Furniture and Industrial Carpenters Health Trust

General Information Booklet

SUMMARY PLAN DESCRIPTION OF
ELIGIBILITY AND BENEFITS

Revised January 1, 2017

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TRUST ADMINISTRATIVE OFFICE:

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Foreword

This Summary Plan Description has been prepared to give you basic information concerning the benefits available to you through the Furniture and Industrial Carpenters Health Trust. Summarized in this booklet are eligibility requirements, which you must satisfy in order to qualify for benefits, the benefit plans themselves, and the procedures for review or appeal of claims. The booklet also provides information about the administration of the Plan and your rights under the law.

Detailed information about the life and accidental death and dismemberment benefits (provided through Prudential Life Insurance Company) are contained in this booklet. This booklet also contains a summary of the medical, dental and vision benefits provided through contracts between the Board of Trustees, Kaiser Permanente, Prudential, Delta Dental of California, Safeguard Dental (*a MetLife Company)* and Vision Service Plan. The provisions of these benefit plans are described in separate booklets prepared by each provider.

This booklet is being given general distribution to be certain everyone who is entitled to receive a copy does so. Because of this, you may receive a Summary Plan Description booklet whether or not you are currently eligible for benefits.

You are cautioned that no Employer or Union, nor any representative of any Employer or Union, is authorized to interpret the various Insurance policies, agreements, or the coverages provided by these documents, nor can any such person act as an agent of the Trustees in any matter relating to these contracts, agreements, or coverages. The Trustees are charged with the responsibility of interpreting the provisions of the Plan and of establishing rules and regulations to assist in the administration of the Plan. They are also responsible for determining the Plan's schedule of benefits and rule on appeals by participants with respect to benefit denials.

Accordingly, any questions you may have pertaining to your participation in the Furniture and Industrial Carpenters Health Trust summarized in this booklet should be directed to the Trust Administrative Office and are subject to final interpretation by the Trustees. Any questions regarding the specific benefits summarized in this booklet should be directed to the appropriate provider and are subject to final interpretation by each provider. A list of the providers is contained on page 36.

REMEMBER, the benefits described in this booklet are only summaries of the plans offered. If there is a conflict between these summaries and the coverage described in the Evidence of Coverage document prepared by each provider, the provisions of the Evidence of Coverage document will govern.

Though the Plan is intended to continue, it can be changed or terminated at any time in the sole discretion of the Board of Trustees.

Important Phone Numbers

Prudential Insurance Company **National Service Center**	**888-598-5671**
Kaiser Permanente Health Plan **Member Services – Northern California**	**800-464-4000**
Delta Dental of California	**800-765-6003**
Safeguard Dental (*a MetLife Company)*	**800-275-4638**
Vision Service Plan	**800-877-7195**
Trust Administrative Office	**925-208-9997**

Relationship Between Plan And Healthcare Providers

No healthcare provider is an agent or representative of the Plan. The Plan does not control or direct the provision of healthcare services and/or supplies to employees and beneficiaries by anyone. The Plan makes no representation or guarantee of any kind concerning the skills or competency of any healthcare provider. The Plan makes no representation or guarantee of any kind that any provider will furnish healthcare services or supplies that are malpractice free.

The foregoing statement applies to any and all healthcare providers and all entities (and their agents, employees, and representatives) which contract with the Plan to offer other health-related services or supplies to employees and beneficiaries, including, but not limited to, Kaiser Permanente, Delta Dental of California, Safeguard Dental (*a MetLife Company)*, Prudential, and Vision Service Plan.

Eligibility

Eligibility for individual participants shall be determined according to the provisions of the Collective Bargaining Agreements between the various Unions and Employers participating in the Trust. The Trustees are empowered to create and enforce the rules pertaining to individual eligibility. The Trustees, in exercising their responsibilities, reserve the right to modify the eligibility requirements without prior notice.

Employees

Initial Eligibility for Coverage under the Plan begins on the first day of the month following the month during which contributions are required to be paid on your behalf for **87 hours** or more in the previous month.

Continuing Eligibility is provided if contributions are required to be paid on your behalf for 87 hours or more in the previous month for a Participating Employer, and the Participating Employer pays the required contributions to the Plan on your behalf in the month following the month in which you worked.

If you work less than 87 hours for a Participating Employer and no contributions are paid by the Participating Employer on your behalf for a period exceeding six consecutive months, you will be subject to the Initial Eligibility requirements in order to regain eligibility.

Eligibility for coverage under the Industrial Carpenters Plan for Non-Bargaining unit Employees – Initial eligibility and continuing coverage rules for non-bargaining unit Employees are the same as for those bargaining unit Employees of the same Employer.

Enrollment of Benefits

When you are hired, your Employer will notify the Trust Administrative Office to furnish you with an enrollment form so you can indicate your choice of medical and dental plan (**see page 14 of this booklet concerning** "Choice of Medical and Dental Plans").

You cannot be properly enrolled for benefits until the Trust Administrative Office receives the necessary completed selection card and the appropriate HMO enrollment form. Therefore, if your Employer cannot provide the enrollment package, contact the Trust Administrative Office immediately.

Termination of Participant Eligibility

Your coverage will terminate on the earliest of the following dates:

1. Termination of Employment

    a) If you work 87 hours or more during the month your employment ends, eligibility for coverage under the Plan will end on the last day of the month following the month your employment ends, and the Participating Employer will pay to the Plan the required contributions to the Plan on your behalf.

    b) If you work less than 87 hours during the month and your employment ends, eligibility for coverage under the Plan will end on the last day of that month.

2. Military Service: The date you enter into full-time military service; or

3. The date coverage for which you are eligible is eliminated from the Plan.

Military Leave of Absence

If you are on a military leave of absence from your employment and the period of military leave is less than thirty-one (31) days, you will continue eligibility for coverage under this Plan during the thirty-one day leave with no self-payments required, provided you are in an eligible status under this Plan at the time your military leave begins.

If you are on a military leave of absence from your employment and the period of military leave is longer than thirty-one (31) days, you may continue to be eligible for coverage under the Plan for up to 24 months under the COBRA continuation coverage provision, provided you pay the applicable COBRA premium.

Dependents

Once an Employee qualifies for eligibility (initial and continuing eligibility), eligible Dependents are entitled to the benefits provided by the Plan, as long as the Employee remains eligible. Eligible Dependents will be covered under the same medical, prescription drug, dental and vision plans selected by the Eligible Employee.

Enrollment for Benefits

All eligible Dependents must be enrolled, including newly-acquired Dependents (such as newborn children). Services and reimbursement can be delayed or denied to Dependents who are not properly enrolled. You may obtain the necessary forms to enroll newly acquired Dependents from your Employer or the Trust Administrative Office.

Eligible Dependents

As defined below, your Dependents will become eligible for medical, prescription drug, dental and vision benefits at the same time that you become eligible. The term "Dependent" includes:

1. your legal spouse; and

2. your Dependent children, including adopted children, stepchildren and children of your domestic partner under 26 years of age.

3. any unmarried Dependent child who is 26 years of age or older, but is incapable of self-support because of physical handicap or mental incapacity that commenced: 1) prior to the child's 26th birthday and 2) while the child was insured under this group Plan provided the child was insured on the date of termination of the prior plan. A physician's certificate of such incapacity must be submitted to the Trust Administrative Office within 31 days following the child's 26th birthday.

4. If you did not enroll yourself or your Dependent in this plan when you were first eligible, you are also allowed to enroll yourself or your Dependent, pursuant to the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), provided that you request enrollment within 60 days after the occurrence of either of the following:

    a) You or your Dependent is covered under a Title XIX Medicaid plan or under a Title XXI State child health plan and coverage of you or your Dependent under such a plan is terminated as a result of the loss of eligibility for such coverage or;

    b) You or your Dependent become eligible for CHIPRA assistance with the cost of participating in this Plan.

Dependents in military service or those who live outside of the United States or Canada are not covered.

Self-Payment For Employees of Delinquent Employers

If you work sufficient hours to be eligible for coverage, however, your Employer has not paid its required contributions, your coverage can be established for a period of three (3) months if you make the required self-payment. The self-payment rate may be changed from time to time by the Board of Trustees. Self-payments must be continuous. If you fail to make your timely self-payment, your coverage will terminate on the last day of the month for which coverage is lost. A grace period of 20 days is allowed for receipt of payment. If you make a delinquent Employer self-payment and the Plan subsequently collects the delinquent Employer's contributions, you will receive a refund of the self-payments that you have made.

Domestic Partner

The Trust will provide registered domestic partners with the same benefits that spouses receive. The program is open to both opposite sex and same sex registered domestic partnerships. To be eligible for benefits, you and your domestic partner must provide the Trust Administrative Office a signed, notarized Declaration of Domestic Partnership (available from the Trust Administrative Office) certifying that:

a) Neither partner has had a different domestic partner less than six months before they signed the Declaration of Domestic Partnership (unless you had a partner who died).

b) Neither partner is related to the other;

c) You and your domestic partner have assumed mutual obligations for the welfare and support of each other; and

d) You and your domestic partner live together.

If you and your domestic partner are living in a city or county providing for such registration, and have registered as domestic partners, you may provide the Trust Administrative Office with a copy of the Certificate of Domestic Partnership instead of the Declaration of Domestic Partnership.

The children of an Employee's domestic partner will be eligible for health coverage under the same conditions as the children of active Employees or their spouses. Upon dissolution of the domestic partner relationship, the former partner and any covered Dependents will be eligible for COBRA continuation coverage.

If you elect to participate in the domestic partner benefit program and cover your domestic partner under the Furniture and Industrial Carpenters Health Trust, the cost of the coverage is taxable income to you unless your domestic partner qualifies as your Dependent in accordance with Section 152 of the Internal Revenue Code. To qualify as a Dependent under Section 152, your domestic partner must receive over half of his or her support from you, reside in your principal residence for the taxable year, and be a Member of your household. If your domestic partner qualifies as your Dependent, the Plan will require that you annually submit a copy of your personal income tax return (Form 1040) to the Trust Administrative Office.

If your domestic partner does not qualify as a Dependent in accordance with Section 152 of the Internal Revenue Code, your Employer must include the Fair Market Value of the medical coverage in your gross income as wages for income and employment tax purposes. The Fair Market Value of a fringe benefit is the amount that an individual would have to pay for the particular fringe benefit in an arm's length transaction. Under the Trust, this amount will be the difference between the cost for an individual Employee and the cost for an Employee with additional covered persons. Your Employer will report the Fair Market Value of your domestic partner's coverage to the IRS each year as additional income to you. Your Employer will include the value of the coverage as taxable income to you and include it in your wages for employment tax purposes.

Termination of Dependent Eligibility

Dependent eligibility will terminate upon the earlier of the following dates:

a) When the Employee ceases to be eligible; or

b) The date the Dependent no longer qualifies as an eligible Dependent;

c) The date the Dependent enters into full-time military service; or

d) The date the Trustees terminate coverage for Dependents.

Qualified Medical Child Support Order

Under the Omnibus Budget Reconciliation Act of 1993, the Plan must recognize any Qualified Medical Child Support Order and enroll as directed by the Order any child of a Plan participant. A Qualified Medical Child Support Order is any judgment, decree, or order (including approval of a settlement agreement) issued by a court which provides the child of a Plan participant with health benefits under the Plan. It also enforces a state law relating to medical child support pursuant to Section 1908 of the Social Security Act, which provides in part that if the employee's parent does not enroll the child, the non-employee parent or State agency may enroll the child.

To qualify, a Medical Child Support Order must clearly specify:

a) The name and last known mailing address of the participant and the name and mailing address of each child covered by the order;

b) A reasonable description of the type of coverage to be provided by the Plan to each such child, or the manner in which such type of coverage is to be determined;

c) The period to which each order applies and each plan to which such order applies.

A Medical Child Support Order will not qualify if it would require the Plan to provide any type or form of benefit or any option not otherwise provided under the Plan, except to the extent necessary to comply with Section 1908 of the Social Security Act.

If you are required by a Qualified Medical Child Support order, as defined by ERISA, to enroll under this Plan, the Plan shall permit your child to enroll without regard to any eligibility requirements or limits and shall provide the benefits of this Plan in accordance with the applicable requirements of such order. The Plan shall provide coverage and any benefits for which the child is eligible directly to the child through the child's custodial parent or legal guardian. The Plan shall make information available to the child, custodial parent, or legal guardian on how to obtain benefits under this Plan directly.

Adopted Children

The Plan shall provide benefits to children placed with you for adoption under the same terms and conditions as in the case of Dependent children who are natural children, irrespective of whether the adoption has become final. Coverage may not be restricted solely on the basis of a pre-existing condition of the child at the time that such child would otherwise become eligible for coverage under the Plan, if the adoption or placement for adoption occurs while you are eligible for coverage under the Plan.

For purposes of this provision only, **"**Adopted Child" means a child in the home for adoption purposes and "Adoption Placement" means the assumption and retention by a Plan participant of a legal obligation for total or partial support of such child in anticipation of adoption. The child's "placement" terminates upon the termination of such legal obligation.

Family And Medical Leave Act (FMLA)

The Family and Medical Leave Act 1993 (FMLA**)** requires some Employers to give their employees up to twelve weeks of unpaid leave during any twelve-month period for certain family and medical reasons. During FMLA leave, you may continue coverage for medical, prescription drug, dental and vision benefits under the Plan provided that your contributing Employer continues to pay the required contributions for you and you continue to pay any required Employee contributions.

As of January 16, 2009, the National Defense Authorization Act for 2008 created two new forms of FMLA leave related to a family Member's military service:

Leave to Care for Service Member – An Employee may take up to 26 weeks during one twelve-month period, if his/her parent, spouse, son or daughter (any age) or "next of kin" has suffered a serious Injury or illness in the line of active duty and is undergoing medical treatment, recuperation or therapy, or is in outpatient status or on the "temporary disability retirement list." The term "next of kin" is defined as the nearest blood relative (other than parent, spouse, son or daughter).

Qualifying Exigency Leave – An Employee whose parent, spouse, son or daughter (any age) is on active-duty status or on call to active-duty status in support of a U.S. military "contingency operation" may take FMLA leave due to "qualifying exigencies." This form of leave is only available if the family Member is called to active duty as a Member of the U.S. Reserve or National Guard, or as a retired regular Member of the U.S. Armed Forces. The new rule defines "qualifying exigencies" as: (1) short-notice deployment; (2) military events and related activities; (3) childcare and school activities; (4) financial and legal arrangements; (5) counseling; (6) rest and recuperation; (7) post-deployment activities; and (8) additional activities where the Employer and Employee agree to the leave.

Whether you are entitled to FMLA leave is determined by your Employer and your Union, not by the Plan. If you are not receiving paychecks while on FMLA leave, you must make arrangements with your contributing Employer and/or Union to ensure that contributions to the Plan are made on your behalf. If contributions are late by 30 days or more, your coverage may be cancelled until you return to work.

When you return to work your benefits will be reinstated as though you had not taken leave. If you do not return to work after taking FMLA leave:

a) Your coverage will end on the date you give notice that you are not returning to work;

b) You may be required to repay your Employer the cost of the coverage you had while on leave (unless you do not return to work because of a serious medical condition beyond your control); and

c) You may be eligible for COBRA (explained on page 8).

FMLA leave will not cause you to lose any accumulated benefits – For more information on your Employer's and Union's FMLA and other leave policies, please call your Employer or your Union.

COBRA Continuation of Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) (effective January 1, 1987), requires employers sponsoring group health plans to give certain categories of employees and beneficiaries an opportunity to elect continued coverage after an event which might otherwise result in their loss of coverage.

You and your eligible Dependent(s) have the right to continue your medical coverage (prescription drug, dental or vision coverage, if applicable) under this Plan on a self-pay basis if coverage would otherwise terminate due to a Qualifying Event. See the COBRA continuation period section for a description.

"Qualifying Event" means one of the following occurrences which would otherwise terminate your, or your Dependents, coverage in the absence of this provision.

a) Your employment is terminated, for reason other than gross misconduct;

b) Your work hours are reduced;

c) Your retirement;

d) Your death;

e) Your entitlement to Medicare after the Qualifying Event;

f) Your divorce or legal separation or dissolution of a domestic partnership; or

g) With respect to your Dependent child, he or she ceases to satisfy the Plan's definition of an eligible Dependent.

Qualified Beneficiary

A Qualified Beneficiary as defined under COBRA is an individual who loses coverage under any of the above referenced Qualifying Events. A child born to or placed for adoption with a Qualified Beneficiary during a period of COBRA continuation coverage is a Qualified Beneficiary.

Election Period

You and/or your Dependent(s) may elect to continue coverage within (sixty) 60 days of the later of:

a) The date you or your Dependents would otherwise lose coverage due to the Qualifying Event; or

b) The date of the notice from the Administrative Office notifying you of your right to elect COBRA continuation coverage.

It is your, or your Dependents responsibility to notify the Trust Administrative Office of any of the following Qualifying Events:

a) Your divorce or legal separation or dissolution of a domestic partnership; or

b) Your Dependent child ceases to be an eligible Dependent.

You or your Dependents must provide such notification within (sixty) 60 days after the later of:

a) The date of the Qualifying Events; or

b) The date your Dependent would otherwise lose coverage due to the Qualifying Event.

Such election must be in writing on a form provided by the Trust Administrative Office. Elected benefits will be continued provided:

a) The election form is duly completed and returned to the Trust Administrative Office within the 60-day period noted above; and

b) The required self-payment is paid to the Trust Administrative Office within 45 days of election and is subsequently remitted to the Trust Fund on your, or your Dependent's, behalf.

COBRA Continuation Period

Coverage may continue, on a self-pay basis, as follows:

1. Coverage for you and/or your Dependent(s) may be continued for up to 18 months*, if coverage is terminated due to:

   a) Termination of employment (other than for gross misconduct in which case no COBRA is available);

   b) Reduced work hours, except in the case of the employer's filing a bankruptcy proceeding under Title 11 of the United States Bankruptcy Code; or

   c) Retirement.

**The 18-month period of continuation may be extended an additional 11 months if your employment ends due to your termination of employment, retirement, or reduction in hours, and at that time or within 60 days of the event, you or one of your Dependents is Totally Disabled (as determined by social security), coverage may continue for an additional 11 months, for a total of 29 months. To continue coverage for an additional 11 months, you must notify the Trust Administrative Office of your determination of disability by the Social Security Administration. You must notify the Trust Administrative Office within 60 days of the date the determination was received and before the 18-month COBRA continuation period ends.*

2. Coverage for your Dependent(s) may be continued for up to 36 months, if coverage terminated due to:

   a) Your death;

   b) Divorce or legal separation or dissolution of a domestic partnership; or

c) With respect to your Dependent child, he or she no longer satisfies the Plan's definition of an eligible Dependent.

3. If an active participant loses coverage due to the Qualifying Event after the active participant has become entitled to Medicare, the Dependents of the active participant will be allowed to receive COBRA continuation coverage until the later of:

   a) 18 months from the date of the Qualifying Event; or

   b) 36 months from the date the active participant become entitled to Medicare.

4. Notwithstanding the maximum duration of coverage described in the above paragraphs, a Qualified Beneficiary's COBRA continuation coverage will end on the earlier of the date on which:

   a) The Employer of the active participant ceases to provide group health coverage to any participant;

   b) The self-payment is not timely paid;

   c) The Qualified Beneficiary becomes covered under any other group plan after the Qualifying Event (as an Employee or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition of the beneficiary;

   d) The Qualified Beneficiary becomes entitled to Medicare coverage after the Qualifying Event; or

   e) The participant or Dependent has continued coverage for additional months due to a disability and there has been a final determination by social security that the individual is no longer disabled.

If your Dependent's coverage is continued for reasons listed under item 1 of this section and during the initial continuation period, a Qualifying Event occurs which entitles the Dependent to continue coverage under item 2 of this section; your Dependent may elect to continue coverage up to a combined maximum of 36 months.

You and/or your Dependent(s) who elect to continue coverage, shall be solely responsible for the self-payment of the premium for such continued coverage. If an election is made after the Qualifying Event, a self-payment for COBRA continuation coverage during the period preceding the election must be made within forty-five (45) days of the date of the election. Thereafter, the self-payment must be paid in timely monthly installments.

Types of Benefits Provided

A Qualified Beneficiary will be provided health coverage under these rules and regulations which, as of the time the health coverage is being provided, is identical to the health coverage that is provided to similarly situated Beneficiaries with respect to whom a Qualifying Event has not occurred. A Qualified Beneficiary will have the option of taking "Core Coverage" only instead of full coverage. "Core Coverage" refers to the health benefits the Qualified Beneficiary was receiving immediately before the Qualifying Event, excluding dental, vision and life Insurance benefits.

COBRA Self-payment

A self-payment for COBRA continuation coverage will be charged to Qualified Beneficiaries in amounts established by the Board of Trustees in accordance with federal regulations. This self-payment will be payable in monthly installments.

Any self-payment due for coverage during the period before the election was made must be received by the Trust Administrative Office within forty-five (45) days of the date the Qualified Beneficiary elects COBRA continuation coverage.

Thereafter, a monthly self-payment must be received by the Trust Administrative Office no later than the 30th day of the month for which COBRA continuation coverage is elected. Notwithstanding the previous sentence, the Board of Trustees may, for good cause shown, extend the self-payment due date.

Notice Requirement

If the Qualifying Event is a divorce, legal separation or dissolution of a domestic partnership, or a child losing Dependent status, the Employee or Qualified Beneficiary must notify the Trust Administrative Office in writing of the Qualifying Event no later than sixty (60) days after the later of the date of the Qualifying Event or the date the Qualified Beneficiary loses coverage. If the Qualifying Event is the death of the active Employee, the Employer shall notify the Trust Administrative Office in writing of the Qualifying Event within 30 days after the Qualifying Event. If the Qualifying Event is a reduction in hours, the determination that an active Employee's Employer(s) has reported less than the minimum required hours on the active Employee's behalf will be made by the Trust Administrative Office. No later than 14 days after the date on which the Trust Administrative Office receives this written notification, the Trust Administrative Office will notify in writing the Qualified Beneficiary affected by the Qualifying Event of his rights to COBRA continuation coverage.

Notwithstanding the immediately preceding paragraph, the Trust Administrative Office's written notification to a Qualified Beneficiary who is a Dependent spouse or domestic partner will be treated as notification to all other Qualified Beneficiaries residing with that person at the time the notification is made.

The American Recovery and Reinvestment Act of 2009 (ARRA) signed by the President on February 17, 2009, includes significant changes to the COBRA continuation coverage rules. In general, these changes provide a new COBRA election opportunity and a federal government subsidy of COBRA continuation coverage costs for a maximum of fifteen (15) months for certain individuals who are COBRA qualified beneficiaries because of a covered Employee's termination of employment on or after September 1, 2008, and before May 31, 2010.

If you believe you have experienced an involuntary termination of employment and would like more information, please contact the Trust Administrative Office.

Addition of New Dependents

If, while a participant is enrolled for COBRA continuation coverage, the participant marries, enters into a registered domestic partnership, has a newborn child or has a child placed with the

participant, the participant may enroll that spouse, domestic partner or child for coverage for the balance of the period of COBRA continuation coverage, by doing so within thirty (30) days after the birth, marriage or placement. Adding a child or spouse, or domestic partner may cause an increase in the amount that must be paid for COBRA continuation coverage.

Qualified Beneficiary

A participant can add a new spouse, domestic partner or child to his or her COBRA continuation coverage, but the only newly added family Members who have the rights of a qualified beneficiary, such as the right to stay on COBRA continuation coverage longer in certain circumstances, are natural or adopted children.

Termination of Coverage

The continued coverage will cease on the first of the following dates:

a) The date the Plan terminates;

b) The date a required self-payment is due and unpaid at the end of any applicable grace period;

c) The date you and/or your Dependent(s) become insured under another group health plan after the date of election. This may not apply if you or your Dependents have a pre-existing condition not covered by the new plan. Contact the Trust Administrative Office for additional information when you or your Dependents become insured under another plan;

d) The date you or your Dependents become eligible for Medicare. This does not apply in a situation where the Qualifying Event is the employer's bankruptcy proceeding under Title 11 of the United States Bankruptcy Code;

e) The date of a retired person's death;

f) The date the applicable period of COBRA continuation coverage is exhausted; or

g) The 31st day after you or your Dependents receive a final determination from social security that you are no longer disabled in situations where the Qualifying Event was termination of employment or reduction in hours, and COBRA continuation coverage was being continued for an additional 11 months.

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA), effective July 1, 1997, requires this plan to furnish you with the following information.

The primary purpose of HIPAA is to help families minimize the impact of pre-existing condition exclusions as they move from job to job. A pre-existing condition exclusion means a medical plan may not cover certain illnesses (for example, a heart condition) until an individual is covered under the plan for a designated period of time – typically, six to twelve months.

Other HIPAA Information

HIPAA requires that plan participants be notified of material reductions in health plan coverage within sixty (60) days of the change. This plan will provide notice of such changes to plan participants not less than sixty (60) days prior to the effective date of such changes.

Certain benefit plans under this health plan have benefits guaranteed under a contract or policy of Insurance between the Board of Trustees and the benefit provider.

Each of these providers maintains an appeals procedure. This appeals procedure is explained in the Evidence of Coverage document provided by each benefit provider. An example of an appeal under an HMO may be where you received emergency care outside of the HMO and the claim was denied by the HMO because they did not deem it an emergency. You can contact the benefit provider directly for information on the appeals procedure. Of course, the Trust Administrative Office will assist you if you have questions or need information.

You can contact the United States Department of Labor for assistance on your rights as provided by the Health Insurance Portability and Accountability Act. Following is their address:

United States Department of Labor
Pension and Welfare Benefits Administrator
1055 E. Colorado Boulevard, Suite 200
Pasadena, California 91106

Choice of Medical and Dental Plans

As a new Employee, when you become eligible for coverage for the first time, you must complete an enrollment form designating Kaiser Permanente as your Health Maintenance Organization (HMO) provider. A dental option will also be offered at that time and your dental choice (Delta Dental or Safeguard Dental) should be specified if offered through your Participating Employer under your Collective Bargaining Agreement. **These are described in separate booklets called Evidence of Coverage and can be obtained by contacting the Trust Administrative Office.** It is important you understand the benefits provided under the medical and dental plans before you make your selection and complete the necessary enrollment forms.

Your dental plan selection is made by enrollment in a plan of your choice. You must complete the appropriate enrollment form in full.

It is important you send the completed enrollment form to the Trust Administrative Office. Services can be delayed or denied unless you have made your selection in writing, and all the required information has been correctly filled in. The Evidence of Coverage booklet for each plan contains the insuring provisions, including applicable limitations and exclusions for each program. If you have any questions regarding your Plan coverage, please contact the Trust Administrative Office before incurring any expenses.

Kaiser Permanente – Under the Kaiser Permanente HMO plan, you and your eligible Dependents will be provided hospital and medical care under an agreement with Kaiser Permanente. Under this plan, you are required to use the medical clinics, hospitals and doctors, which are part of the Kaiser Permanente Health Plan. To be eligible to enroll, you **MUST** live within a Kaiser Permanente service area (as described in the Kaiser Permanente Evidence of Coverage Booklet).

Delta Dental of California – If you select Delta Dental for your PPO dental plan, you and your eligible Dependents may visit a licensed dentist of your choice in California either in-network or out-of-network under the dental preferred option plans, which offers optional levels of benefit coverage.

Safeguard Dental (*a MetLife Company)* – If you select Safeguard Dental for your prepaid dental plan, you and your eligible Dependents will select a general dentist from a managed care dental network of dentists to provide your primary dental care.

Although the programs cover the most commonly needed services, some services are not covered. **For specific benefit information, please contact the Trust Administrative Office for an Evidence of Coverage booklet containing full benefit descriptions, coverage, limitations and exclusions of the various medical and dental benefit programs.**

You may change your dentist every month by contacting Safeguard Dental. This plan has no calendar year maximum or co-insurance; you have co-payments based on the procedure and schedule of benefits.

Vision Plan – Vision Service Plan

When you and your Dependents are eligible for medical benefits from the Plan, you are also eligible for vision care benefits through the Plan's vision care provider, Vision Service Plan. This is a summary, so please contact the vision care provider for complete details of your vision benefits.

What Is a Vision Care Provider – The vision care plan provides a network of over 39,000 doctors to provide professional vision care for you and your Dependents. This concept assures the finest quality professional care and materials at a uniform cost.

How Does the Vision Benefits Plan Work

When you select a doctor from the vision care provider's network list (network doctor), the Plan will cover the vision care described below at no expense to you except for a copayment for exams and for prescription glasses. Any additional care, service and/or material not covered by this Plan may be arranged between you and the doctor.

Selecting a network doctor assures direct payment to the doctor and a guarantee of quality and cost control. However, if you seek the services of a doctor who is not a network doctor, you must pay the doctor his full fee. You will be reimbursed in accordance with the reimbursement schedule. There is no assurance that the schedule will be sufficient to pay for the examination or the glasses. Reimbursement benefits are not assignable.

NOTE: When you obtain service from a doctor who is not a network doctor, and/or obtain glasses from a dispensing optician, be sure to call the vision care provider first, and send your itemized statement of charges to the vision care provider listed in the back of this booklet. Your claim must be submitted within six (6) months of services.

Changing Plans – Open Enrollment

You may elect to change your medical and/or dental plan once in any twelve month period. Changes are effective the first day of the second month following your election. Once you have made a change, you may not change your medical and/or dental plan for another twelve months.

Contact the Trust Administrative Office for information regarding the dental plans available, including brochures which describe the dental benefits provided by Delta Dental of California and Safeguard Dental (a MetLife Company).

Life and Accidental Death and Dismemberment Benefits

Enrollment for Benefits and Beneficiary Designation

In order to enroll for life Insurance coverage, you must complete an enrollment form which may be obtained from the Trust Administrative Office.

The enrollment form will have a space for you to name your beneficiaries. If you die, benefits are payable to the beneficiary you have selected. You may change your beneficiary at any time. Any change in a designated beneficiary must be filed in writing with the Trust Administrative Office. The enrollment form may be obtained from the Trust Administrative Office.

Schedule of Life Insurance And AD&D Benefits

Prudential Insurance Company underwrites the Life and AD&D Insurance based on the schedule shown below (hereby known as the Company).

Non-Contributory Life Insurance and AD&D

Actives **Life & AD&D**	**Dependents** **Life Only**
$10,000	$1,000 for spouse or domestic partner $ 500 for child Dependent $ 100 for child infant (less than six months)

Life Insurance

The amount of your life Insurance shown in the Schedule of Life Insurance and AD&D Benefits will be payable to your beneficiary if you die while insured. Payment will be made after the Trust Administrative Office receives written proof of claim satisfactory to the Company at its Home Office. This amount is payable in a single sum unless you choose to have it paid in installments. If you do not choose a method of payment, your beneficiary may do so after your death. This choice must be made in a written notice sent to, and accepted by the Company. You may change your beneficiary at any time (See Beneficiary). You may assign this Insurance.

Right to Convert

If all, or any part, of your life Insurance terminates while this group policy is in force because: (1) you are no longer employed; or (2) you are transferred to a class of Members that is not insured for life Insurance by this group policy; or (3) your Waiver of Premium benefit terminates; or (4) the amount of your life Insurance is reduced as otherwise provided in this group policy; then you may convert any amount of this terminated Insurance to an individual policy.

If you have been continuously insured for at least five years immediately preceding the date your life Insurance terminates because this group policy is: (1) cancelled; or (2) changed and no

longer provides you with life Insurance, you may convert some of this terminated Insurance to an individual policy. There is a limit on the amount you may convert. You may convert the smaller of: (1) the amount of this terminated Insurance, less the amount of any group life Insurance you may be eligible for within 31 days after this Insurance terminates; or (2) $10,000. This provision also applies at the time of termination of the Waiver of Premium benefit to individuals: (1) who were receiving the Waiver of Premium benefit at the time of termination of this group policy; and (2) for whom the Waiver of Premium benefit subsequently terminates.

The individual policy will be a policy customarily issued by the Company at the time of conversion. It will not provide:

1. term Insurance;
2. accidental death and dismemberment, or loss of sight benefits;
3. disability benefits; or
4. any other supplemental benefits.

To get an individual conversion policy, you must apply for it. You must apply using the proper forms. You may get these forms by asking the Trust Administrative Office or the Insurance Company (Company). The completed forms and the first premium must be received by the Company at its Home Office within 31 days after your life Insurance terminates. You cannot get this policy by applying later. The Company will not ask any questions about your health. If an individual policy is issued, it will take effect at the end of the 31 day conversion period. The premium for your policy will be based on your age as your nearest birthday on the conversion policy's effective date and the amount you convert.

If you die within your 31 day conversion period, the amount of life Insurance you are entitled to convert will be payable under this group policy. It is payable even if no request for conversion is made.

Waiver of Premium Benefit

If you become Totally Disabled while you are covered under this group policy, the waiver of premium benefit may apply to you. If you qualify for the waiver of premium benefit, your life Insurance will be continued without payment of premiums for as long as you continue to qualify.

If retired Members are covered under this group policy, these benefits do not apply to them.

Qualifying for Waiver of Premium Benefit

To first qualify for the waiver of premium benefit, you, or someone on your behalf, must give written proof satisfactory to the Company that you are Totally Disabled. The proof must also show that your Total Disability: (1) began before your 60th birthday; and (2) has continued for at least nine months. The Company must receive this proof at its Home Office between the ninth and twelfth months after the date you stop being Actively at Work. If the Company does not receive the proof before the end of the twelfth month, your Insurance will not be continued. If you qualify, your life Insurance is continued without payment of premiums for twelve months from the date the proof is received.

To continue to qualify for the waiver of premium benefit for an additional twelve months, you, or someone on your behalf, must give written proof satisfactory to the Company that shows you continue to be Totally Disabled. The Company must receive this proof at its Home Office between the ninth and twelfth month of each successive twelve month period. If the Company does not receive the proof before the end of the twelfth month, your Insurance will not be continued.

It is up to you, or to someone on your behalf, to send the proof to the Company on time. It is not up to the Company to ask for it or to remind you to send it.

Physician Examinations and Autopsies

The Company has the right to have a physician of its choice examine you periodically. This exam will be paid for by the Company. If you die, the Company has the right to have an autopsy performed unless it is not permitted by law.

Amount of Life Insurance Continued and Changes in that Amount

The initial amount of life Insurance continued under the waiver of premium benefit will be the amount you were insured for on the date you stopped being Actively at Work. Life Insurance continued under the waiver of premium benefit will be subject to the same reductions that would apply if you were still insured on a premium-paying basis under the plan of Insurance in force on the date you stopped being Actively at Work. The amount of your continued Insurance will also be reduced at the time of issue of any individual policy, unless the conversion policy is surrendered (without claim for benefits) to the Company at its Home Office. While your life Insurance continues under the waiver of premium benefit, changes in benefits made by the policyholder will not apply to you.

If you die before qualifying:

1. within twelve months after the date you stopped being Actively at Work; but
2. before the Company approved continuation of your Insurance under the waiver of premium benefit;

then the death benefit is payable provided:

1. you are Totally Disabled;
2. your Total Disability began before your 60th birthday;
3. you stay Totally Disabled from the date you stopped being Actively at Work until the date of your death; and
4. the Company receives written proof of claim satisfactory to the Company at its Home Office within one year after your death.

The amount of the death benefit payable will be:

1. the amount you were insured for on the date you stopped being Actively at Work;
2. subject to the same reductions that would apply while you are Actively at Work; and

3. reduced by the amount of any individual policy issued to you or benefit otherwise payable during the 31 day conversion period under the right to convert (unless surrendered without claim for benefits).

If You Convert to an Individual Policy and Also Qualify for a Waiver of Premium

If:

1. you convert to an individual policy; and
2. you are approved for the waiver of premium benefit;

the Company will refund all premiums you paid under the conversion policy if you surrender it without any claim for benefits.

If you elect to keep the conversion policy, the amount of the waiver of premium benefit will be reduced by the amount of the conversion policy.

Termination Of The Waiver Of Premium Benefit

Life Insurance continued under the waiver of premium benefit will terminate on the earliest of the following:

1. the age, if any, at which coverage would have terminated under this group policy if you had continued as a full-time active Member;
2. the date you are no longer Totally Disabled;
3. the date you refuse to have an exam; or
4. the end of any twelve month period in which the Company does not receive proof satisfactory to the Company that shows you continued to be Totally Disabled.

If your Insurance continued under Waiver of Premium terminates, you may then have the right to convert. If you:

1. return to work as a full-time active Member during your 31 day conversion period; and
2. become eligible for life Insurance under the group policy as an active Member, you will not have the right to convert.

Beneficiary

The beneficiary for any amount of: (1) life; or (2) accidental death and dismemberment Insurance payable under this group policy due to your death will be the beneficiary named by you. Your choice must be stated on the enrollment form the Company approves. The form must be filed with and recorded by the Company before the date the amount of Insurance is paid.

If you name more than one beneficiary and you do not state the share of each, they will share equally. If any named beneficiary is not living when you die, his or her share will be payable equally to the named beneficiaries who survive you, unless you have requested otherwise.

The amount of Insurance will be payable to your estate if:

1. you have not named a beneficiary; or

2. if no named beneficiary survives you.

You may change your beneficiary at any time by making a written request on a form the Company approves. The change takes effect only if it is filed with the Company. If filed, the change takes effect on the date it is recorded by the Company. The Company will honor a request for change in beneficiary only if it is recorded before any payment has been made.

If you die after your Insurance terminates and you have been issued an individual policy (see Right to Convert), payment will be made to the beneficiary you named in your application for this policy.

Assignment of Life Insurance

An absolute assignment of his or her life Insurance may be made by a Member if the Company is notified of the assignment. The assignment must be made in writing on a form the Company approves.

The assignment will take effect on the date notification is received and recorded by the Company at its Home Office.

Collateral assignments by whatever name called will not be permitted.

The Company will not be responsible for the validity of an assignment.

Postponement Of Changes In Amount Of Insurance For Members

If you are not Actively-at-Work on the date the increased Member's Insurance would take effect due to a change in your Insurance, the change will take effect on the day you return to work as a full-time active Member with the Participating Employer.

Life Insurance For Dependents

The amount of life Insurance for your Dependents is shown in the Schedule of Life Insurance. If your Dependent dies while insured, this amount will be payable as stated below.

Payment of Claim

Payment will be made to you after the Company receives written proof of claim satisfactory to the Company at its Home Office. If you are not living when payment is made, the amount will be paid in a single sum to your Dependent's estate

Right to Convert

Your Dependent spouse or domestic partner will have the right to convert (See life Insurance) if all or any part of his or her life Insurance terminates because of the following:

1. your Dependent spouse or domestic partner is no longer eligible to be insured as a Dependent;
2. you are no longer employed;
3. you are no longer a Member of a class that is eligible to insure Dependents for life Insurance;
4. this group policy terminates and your Dependent spouse or domestic partner has been insured for at least five consecutive years; or
5. this group policy is changed and no longer provides your Dependent spouse or domestic partner with life Insurance, and he or she has been insured for at least five consecutive years.

However, if your Dependent spouse or domestic partner's Insurance terminates because he or she becomes insured as a Member, your Dependent spouse or domestic partner will not have the right to convert.

Accidental Death and Dismemberment Insurance

These benefits are payable for losses that: (1) are caused by injuries you sustain in an accident that occurs while you are insured; and (2) are a direct result of the injuries, independent of all other causes.

Benefits Payable

Benefits for loss of life are payable to your beneficiary. Benefits other than for loss of life are payable to you.

Your full amount is shown as follows and is payable for loss of:

a) Life;

b) Both hands or both feet;

c) Sight of both eyes; or

d) Any two or more; one foot, one hand, sight of one eye;

e) Speech and hearing; or

f) Quadriplegia.

Your three quarter amount is shown as follows and is payable for the loss of:

a) Paraplegia.

Half of your full amount is payable for loss of:

a) One hand;

b) One foot;

c) Sight of one eye;

d) Speech;

e) Hearing; or

f) Hemiplegia.

Your one quarter amount is shown as follows and is payable for the loss of:

a) Thumb and index finger of the same hand.

Loss of hand or foot means severance of the hand or foot at or above the wrist or ankle joint. Loss of sight means total and permanent loss of sight. Loss of thumb and index finger means severance at the joint closest to the wrist.

The total amount payable for all losses resulting from injuries sustained in any one accident will not be more than the full amount of Insurance.

This benefit may not be assigned. This benefit may not be converted to an individual policy.

Exclusions

No benefits will be paid for losses caused or contributed by:

1. medical or surgical treatment of sickness, whether the loss results directly or indirectly from the treatment;
2. sickness, whether the loss results directly or indirectly from the sickness;
3. any infection. But does not include a pyogenic infection resulting from an accidental cut or wound or a bacterial infection from accidental ingestion of a contaminated substance;
4. the taking of drugs or poison or asphyxiation from the inhaling of gas, when done on a voluntary basis. (This will not apply to drugs that are taken on the advice of a physician);
5. suicide or, attempted suicide, or intentionally self-inflicted Injury, while sane or insane;
6. war or act of war. War means declared or undeclared war and includes resistance to armed aggression;
7. an accident that occurs while you are serving on full-time active duty for more than 30 days in any armed forces. But this does not include Reserve or National Guard active duty for training;
8. committing or attempting to commit a felony;
9. travel or flight in any vehicle used for aerial navigation. This includes getting in, out, on or off any such vehicle. This applies only if you are:

    a) Riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; performing as a pilot or a crew member of any aircraft; or

    b) Riding as a passenger in an aircraft owned, leased or operated by your Employer.

10. being legally intoxicated or under the influence of any narcotic unless administered or consumed on the advice of a doctor.

11. participation in these hazardous sports, scuba diving, bungee jumping, skydiving, parachuting, hang gliding, or ballooning.

The information provided by Prudential is intended to be a summary of your benefits and does not include all plan provisions, exclusions and limitations. Please refer to the Booklet-Certificate, which is made a part of the Group Contract for all plan details, including any exclusions, limitations and restrictions which may apply. If there is a discrepancy between this information and the Booklet-Certificate/Group Contract issued by The Prudential Insurance Company of America, the terms of the Group Contract will govern. Contract provisions may vary by state.

Definitions

Actively at Work means performing every duty of your job in the Participating Employer's usual place of business.

Collective Bargaining Agreement means a written agreement between the Union and an Employer that requires contributions to the Trust.

Dependent means: (1) the spouse you are legally married to or your registered domestic partner as defined on page 4; or (2) your children, including adopted children, stepchildren and children of your domestic partner from birth until their 26th birthday. It does not mean anyone who: (1) lives outside the United States or Canada; or (2) is in the armed forces of any country; or (3) has coverage under this group policy as a Member or as a child under your legal guardianship, but only if this child depends on you for support and maintenance and if the child lives with you in a parent-child relationship. The term child does not include a foster child who is eligible for benefits provided by any governmental program or law, unless such inclusion is required by the laws of this state.

The age limits that apply to Dependent children will not apply to any covered child of yours who remains dependent on you for support and maintenance because he or she becomes incapable of working:

1. due to a physical handicap or mental retardation;
2. before reaching the limiting age; and
3. while insured under

    a) This group policy; or

    b) Any prior plan provided such child was insured on the date of termination of the prior plan. Written proof satisfactory to Prudential of his or her incapacity and dependency must be furnished to Prudential at its Home Office at least 31 days prior to the Dependent reaching the limiting age.

Dependent Insurance means the coverage for the Dependents of all of the Members who are eligible to be insured.

Employee means a person who is eligible for benefits provided by the Trust Fund.

Employer or Participating Employer means an Employer who participates in the Furniture and Industrial Carpenters Health Trust and is required by a Collective Bargaining Agreement to make contributions to the Trust.

Evidence of Coverage means the booklet provided by your HMO, vision, dental or life insurance provider describing the terms and benefits of your medical, vision, dental, or life insurance plan.

Home Office means the Home Office of Prudential Insurance Company. It may also mean any other Regional Home Office, Head Office, or Executive Office that the Insurance Company designated and maintains.

Injury means an Injury to the body that is sustained accidentally.

Insurance means the coverage that is provided through the Trust.

Insured Person(s) means the Employee eligible for the life, accidental death and dismemberment benefits provided by Prudential Insurance Company.

Member means a person who is eligible for benefits provided by the Trust.

Qualifying Event means an event, which qualifies an Employee or Dependent for continuation of benefits coverage under the Consolidated Omnibus Reconciliation Act (COBRA) of 1985 Public Law 99272 and any amendments thereto.

Sickness means illness or disease. It includes pregnancy and the resulting childbirth, miscarriage, or spontaneous or involuntary abortion.

Total Disability or Totally Disabled as used in connection with all life Insurance means that due to Sickness an Insured Person is:

1. under a physician's care; and

2. completely and continuously unable to engage in any occupation or business for an income or profit.

Trust or Plan means the Furniture and Industrial Carpenters Health Trust.

Union means the Northern California Carpenters Regional Council and any Local Unions that have negotiated Collective Bargaining Agreements requiring contributions to the Trust Fund.

Claims Appeal And Review Procedures

If your claim for any benefit provided by the Plan is denied in whole or in part, you will receive a written notice of the denial from the applicable provider advising you of the specific reason for the denial and a description of any additional information necessary for you to complete the claim.

The notice of denial shall be given within 90 days after the claim is filed, unless special circumstances require an extension of time for processing the claim. If such an extension is required, you will be sent written notice within 90 days of the time the claim is filed, stating the special circumstances requiring the extension and the date by which a decision on the claim can be expected. The final date for the decision shall not be more than 180 days from the date the claim was filed.

If you are not satisfied, or do not agree with the reasons for the denial of your claim, you may appeal the decision by writing to the appropriate provider (listed below) who is the fiduciary under the Plan designated to review any claim appeals by you:

Appeal for:	**Name of Provider** (for addresses see page 36):
Life and Accidental Death and Dismemberment Benefits	Prudential Insurance Company
Medical Benefits	Kaiser Permanente – Northern California
Dental Benefits	Delta Dental of California Safeguard Dental (*a MetLife Company)*
Vision Benefits	Vision Service Plan

Your appeal must be in writing, and can be made by you or a duly authorized representative. It must set forth your reasons for the appeal and your dissatisfaction or disagreement. Any evidence or documentation to support your position should be submitted with your written appeal. You have the right to review pertinent documents that pertain to your claim and its denial.

Your appeal must be made within sixty (60) days of the date you receive the letter denying your claim.

The provider will promptly review your denied claim and appeal. It will advise you of its decision, in writing, giving specific reasons for the decision with reference to policy provisions on which the decision is based. This written decision will be sent to you no later than sixty (60) days after the receipt of your written appeal, unless special circumstances require an extension of time for processing the appeal, or obtaining additional information, or conducting an investigation of the facts. In no event will the written decision be sent later than 120 days after receipt by the provider of your written appeal.

For participants covered under one of the Health Maintenance Organizations, you must follow the procedures outlined in the Evidence of Coverage booklet. In addition, it is important that you review information concerning required arbitration.

CLAIMS PROCEDURES

Prudential

Determination of Benefits

Prudential will notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by thirty (30) days if such an extension is necessary due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension and the date by which the plan expects to decide your claim, shall be furnished to you within the initial 45-day period. This period may be extended for an additional thirty (30) days beyond the original 30-day extension if necessary due to matters beyond the control of the plan. A written notice of the additional extension, the reason for the additional extension and the date by which the plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information. If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will be written in a manner calculated to be understood by you and shall include:

a) the specific reason(s) for the denial;

b) references to the specific plan provisions on which the benefit determination was based;

c) a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary;

d) a description of Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals; and

e) if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

Appeals of Adverse Determination

If your claim for benefits is denied or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access

to, and the right to obtain copies of all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

Prudential shall make a determination on your claim appeal within forty-five (45) days of the receipt of your appeal request. This period may be extended by up to an additional forty-five (45) days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period of making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the claim on appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include:

a) The specific reason(s) for the adverse determination;

b) References to the specific plan provisions on which the determination was based;

c) A statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of all records, documents and other information relevant to your benefit claim upon request;

d) A description of Prudential's review procedures and applicable time limits;

e) A statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination; and

f) A statement describing any appeals procedures offered by the plan, and your right to bring a civil suit under ERISA.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

If the appeal of your benefit claim is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may make a second voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial, or 180 days from the date such claim is deemed denied. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of all documents, records and information relevant to your claim free of charge.

Prudential shall make a determination on your second claim appeal within forty-five (45) days of receipt of your appeal request. This period may be extended by up to an additional forty-five (45) days if Prudential determines that special circumstances requires an extension of time. A written notice of the extension, the reason for the extension and the date by which Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Your decision to submit a benefit dispute to this voluntary second level of appeal has no effect on your right to any other benefits under this plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include the same information that was included in the first adverse determination letter. If a decision of appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

GRIEVANCES

Kaiser

A grievance can be filed for any issue. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied about services you received. You must submit your grievance orally or in writing within 180 days of the date of the incident that caused your dissatisfaction as follows:

- To a Member Services representative at your local Member Services Department at a plan facility or by calling the Member Services Call Center.

- Through Kaiser's web site at www.kp.org

- To the following location for claims described under "emergency, post-stabilization, or out-of-area urgent care" under requests for payment.

Kaiser Foundation Health Plan, Inc.
Special Services Unit
P.O. Box 23280
Oakland, CA 94623

Kaiser will send a confirmation letter within five days after they receive your grievance. Kaiser will send you a written decision within thirty (30) days after they receive your grievance. If Kaiser does not approve your request, Kaiser will tell you the reasons and about additional dispute resolution options. Note: If Kaiser resolves your issue to your satisfaction by the end of

the next business day after Kaiser receives your grievance and a Member Services representative notifies you orally about Kaiser's decision, Kaiser will not send you a confirmation letter or a written decision unless your grievance involves a coverage dispute, a dispute about whether a service is medically necessary, or an experimental or investigational treatment.

Binding Arbitration

Both claimants and respondents give up the right to a jury or court trial and accept the use of binding arbitration.

Scope of Arbitration

Any dispute shall be submitted to binding arbitration if:

1. The claim is asserted by one or more of the following (claimants):

    a) A Member;

    b) A Members heir or personal representative, or

    c) Any person claiming that a duty to him or her arises from a Member's relationship to one or more respondents.

2. The claim is asserted against any of the following (respondents):

    a) Kaiser Foundation Health Plan, Inc., (health plan);

    b) Kaiser Foundation Hospitals (KFH);

    c) Southern California Permanente Medical Group (SCPMG);

    d) Any KFH, TPMG or SCPMG physician;

    e) Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more claimants; or

    f) Any Employee or agent of any of the foregoing.

3. The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to the Evidence of Coverage, including any claim for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of services, irrespective of the legal theories upon which the claim is asserted.

For all claims subject to the binding arbitration section, both claimants and respondents give up the right to a jury or court trial and accept the use of binding arbitration.

Initiating Arbitration

Claimants shall initiate arbitration by serving a Demand for Arbitration. The Demand for Arbitration shall include the basis of the claim against the respondent, the amount of damages the claimants seek in the arbitration; the names, addresses, and telephone numbers of the claimants and their attorney, if any; and the names of all respondents. Claimants shall include all claims against respondents that are based on the same incident, transaction, or related circumstances in the Demand for Arbitration.

Serving Demand for Arbitration

All Respondents served with a Demand for Arbitration shall be parties, and the arbitrators shall have jurisdiction only over respondents actually served. Health Plan, KFH, KP Cal, TPMG, SCPMG, must be served by registered or certified letter, addressed to respondent in care of Kaiser Foundation Health Plan, Inc., Legal Department, 1950 Franklin St., 17th Floor, Oakland, CA 94612. Service by mail will be deemed completed when received. Any other respondent, including natural persons, must be served as in a California civil action.

Filing Fee

A Demand for Arbitration shall pay a single, nonrefundable filing fee of $150 per arbitration payable to Arbitration Account regardless of the number of claims asserted in the Demand for Arbitration or the number of Claimants or respondents named in the Demand for Arbitration.

Any claimant who claims extreme hardship may request that the Office of the Independent Administrator waive the filing fee and the neutral arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Office of the Independent Administrator and simultaneously serve it upon the respondents. The fee Waiver Form sets forth the criteria for waiving fees and is available by calling the Member Service Call Center.

Number of Arbitrators

The number of arbitrators may affect the claimant's responsibility for paying the neutral arbitrator's fees and expenses. If the Demand for Arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one neutral arbitrator, unless the parties otherwise agree in writing that the arbitration shall be heard by two party arbitrators and one neutral arbitrator. The neutral arbitrator shall not have authority to award monetary damages that are greater than $200,000.

In cases other than those where the total damages claimed by all claimants is $200,000 or more, the dispute shall be heard and determined by one neutral arbitrator and two party arbitrators, one jointly appointed by all claimants and one jointly appointed by all respondents. Parties who are entitled to select a party arbitrator may agree to waive this right. If all parties agree, these arbitrations will be heard by a single neutral arbitrator.

General Provisions

A claim shall be waived and forever barred if (1) on the date the demand for arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the respondent

served by the applicable statute of limitations, or (2) claimant fails to pursue the arbitration claim in accord with procedures prescribed herein with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (i) the date the demand for arbitration was served in accord with the procedures prescribed herein, or (ii) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the neutral arbitrator based on a showing of good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any Insurance or disability benefit payment to the patient, the limitation on recovery for noneconomic losses, and the right to have an award for future damages conformed to periodic payments, shall apply to any claims for professional negligence.

With respect to any matter not herein expressly provided for, arbitration shall be governed by Section 2 of the Federal Arbitration Act ("FAA") and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied.

GRIEVANCE PROCEDURES AND CLAIMS APPEAL

Delta Dental

If an enrollee's claim has been denied or modified, you may file a request for review with Delta Dental within 180 days after receipt of the denial or modification. If in writing, the correspondence must include your group name and number, the primary enrollee's name and I.D. number, the inquirer's telephone number and any additional information that would support the claim for benefits. Your correspondence should also include a copy of the treatment form, Notice of Payment (EOB) and any other relevant information. Upon request and free of charge, we will provide the enrollee with copies of any pertinent documents that are relevant to the claim, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in denying or modifying the claim. Delta Dental will take into account all information, regardless of whether such information was submitted or considered initially. Delta Dental's review shall be conducted by a person who is neither the individual who made the original claim denial, nor the subordinate of such individual, and we will not give deference to the initial decision. Delta Dental will provide a written acknowledgement within five (5) calendar days of receipt of the request for review. Delta Dental will make a written acknowledgment within five calendar days of receipt of the request for review. Delta Dental will make a written decision within (thirty) 30 calendar days of receipt of the request for review. Delta Dental will respond with three (3) calendar days of receipt, to complaints involving severe pain and imminent and serious threat to an enrollee's health. You may file a complaint with the Department of Managed Health Care after you have completed Delta Dental's grievance procedure or after you have been involved in Delta Dental's grievance procedure for thirty (30) calendar days. You may file a complaint with the Department immediately in an emergency situation, which is one involving severe pain and/or imminent and serious threat to the enrollee's health.

You may also call Delta Dental toll-free at 800-765-6003, contact them at their web site at: www.deltadentalins.com or write us at P.O. Box 997330, Sacramento, CA 95899-7330, Attention: Customer Service Department.

GRIEVANCE PROCEDURES

Safeguard Dental (*a MetLife Company)*

If an enrollee or one of your eligible dependents has a grievance with us or your dentist, you may orally submit such grievance by calling the Customer Service Department at (800) 880-1800. Safeguard Dental will permit grievances which are filed within 180 days of the occurrence or incident that is the subject of the grievance.

You may also submit a completed written grievance form (available by calling the Customer Service number) or a detailed summary of your grievance to:

Safeguard Dental
c/o Quality Management Department
P.O. Box 3532
Laguna Hills, CA 92654-3532

You may also file a written grievance via Safeguard Dental's web site at www.safeguard.net. Click on Members, then Grievance Forms and Grievance Forms to Print. Be sure to include your name (patient's name, if different), members identification number, facility (or selected general dental office) name and telephone number on all written correspondence.

Safeguard Dental will confirm receipt of the complaint in writing within five (5) calendar days of receipt. Safeguard Dental will resolve the complaint and communicate the resolution in writing within thirty (30) calendar days.

GRIEVANCES AND COMPLAINTS

Vision Service Plan

Covered persons shall report any complaints and/or grievances to Vision Service Plan at the address provided on page 36 of this booklet. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Complaints and grievances may be submitted to Vision Service Plan verbally or in writing. A covered person may submit written comments or supporting documentation concerning his complaint or grievance to assist in Vision Service Plan's review. Vision Service Plan will resolve the complaint or grievance within thirty (30) days after receipt.

Claim Denial Appeals

If, under the terms of this Plan, a claim is denied in whole or in part, a request may be submitted to Vision Service Plan by covered person or covered person's authorized representative for a full review of the denial. Covered person may designate any person, including his/her provider, as his/her authorized representative.

Initial Appeal

The request must be made within 180 days following denial of a claim and should contain sufficient information to identify the covered person for whom the claim was denied, including the enrollee's name, the enrollee's Member identification number, the covered person's name and date of birth, the provider of services and the claim number. The covered person may review, during normal working hours, any documents held by Vision Service Plan pertinent to the denial. The covered person may also submit written comments or supporting documentation concerning the claim to assist in Vision Service Plan's review. Vision Service Plan's determination, including specific reasons for the decision, shall be provided and communicated to the covered person within thirty (30) calendar days after receipt of a request from the covered person or covered person's authorized representative.

Time of Action

No action in law or in equity shall be brought to recover on the Plan prior to the covered person exhausting his grievance rights under this Plan and/or prior to the expiration of sixty (60) days after the claim and any applicable invoices have been filed with Vision Service Plan. No such action shall be brought after the expiration of six (6) years from the last date that the claim and any applicable invoices may be submitted to Vision Service Plan, in accordance with the terms of this Plan.

Name And Addresses Of Trustees

Board of Trustees of the Furniture and Industrial Carpenters Health Trust are:

EMPLOYER TRUSTEES

Robin Azevedo
McRoskey Mattress Company
1400 Minnesota Street
San Francisco, CA 94107

Mark Vignoles
Service West
2054 Burroughs Avenue
San Leandro, CA 94577

UNION TRUSTEES

David Imus
Carpenters Local Union #2236
115 Broadway
Oakland, CA 94607

Gerardo Blum
Carpenters Local Union #2236
115 Broadway
Oakland, CA 94607

Arturo Rodriquez
Carpenters Local 9144
115 Broadway
Oakland, CA 94607

ADMINISTRATOR

BeneSys Administrators, Inc.

LEGAL COUNSEL

Weinberg, Roger & Rosenfeld

AUDITOR

Lindquist LLP

CONSULTANT

Milliman, Inc.

Insurers And Providers Of Service To The Trust

The carriers and providers of service to the Trust are as follows:

For Life and Accidental Death and Dismemberment Benefits:

Prudential Insurance Company
101 California Street, Suite 1025
San Francisco, CA 94111
1-888-598-5671

For Hospital, Medical and Surgical Benefits:

Kaiser Permanente
Northern California Region
1800 Harrison, 9th Floor
Oakland, CA 94612-3412
1-800-464-4000

For Dental Benefits:

Delta Dental Plan of California
P.O. Box 997330
Sacramento, CA 95899-7330
1-800-765-6003

Safeguard Dental (*a MetLife Company*)
P.O. Box 981282
El Paso, TX 79998-1282
1-800-275-4638

For Vision Benefits:

Vision Service Plan
P.O. Box 997105
Sacramento, CA 95899-9989
1-800-877-7195

Rights Under ERISA

As a participant in the Furniture and Industrial Carpenters Health Trust, 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:

- Examine, without charge, at the Trust Administrative Office, all Plan documents, including the Group Medical Contract, any relevant Collective Bargaining Agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as annual reports and Plan descriptions.

- Obtain copies of all Plan documents and other Plan information upon written request to the Trust Administrative Office. The Trust Administrative Office may make a reasonable charge for the copies.

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

In addition to creating rights for Plan participants, ERISA imposes obligations upon the persons who are responsible for the operation of the employee benefit Plan.

These persons who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and the other Plan participants and beneficiaries.

No one, including your Employer, your Union or other person, may fire you or discriminate against you in any way to prevent you from obtaining a benefit under this Plan or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Trust Administrative Office, and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Trust Administrative Office to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Trust Administrative Office. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that 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 Trust Administrative Office. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the U.S. Department of Labor at:

United States Department of Labor
Pension and Welfare Benefits Administration
1055 E. Colorado Boulevard, Suite 200
Pasadena, CA 91106

Newborns' and Mothers' Health Protection Act

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 normal 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 insurer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998

A federal law called the Women's Health and Cancer Rights Act of 1998 became effective for this Plan on September 1, 1999. Under this law, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. In the case of a participant or beneficiary who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, the law requires coverage in a manner determined in consultation with the attending physician and the patient, for:

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

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

3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

If you have any questions about Plan coverage of mastectomies or reconstructive surgery, please contact the Trust Administrative Office.

Information Required By The Employee Retirement Income Security Act Of 1974 (ERISA)

1. Plan Name:

   Furniture and Industrial Carpenters Health Trust

2. Plan Sponsor:

   Furniture and Industrial Carpenters Health Trust

   2610 Crow Canyon Road, Suite 200
   San Ramon, CA 94583
   (925) 208-9997

3. Identification Number and Plan Number:

   The taxpayer identification number assigned to the Trust Fund by the Internal Revenue Service is **94-2621654**. The plan number assigned by the Sponsor is **501.**

4. Type of Plan:

   This plan is a welfare benefit plan providing coverage of life Insurance and medical expenses.

5. Type of Administration:

   The Plan is administered and maintained by the Board of Trustees.

6. Name, Address and Telephone Number of the Plan Administrator:

   Board of Trustees: Furniture and Industrial Carpenters Health Trust, at BeneSys Administrators, Inc., 2610 Crow Canyon Road, Suite 200, San Ramon, CA 94583

7. Name and Address of Agent for Service of Legal Process:

   The Trust Fund's Agent for Service of Legal Process: Ms. Abigail Modelowitz, at 1731 Technology Drive, Suite 570, San Jose, CA 95110.

8. Collective Bargaining Agreements:

   Under all of the Collective Bargaining Agreements, which provide for contributions to the medical Plan, the Employers are obligated to make monthly contributions to the Plan, as specified in the Collective Bargaining Agreements. You may obtain a copy of the specific Agreement applicable to your employment with your Employer from your own local Union. Some Employers have Collective Bargaining Agreements with more than one local Union. Do not assume that because a Member of a different Local or a Member of the same local under a different industry contract has medical that you are automatically eligible. Be sure

to obtain a copy of the Collective Bargaining Agreement which covers your employment. Copies of the Agreement will be furnished by the Trustees upon written request addressed to the Board of Trustees. The Trustees may impose a reasonable charge for these copies. Also, copies are available for examination at the Trust Administrative Office upon 10 days advance written request.

9. Source of Contributions:

   All contributions to the plan are made by individual Employers in accordance with Collective Bargaining Agreements described in item 8, above. A complete list of such Employers may be obtained by eligible employees upon 10 days written request to the Administrative Office. The Trustees may impose a reasonable charge for the list of Employers.

10. Sufficiency of Contributions:

    The benefits established by this Plan have been adopted by the Trustees based on the best information available to them as to the cost of benefits and the contributions which they anticipate receiving under applicable Collective Bargaining Agreements. The Trustees must and do reserve the right to modify benefits at any time, or to reduce or even eliminate benefits if necessary to maintain the financial soundness of the Plan.

11. Plan Year:

    The date of the end of the fiscal year is May 31.