only to the extent such PHI is relevant to their representation. For example, a personal representative with limited health care power of attorney regarding specific treatment, such as use of artificial life support, is your representative only with

respect to PHI that relates to decisions concerning this treatment. The personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to PHI or allowed to take any action.

Proof of such authority may take the form of a notarized power of attorney for health care purposes (general, durable or health care power of attorney), a court order of appointment as your conservator or guardian, an individual who is the parent, guardian or other person acting in loco parentis with legal authority to make health care decisions on behalf of a minor child, or an executor of the estate, next of kin, or other family member on behalf of a decedent.

This Plan retains discretion to deny a personal representative access to PHI if this Plan reasonably believes that you have been or may be subjected to domestic violence, abuse, or neglect by the personal representative or that treating a person as your personal representative could endanger you. This also applies to personal representatives of minors. Also, there are limited circumstances under state and other applicable laws when the parent is not the personal representative with respect to a minor child's health care information.

g. This Plan's Duties

In accordance with the Privacy Rule, only certain employees may be given access to your PHI. The Plan Administrator has designated this group of employees to include all employees dealing with the Trust. The employees described above may only have access to and use and disclose PHI for plan administration functions. A mechanism shall be provided for resolving issues of noncompliance, including disciplinary sanctions or termination, to any person who does not comply with the Privacy Rule.

This Plan is required by law to provide you with its Notice of Privacy Practices ("Notice") by April 14, 2003, and thereafter, upon request. Also, the Notice must be distributed by this Plan to new employees and dependents upon enrollment. You will be advised at least once every three years of the availability of the Notice and how to obtain a copy of it. This Plan is required to comply with the terms of the Notice as currently written. However, this Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by this Plan prior to the date of the change. This Plan will promptly revise and distribute the Notice within 60 days if there is a material change in its privacy policies and procedures.

This Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. This minimum necessary standard, however, will not apply to disclosures to or requests by a health care provider for treatment purposes, disclosures made to you, uses or disclosures pursuant to your authorization, disclosures made to HHS or its

OCR for enforcement purposes, uses or disclosures that are required by law, and uses or disclosures that are required for this Plan's compliance with HIPAA's Administration Simplification Rules.

h. Miscellaneous

This Plan may disclose de-identified health information. Health information is considered de-identified if it does not identify you and there is no reasonable basis to believe the information can be used to identify you, such as your name and Social Security Number.

This Plan may disclose summary health information to the Board of Trustees or a Business Associate. Summary health information is PHI, which includes claims history and claims experience, and from which identifying information has been deleted in accordance with the Privacy Rule.

This Plan will not use and/or disclose PHI for purposes of marketing. Marketing is defined as a communication that encourages the purchase or use of a product or service, such as sending a brochure detailing the benefits of a certain medication that encourages it use or purchase. However, this Plan may use PHI without authorization in certain situations, including but not limited to sending information describing the participating providers in its provider network(s), and the benefits provided under the plan, providing information for the management of treatment, or recommending alternative treatment, providers, or health coverage.

i. Duties of the Board of Trustees With Respect to PHI

This Plan will also disclose PHI to the Board of Trustees for Plan administration purposes. The Trustees have amended this Plan and signed a certification agreeing not to use or disclose your PHI other than as permitted by the plan documents, the Privacy Rule, or as required by law. The Trustees' uses and disclosures are more fully described in this Plan's Privacy Policy Statement, Notice of Privacy Practices for Protected Health Information, and Board of Trustees' Certificate. Additional copies of these documents can be obtained from the Plan Administrator.

j. Complaints

If you wish to file a complaint with this Plan or have any questions regarding the uses or disclosures of your PHI (i.e., access, amendment or accounting of PHI), you may contact the Privacy Officer Jeff Van De Moere at the following address:

Coast Benefits, Inc.
3444 Camino Del Rio North, Suite 101
San Diego, CA 92108
(619) 280-2009 and (800) 886-7559

A complaint may also be filed with the HHS or its OCR, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, DC 20201.

All complaints must be in writing and filed within 180 days of the date you knew or should have known of the violation. This time limit can be waived if good cause is shown. This Plan will not retaliate against you for filing a complaint.

k. Security Standards Under HIPAA

The Board of Trustees will implement reasonable and appropriate safeguards to protect the confidentiality, integrity, and availability of electronic protected health information that the Fund creates, receives, maintains, or transmits on behalf of the Plan. The Trustees will ensure that the adequate separation required by the Privacy Rule is supported by reasonable and appropriate security measures. The Trustees will ensure that any agent, including a sub-contractor, to whom it provides electronic protected health information, agrees to implement appropriate safeguards to protect the information. The Trustees will report to the Plan any security incident of which it becomes aware.

10. Continuing Coverage (USERRA).

If you experience a leave of absence from your employment to perform service in the uniformed services, the Uniformed Services Employment and Reemployment Rights Act ("USERRA") provides you with rights to elect to continue your coverage under the Plan that is separate from and in addition to COBRA continuation coverage rights. Uniformed services - means the Armed Forces, and the Army National Guard, when you are engaged in active duty or training, or inactive duty training. Uniformed services also includes full-time National Guard duty, the commissioned corps of the Public Health Service, and any other persons designated by the President in a time of war or national emergency. Service in the uniformed services means voluntary or involuntary duty, active duty, and inactive duty for training. It also includes periods away from work for an examination to determine fitness to perform duty.

If you are a Participating Employee, you have a right to elect continuation coverage under USERRA for yourself and your covered dependents if you would otherwise lose coverage under the Plan because of service in the uniformed services. Unlike under COBRA, your dependents do not have an independent right to elect USERRA continuation coverage.

Under USERRA, you may elect to continue coverage under the Plan up to the lesser of (a) 24 months or (b) the date you return or should have returned to active employment, or, if applicable, applied for reemployment. Unlike COBRA, there are no additional qualifying events that would entitle you to extend the period of continuation coverage beyond the 24-month period. In addition, there is no entitlement under USERRA for any extension based on your disability or the disability

of a qualified beneficiary. USERRA continuation coverage is identical to coverage provided under the Plan to similarly situated individuals.

USERRA continuation coverage is similar to COBRA continuation coverage, but it is not identical, and there are important differences. If you elect both USERRA and COBRA continuation coverage, they will run concurrently. If you elect continuation coverage under both federal laws, you will be provided with the coverage that is most favorable to you. For example, if your COBRA continuation coverage terminates at the end of an 18-month period, you may continue to receive continuation coverage under USERRA up to a total of 24 months. Similarly, if your COBRA continuation coverage terminates before the maximum period because you become covered under another employer's plan, you may continue USERRA continuation coverage up to a total of 24 months.

USERRA continuation coverage terminates when any one of the following events occurs:

(a) The date on which you fail to return from military service to active employment or apply, if applicable, for reemployment as required under USERRA;

(b) The end of the maximum 24-month period, beginning on the date on which your military leave of absence began;

(c) You fail to make a timely payment for your continuation coverage;

(d) The date on which you are discharged from military service under other than honorable conditions, or under conditions that prohibit your reinstatement under USERRA; or

(e) The Participating Employer no longer provides group health coverage to any employees.

To qualify for USERRA continuation coverage, you must provide your employer with advanced notice of your military service, as required under USERRA. You will receive a notice from the Plan Administrator regarding USERRA continuation coverage and an Election Form. Like COBRA, you must elect USERRA continuation coverage by returning the election form to the Plan Administrator within the 60-day period identified in the election form. If you fail to return the election form during this time period, you will lose the right to continuation coverage under USERRA. There are limited exceptions when it would be unreasonable or impossible under the circumstances to provide a timely notice, such as military emergency.

Like under COBRA, you must pay the entire cost of continuation coverage under USERRA for your coverage and coverage for any dependents. In addition, you will be required to pay a 2 percent administration fee along with each premium

payment. The costs of continuation coverage will be identified in the Election Form provided to you by the Plan Administrator. Like COBRA continuation coverage, your initial premium payment(s) must be made within 45 days of your electing USERRA continuation coverage. Subsequent payments must be made on a monthly basis. You will be provided a grace period of 30 days after the first day of the coverage period to make each monthly payment. Failure to pay premium costs before the end of the grace period will result in the loss of continuation coverage.

If your coverage under the Plan is terminated as a result of your service in the uniformed services, your coverage will be reinstated upon your return to active employment under the requirements of USERRA. Your coverage will be reinstated without any preexisting condition exclusions or waiting periods, unless you have an injury or illness incurred during your military service.

Questions concerning your rights to USERRA continuation coverage should be addressed to the Plan Administrator. For more information on your rights under USERRA, contact the nearest office of the Department of Labor Veterans' Employment and Training Service ("VETS") or access the VETS website at www.dol.gov/vets.

In order to protect your and your dependents' rights under USERRA, you should keep the Plan administrator informed of any changes in your or the addresses of family members. You should also keep a copy, for your records, of any notices or form that you send to the Plan Administrator.

11. Restrictions on Lifetime Limits for Coverage of Benefits.

There is no lifetime or annual limits on the dollar value of medical benefits under the Plan.

12. Patient Protection Disclosure.

Under the Affordable Care Act the Plan provides the following additional patient protections:

The Plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the health insurance issuer designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the Plan or health insurance issuer or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be

required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator.