TILE INDUSTRY HEALTH & WELFARE FUND
SUMMARY PLAN DESCRIPTION

EFFECTIVE January 1, 2018

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INTRODUCTION

Dear Participant:

This booklet known as a Summary Plan Description contains general information regarding your Insurance Benefits and an explanation of the eligibility provisions. We urge you to familiarize yourself with the provisions and benefit structure of your Plan. Please direct any questions you have to the Trust Fund Office at (626) 646-1075 or toll free at (877) 908-9996.

Please remember that this booklet is only a summary. In the event of any dispute regarding an insured benefit, the official language of the group insurance policy will control.

For details on your benefit coverage, please refer to the Providers' Evidence of Coverage. These documents are the binding documents between the Insurance Plan and its participants. You should review the booklets and other documents furnished by the entities providing benefits for the Plan.

The Board of Trustees has authorized the Trust Fund Office to respond in writing to your written questions. If you have an important question about your benefits, you should write to the Trust Fund Office for a definitive answer. The Trust Fund Office is located at:

Tile Industry Health & Welfare Trust Fund
1050 Lakes Drive, Ste. 120
West Covina, CA 91790

Plan rules and benefits may change from time to time. The Plan will provide you with a summary of important material changes. You may also receive replacement pages for this booklet. Please be sure to read all Plan communications and keep your booklet up to date by adding replacement pages as soon as you receive them.

The Board of Trustees

IMPORTANT NOTICES

FUTURE PLAN AMENDMENTS

Future amendments to the Plan may be made from time to time to comply with new laws passed by Congress, rulings by federal agencies or courts, and other changes deemed necessary or prudent by the Trustees.

LIMITATION UPON RELIANCE ON BOOKLET AND STATEMENTS

This booklet provides a brief, general summary of the Plan rules and is also the Plan document. You should review the Plan to fully determine your rights.

You are not entitled to rely upon oral statements of Employees of the Trust Fund Office, a Trustee, an Employer, any Union representative, or any other person or entity.
As a courtesy to you, the Trust Fund Office may respond orally to questions; however, oral information and answers are not binding upon the Plan and cannot be relied upon in any dispute concerning your benefits.

If you would like an interpretation of the Plan, you should address your request in writing to the Board of Trustees at the Trust Fund Office. To make their decision, the Trustees must be provided with full and accurate information concerning your situation. You should also ensure that you provide accurate facts in all forms and documents submitted to ensure you are not held liable for coverage of ineligible Dependents and/or claims.

You should further understand that, from time to time, there may be an error in a payment or on other matters which may be corrected upon audit or review. The Board of Trustees reserves the right to make corrections whenever any error or overpayment is discovered.

NO VESTED RIGHTS

Benefits under this Plan are NOT vested. The Board of Trustees may amend, reduce, eliminate or otherwise change the Plan at any time and may change, reduce, or discontinue any Plan benefits, in whole or in part, at any time. The Board of Trustees may change the eligibility requirements and any other Plan rules at any time.

LOSS OF GRANDFATHERED STATUS

The Board of Trustees elected to lose its Grandfathered Status under the Patient Protection and Affordable Care Act which will apply to prescription drugs provided through the Plan. The medical plans provided through the Trust already provide non-grandfathered benefits, which generally means all preventive medical care and well baby visits are provided to you free with no co-payment. The effect of this action by the Board of Trustees is to provide its participants and eligible dependents with certain benefit improvements.

ELIGIBILITY RULES FOR PARTICIPANTS WORKING UNDER A COLLECTIVE BARGAINING AGREEMENT BETWEEN BRICKLAYERS AND ALLIED CRAFTWORKERS LOCAL NO. 4, CALIFORNIA, AND CONTRIBUTING EMPLOYERS

These Eligibility Rules and the quarterly coverage afforded hereunder are not applicable to Participants and their Eligible Dependents who are participating in the Fund pursuant to a Non-Bargaining Participation Agreement. The eligibility provisions and coverage for Non-Bargaining Participants are set forth in the Section entitled "Eligibility and Coverage for Non-Bargaining Participants and their Eligible Dependents.

INITIAL ELIGIBILITY

If you meet the labor pool requirements mentioned herein your eligibility for benefits under the Tile Industry Health and Welfare Fund shall be determined in the following manner:

Initially, after you have been credited with 360 or more hours in a qualifying quarter, you will be eligible for benefits during the eligibility quarter as shown in the chart below:

QUALIFYING QUARTERS	ELIGIBILITY QUARTERS
NOV/DEC/JAN	APR/MAY/JUNE
FEB/MAR/APR	JUL/AUG/SEP
MAY/JUN/JUL	OCT/NOV/DEC
AUG/SEP/OCT	JAN/FEB/MAR

For example, if you work and are credited with 125 hours in November 2017, 125 hours in December 2017 and 150 hours in January, 2018 then you will be eligible for benefits during the months of April, May and June 2018.

Any credit hours in excess of 360 per quarter (but not more than 720 hours) shall be credited to your Hours Bank described below and in the following page.

In the event a member who has not been eligible in the preceding two years and does not have sufficient hours credited in one qualifying quarter to become eligible; then a second consecutive quarter's hours, provided there are at least 300 credited hours in either quarter, are to be combined with the first quarter's hours. Three hundred sixty (360) hours will be subtracted from the total, and 50% of the result, up to a maximum of 160 hours, will be added to the Hours Bank to determine if that member qualifies for coverage. The following is an illustration of this rule:

QUALIFYING QUARTER	HOURS
FEB/MAR/APR	290
MAY/JUN/JUL	330
Total Hours Over Two Consecutive Quarters	620
Less Quarterly Eligibility Requirements	-360
Balance	260
Adjustment Factor	x50%
Hours Eligible for Hours Bank	130

PURCHASE OF ELIGIBILITY HOURS

If you would otherwise lose your eligibility due to insufficient hours and you have used up all of your Hours Bank, then you will be allowed to purchase up to 60 credit hours to maintain your eligibility. You will also be allowed to purchase up to 60 credit hours to re-establish your eligibility if you had eligibility during any eligibility quarter in the last four eligibility quarters. You must pay the difference between the cost of coverage and the employer contributions made on your behalf during the applicable qualifying quarter including dental and disability coverage. Additionally, you must remit the payment to the Trust Fund Office by the beginning of the eligibility quarter. For example, if your eligibility is scheduled to terminate at the end of June because you do not have sufficient hours in FEB/MAR/APR or you would like to re-establish eligibility for the JUL/AUG/SEPT eligibility quarter, then you must remit the payment to the Fund Office prior to July 1, to maintain or re-establish your eligibility.

For the sole purpose of determining the total contribution made during a qualifying quarter, which is subtracted from the cost of coverage for the corresponding eligibility quarter to determine the amount of hours required to be purchased to attain eligibility, hours worked under a Special Private Work Agreement are treated as hours worked at the full journeyman contribution rate.

ELIGIBILITY IN SUBSEQUENT QUARTERS

Your eligibility for subsequent eligibility quarters will be determined by a combination of hours worked in the proceeding qualifying quarter and/or the balance in your Hours Bank. For example, in any qualifying quarter in which you were credited with 360 hours, coverage will be purchased in the succeeding eligibility quarter without disturbing the balance in your Hours Bank. If you are credited with less than 360 hours in a qualifying quarter, the additional number of hours required to equal 360 will be subtracted from your Hours Bank balance. If you are credited with more than 360 hours, then the excess hours will be added to your Hours Bank, not to exceed a total of 720 hours. Note that any hours worked in a quarter in which you do not work enough to qualify will be lost for all purposes except the 10,000 hour provisions herein.

If you work sufficient hours to maintain your eligibility for an Employer that has failed to contribute the required contributions to the Trust Fund, you will remain eligible for benefits for a maximum of three months. If after three months your Employer is still delinquent your eligibility shall be terminated.

STATUS OF HOURS BANK DURING NON-BARGAINING SERVICE

A Participant who becomes a Non-Bargaining Employee for a sponsoring union of this Trust, affiliated trust fund or a signatory employer shall be permitted to freeze his or her existing Hours Bank until such time as the Participant ceases such Non-Bargaining employment, subject to any interim reductions or increases in the maximum number of hours bank adopted by the Board of Trustees at the time that Hours Bank coverage is utilized by the Participant. This provision shall be applicable to Non-Bargaining Employees who are employed for a sponsoring union of this Trust, an affiliated trust fund or a signatory employer who are participants of the Trust on or after October 2015. The Hours Bank that existed when the Participant became a Non-Bargaining Employee shall be frozen under this provision.

CHOICE OF PLANS

At the time of your initial eligibility to participate in the plan, you may select one of the HMO plans for your medical coverage. You will also be eligible for dental benefits, prescription drug benefits and vision care benefits.

If your initial eligibility in the plan is on or after January 1, 2013, you will be defaulted into the Kaiser HMO. You must remain in Kaiser HMO for a minimum period of 12 months. On the first date of any month, following the 12 month enrollment period, you may elect to change your medical Plan coverage. If you were previously eligible under the plan at any time prior to January 1, 2013, and regain eligibility at any time after January 1, 2013, you will not be defaulted into the Kaiser HMO, and will have your choice of any plan available at the time you regain eligibility.

Rolling 12-Month Enrollment —

After your initial selection has been made, you must remain in that plan for a minimum period of 12 months. On the first date of any month, following the 12-month enrollment period, you may elect to change your medical Plan coverage.

Changing Medical Plan

To change medical plan, an Enrollment/Change Form must be completed and received by the Trust Fund Office 30 days in advance of the date that you want your new plan choice to become effective.

ELIGIBILITY AND BENEFITS IN THE EVENT OF DISABILITY

In the event you are disabled, you may qualify for extended eligibility and certain benefits under certain circumstances.

DEFINITION OF DISABILITY

The term disability means a licensed medical doctor has certified to the satisfaction of the Fund that you are temporarily or permanently unable to perform the duties of your job.

EXTENSIONS OF ELIGIBILITY

Less Than 10,000 Hours—

If you have been eligible for health and welfare benefits during the 12 consecutive months immediately preceding the onset of the disability, but have less than 10,000 hours in covered employment, you will be eligible for medical, dental, and vision coverage in accordance with the Plan for a period up to six (6) months after the loss of coverage due to disability. However, you must use up all eligibility from your Hours Bank before you are eligible for this extended eligibility.

10,000 or More Hours—

If you have been eligible for health and welfare benefits for 12 consecutive months immediately preceding the onset of your disability, and have 10,000 or more hours in covered employment, you will be eligible for medical, dental and vision coverage in accordance with the Plan for a period up to twelve (12) months after the loss of coverage due to disability. However, you must use up all eligibility from your Hours Bank before you are eligible for this extended eligibility.

10,000 or More Hours and Social Security Disability Award

If—

1. You have been eligible for health and welfare benefits for 12 consecutive months immediately preceding the onset of your disability, and
2. You have more than 10,000 hours in covered employment, and
3. You have a Social Security Disability Award, and
4. You cover yourself for Parts A & B of Medicare when you are first eligible to do so (usually 29 months after onset of disability), then you will be eligible for Trust paid medical coverage (excluding vision and dental) so long as you remain disabled. This Plan will continue to provide primary coverage until you reach age 65. At age 65, Medicare will provide primary coverage.

SELF-PAY OF MEDICAL & VISION CARE BENEFITS DURING DISABILITY

During any qualifying quarter in which a combination of your credited hours and Hours Bank hours do not equal 360 and you are ineligible due to a disability certified by a licensed physician, your medical, dental and vision benefits may be continued by self-payment under the Self-Payment Eligibility Requirements below.

APPLICATIONS FOR EXTENDED ELIGIBILITY AND PROOF OF DISABILITY

In order to be granted extended eligibility under the Eligibility and Benefits in the Event of Disability section you must file an application for extended eligibility on forms provided by the Trust Fund Office. Proof of disability can be shown by a Social Security Administration Award of Disability; or by other proof satisfactory to the Board of Trustees. The Trustees reserve the right to require proof of any disability from a doctor of their choice at the expense of the Trust.

HOUR BANK DURING DISABILITY

Your hour bank will not be charged with any hours during your period of extended eligibility or self-pay under the above rules.

LIFE INSURANCE BENEFITS DURING DISABILITY

If you are disabled prior to your 60th birthday, then, if you are eligible under the Eligibility and Benefits in the Event of Disability section, during your extended eligibility your Life Insurance benefit will be continued. If the disability occurs subsequent to your 60th birthday, your benefit will be determined by the provisions concerning eligibility during retirement.

DISABILITY INCOME BENEFITS

In the event you become disabled, and you are eligible for health and welfare benefits at the time you became disabled, you will be eligible for Disability Income Benefits for up to 26 weeks. The Disability Income Benefits is $70.00 per week for up to 26 weeks. Payment will be made for the actual number of days of disability. For example, the allowance for 10 days would be $100.00. If you are hospitalized, an additional payment of $35.00 per day for a maximum of 30 days per calendar year will be made.

If you continue to be disabled beyond the first 26 weeks, and you were eligible for health and welfare benefits for 36 out of the most recent 60 months prior to the month in which your disability occurred, you will be eligible for the payment of $200.00 a week for 26 additional weeks, with checks being issued every other week.

Payment of this Disability Income Benefit is conditioned upon your receipt of benefits under the California Unemployment Compensation Disability Program or Workers Compensation. To collect your benefit, you must provide a copy of the payment voucher furnished you by the paying organization and complete a claim form furnished by the Trust Fund Office.

You must file your claim within 180 days from the first day you became disabled. Claims will not be paid if they are filed more than 180 days from the first day you became disabled.

The amount of your short-term and/or long-term benefits is subject to change by the Board of Trustees.

SELF-PAY ELIGIBILITY REQUIREMENTS

You may be eligible to continue coverage by self-pay for medical, vision, and dental benefits. You are eligible for this self-pay opportunity if you meet all of the following requirements:

1. The self-pay will be during any qualifying quarter in which a combination of your credited hours and your bank hours do not equal 360 or during which you have exhausted your maximum Trust paid disability extension, or you have recovered from a certified disability extension, and
2. You comply strictly with the payment requirements set forth below and
3. You comply strictly with the labor pool requirements (except during periods in which you were disabled).
4. At the time that you elect self-pay coverage, you have the option of electing medical coverage only, or medical, vision and dental coverage. Your self-pay rate will reflect the amount of coverage elected. This election may only occur when you first elect self-pay coverage, and no changes may be made after your initial election.

Self-Pay Rights if You Have Less Than 10,000 Hours

If you have less than 10,000 hours in covered employment and have been eligible for 9 consecutive months or more prior to your losing coverage because of unemployment, or before you are eligible for a Trust paid disability extension, you may self-pay for a maximum of six months at the rate currently set by the Board of Trustees. Your self-pay rights may be continued for an additional six months provided you are employed by a signatory contractor at all times during the additional six months.

Self-Pay Rights if You Have 10,000 or More Hours—

If you have more than 10,000 hours in covered employment and have been eligible for 9 consecutive months, you have the right of self-pay for a maximum of 12 months.
Self-Pay Rights under the Contractor's Plan—

If you are an owner, officer, superintendent, estimator or other salaried employee of companies that are active in the tile contracting business you may be eligible to participate in the Contractor's self-pay plan. You are eligible for this self-pay opportunity if you meet all of the following requirements:

1. You are an owner, officer, superintendent, estimator or other salaried employee of a company that is active in the tile contracting business. A company that is active in the tile

contracting business means that the company has reported hours for bargaining employees to the Trust within the most recent12 month period;

2. You comply strictly with the payment requirements set forth below; and
3. You comply strictly with any request by the Board of Trustees to verify that the company you work for is active in the tile contracting business.

The Trustees reserve the right to require proof that you work for a company that is active in the tile contracting business.

PAYMENT REQUIREMENTS

Your first self-payment must be in the Trust Fund Office within thirty (30) days following the Trust Fund notice of the loss of your eligibility.

Thereafter, your self-payment premium must be in the Fund Office no later than the first day of the month for which coverage is being purchased. If your coverage is terminated because of your failure to make your self-payment on time, your eligibility to self-pay will not be granted again until you have regained your eligibility as a result of credited hours.

HOUR BANK DURING SELF-PAY

Your hour bank will not be charged with any hours during your period of extended eligibility due to disability or self-pay under the above rules.

LABOR POOL REQUIREMENTS

To be eligible for insurance benefits or extension of such benefits, you must remain in the labor pool of the Bricklayers and Allied Craftworkers Local No. 4, California, in the territory covered by agreements between the Union and the employers.

If you work for a contractor outside of the territory covered by such agreement, insurance benefits shall terminate on the first day of the month following commencement of such employment unless you have been granted credit under a reciprocity agreement between this Trust Fund and trusts in other geographic areas. However, if you are sent out of such territory by a contributing employer, you are to be considered as working in the territory, provided your employer makes proper contributions on your behalf to this Trust Fund. You shall be considered as remaining in the labor pool as long as you remain available for work in the territory covered by the various agreements and do not accept permanent employment outside of the industry. You must remain available for work to retain your labor pool status until such unavailability for work is caused by a certified disability.

MILITARY SERVICE

If you are called into military service for up to 31 days, your health coverage will continue. If you are called into military service for more than 31 days, you may continue your coverage by

making self-contributions for up to 24 months under the Uniformed Services and Employment and Reemployment Rights Act of 1994 (USERRA).

Your coverage will continue to the earliest of the following:

- The date you or your dependents do not make the required self-contributions within 30 days of the due date;
- The date the Plan no longer provides any group health benefits;
- The date you reinstate your eligibility for coverage under the Plan;
- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- The last day of the month after 24 consecutive months.

If you do not continue coverage under USERRA, your coverage will end immediately when you enter active military service. Your dependents will have the opportunity to elect COBRA continuation coverage. When you are discharged or released from military service, you have 90 days to return to work for a contributing employer. If your employer reports your return to the Trust Fund during this 90-day period, your eligibility and your dependent's eligibility will be reinstated on the day you return to work. However, if you are disabled at the time of your discharge and your disability was incurred during your military service, under USERRA you may be allowed more than 90 days to return to work for a contributing employer.

USERRA and COBRA continuation coverage shall run concurrently.

If you are seeking work in the jurisdiction of the Plan, but are unable to find work, be sure to notify the Fund Office within 90 days after your discharge or release from military service.

EMPLOYMENT BY GOVERNMENT AGENCY

If you are employed by a government agency, which is restricted from making contributions to the Trust Fund you may self-pay on an unrestricted basis, providing you comply strictly with the payment requirements mentioned above (See Self-Pay Eligibility Requirements). If you fail to make such payments strictly in compliance with the payment requirements, you may regain this privilege only by re-qualifying for coverage by employment under the collective bargaining agreements providing for contributions to the Trust Fund and by meeting all eligibility rules in effect at that time.

Payment may be made by you, the Agency or a combination of both. Employment with such government agencies shall count toward qualification for disability extensions and retirement rights in the same manner as it does for those working under collective bargaining agreements.

You shall be restricted in the self-payment procedure by the same restrictions that are applicable to employees that attain or retain eligibility with bank hours.

ELIGIBILITY DURING RETIREMENT

Please note that the Board reserves the right to modify, amend, or delete any benefits or eligibility for benefits, including retiree benefits, and the retiree self-pay rate, at any time.

RETIREE VISION CARE BENEFIT

If you meet all conditions described below you will be covered for Trust paid Vision Care:

1. You reached age 62; and
2. You have 12,000 hours in covered employment (each year of past service will count as 1,000 hours); and
3. You were covered as a result of hours worked, self-pay rights or Trust paid disability extension during the month prior to the effective date of your retirement; and
4. You have and remain retired. For purposes of this Plan, the term retired means that the retiree no longer performs any work in the tile industry, either as an employee, or a partner, or shareholder of any contractor, whether such contractor is a contributing employer or not and whether the contractor is within the geographical area of the plan or not.

RETIREE MEDICAL BENEFIT OPTIONS

If you are retired, you may elect to self-pay for Medical benefits in one of the following ways:

To continue your present Medical/Hospital coverage until both you and your spouse reach age 65, you may self-pay at the current monthly rate. However, you must strictly comply with the Payment Requirement mentioned above.

RETIREE SURVIVING SPOUSE OPTION

If your spouse is under age 65 and survives you, he/she may elect to self-pay for certain benefits under COBRA Continuation Coverage as described in the SPD.

ELIGIBILITY RULES FOR NON-BARGAINING PARTICIPANTS AND THEIR ELIGIBLE DEPENDENTS

Eligibility for Participants and their Eligible Dependents who are participating in the Fund pursuant to a Non-Bargaining Participation Agreement shall be provided on a monthly basis pursuant to the receipt of a flat monthly contribution rate established from time to time by the Board of Trustees. The monthly contribution for hours worked shall provide coverage under this Summary Plan Description for the second calendar month following the calendar month in which the hours were worked and for which a monthly contribution was due to the Fund. For example, if a participant works in November, his employer is required to remit a monthly flat rate contribution to the Trust Fund which provides coverage for January.

A monthly contribution is required to be made to the Trust for the final calendar month or any portion thereof in which the Participant ceased working for a participating Employer in a non-

bargaining capacity. Eligibility and coverage for the Non-Bargaining Participant and his Eligible Dependents shall terminate effective as of the end of the second calendar month following the calendar month in which the Participant ceases working for a participating Employer in a non-bargaining capacity, except as otherwise covered by COBRA or CalCOBRA. Application of any frozen hours in the Participant's hours bank shall be applied to provide prospective coverage on a month to month basis.

TERMINATION OF ELIGIBILITY

Your insurance under this Trust Fund will terminate at the end any period for which you fail to meet the eligibility requirements outlined in this SPD. Upon loss of eligibility you and your dependents have the right to choose COBRA Continuation Coverage (you will be advised the details of this option by the Trust Fund Office when this occurs). You may also choose to convert your group Life Insurance and or group Medical coverage within 31 days of the date you cease to be eligible.

If you die while eligible as a result of hours credited, your spouse and dependents as defined in the benefit booklet shall continue to receive Trust paid coverage for medical, vision, and dental benefits until your bank of hours is exhausted, but not to exceed six months, or if death occurs while you are on a Trust paid disability, or self-payment due to unemployment, your family may remain covered by the self-pay for a total of six months from the first of the month following the date of death. After your Trust paid coverage is exhausted, your spouse and dependents will be entitled to self-pay under the COBRA Continuation Coverage.

Once you lose the right to coverage by Trust payment or self-payment, all remaining bank hours will be forfeited and you will be required to re-qualify in accordance with the Initial Eligibility and Subsequent Eligibility provisions of the SPD.

COVERED DEPENDENTS

Your Covered Dependents are as follows:

1. Your Lawful Spouse. A Covered Dependent does not include a person becoming a spouse after a participant is covered under the retiree plan. Additionally, a Covered Dependent does not include a spouse to whom you are legally separated from.

2. Your Dependent Children. A dependent child shall be—
    - A blood descendant of the first degree;
    - A legally adopted child, including children living with adoptive parents during the period of probation and children for whom the adoptive parents have assumed and retained a legal obligation to provide total or partial support in anticipation of adoption;
    - A stepchild residing in the employee's household.

Dependent children are covered until the age of 26. A dependent child also includes a child after their 26th birthday for all benefits provided herein provided the child is—

1. permanently and totally disabled;
2. dependent upon you for more than one-half of their support and maintenance and
3. live with you for more than one-half of the year.

Proof of permanent and total disability must be furnished to the Plan or Trust by you within 31 days of the child's 26th birthday. The Trust Fund may require, at reasonable intervals following the child's 26th birthday, subsequent proof of the child's disability and dependency.

No dependent can ever be deemed a Covered Dependent unless they are a dependent of a Covered Employee.

SUMMARY OF BENEFITS

Your Plan provides Medical, Dental, Prescription Drug, Vision Care, Disability Income Benefit, Life Insurance and Accidental Death and Dismemberment Insurance. All benefits except Dental and Disability Income Benefits are provided through insurance. Dental and Disability Income benefits are self-insured through the Trust Fund. The specific benefits available and the exclusions and restrictions which apply to the coverage summarized below are set forth in detail in the booklets prepared by these providers. If you need copies of any of those booklets, please contact the Trust Fund Office. Those documents are available to you on request and at no charge.

MEDICAL BENEFITS

Medical Benefits are provided through two HMO Plans, Kaiser and UnitedHealthcare. Below is a brief summary of benefits.

	KAISER	UNITEDHEALTHCARE
TYPE OF PLAN	**HMO**	**HMO**
Lifetime Maximum	None	None
Annual Deductible	None	$250/person $500/family
Calendar Year Out-of-Pocket Maximum	$1,500/person; $3,000/family	$3,000/person; $6,000/family
Physician Services (Office Visits)	$15 copay	$20 copay
Hospital Expenses	$250 copay per admission	10% copay per admission after calendar year deductible is satisfied
Emergency Room	$50 copay (waived if admitted)	$150 copay (waived if admitted)
Mental Health Services- Office Visits Hospitalizations	 $15 copay $250 per admission	 $30 copay 10% copay after deductible
Hospice Care	No charge	10% copay after deductible
Skilled Nursing Facility	No Charge (up to 100 days per benefit period)	10% copay after deductible
Home Health Care Visits (up to 100 days per calendar year)	No charge	$20 copay
Specialist Services (office visit)	$15 copay	$35 copay

PRESCRIPTION DRUG BENEFITS

The Prescription Drug benefit is administered by Sav-Rx. Below is a summary of the prescription benefits:

Retail	Mail Order
Brand $10.00	Brand $0.00
Generic $5.00	Generic $0.00
Limited to a 30-day supply	Limited to a 90 day supply

Mandatory Generic Program

If a generic drug is available, your prescription will be substituted to a generic equivalent of the prescribed name brand drug. However, this can be overridden by providing a letter of medical necessity to Sav-Rx.

Specialty Drug Program

Limit to a 30-day supply through Preferred Drug Channels.

Flu-Shots

There will be a $10 co-pay for flu shots.

The following preventive prescription drugs will now be available to participants and eligible dependents free with no co-payment:

Aspirin: All strengths and dosage forms of generic aspirin covered with prescription of men and women ages 45-79.

Oral Fluoride: As prescribed through age 5.

Generic OTC Folic Acid Supplements: Generic strengths covered with prescription for women beginning at age 55.

Iron Supplement Drops: As prescribed by child's physician up to age 1.

Vitamin D: As prescribed by physician for patients over age 65.

Immunizations: Routine childhood and adult immunizations, Herpes Zoster (Shingles) for males and females age 60 and over and influenza.

Breast Cancer Chemo Preventative: The full cost of coverage will be provided in the case of preventative use.

Tobacco Cessation Medications: Both RX and OTC tobacco cessations products covered up to two 90 day treatments per year with additional treatments available as prescribed by the physician and under special circumstances.

In addition, the following woman's prescription drugs for contraceptive coverage will be available through the plan at no co-payment:

Oral Contraceptive (i.e. combination, progestin only, extended cycle, Plan B, Ella).

Rx- Non-Oral Contraceptive (i.e., patch, ring, injection, implant, IUD, Cervical Cap, diaphragm)

OTC - Non-oral Contraceptive (i.e., female condom, sponge, spermicide)

In addition, the following procedures are provided at no cost to the Participant:

Colorectal Cancer Screening Tests: The full cost of coverage will be provided in the case of preventative use.

HIGH IMPACT ADVOCACY PROGRAM

Effective April 1, 2016, when a participant is prescribed a medicine to treat Hepatitis C, the participant needing this type of prescription drug will pay a co-payment equal to twenty-five percent (25%) of the cost of the prescription drug, subject to reimbursement of the twenty-five percent (25%) co-payment less $5.00. The net out-of-pocket cost to the participant who is prescribed prescription drugs to treat Hepatitis C will be $5.00.

SPECIALTY DRUGS

Unless otherwise excluded, the Trust will not pay for any Specialty Drugs on the Specialty List compiled by Sav-Rx. Specialty Drugs are drugs which require special handling or patient care and training or frequent dosing adjustments or other special clinical review. The Trustees will review the Specialty List compiled by Sav-Rx on an annual basis and adjust this provision if deemed appropriate in consultation with Sav-Rx and the Trust's professionals.

SAVRX THERAPEUTIC QUANTITY LIMITS PROGRAM

The Trust is committed to the safety of all Trust participants. For this reason, effective June 1, 2018, the Trust will implement Sav-Rx's Therapeutic Quantity Limits Program, which ensures the proper utilization of certain medications based upon FDA guidelines. The program monitors prescription utilization and helps to identify potential overuse or abuse of medications. The program places therapeutic limits on particular classes of medications including but not limited to: Opioid and Non-Opioid Pain Relievers, Migraine Medications, and Sedative Hypnotics.

VISION CARE BENEFITS

Vision Care Benefits are provided through VSP. Below is a summary of the vision benefits:

$10.00 copay every plan year.
Eye exam.....every 12 months
Prescription Glasses..... every 12 months
Frame……..... every 24 months
- $130 allowance for frame of your choice.
- 20% off amount over your allowance

or
Contact Lens Care..... every 12 months
$120.00 allowance for contacts and the contact lens exam (fitting and evaluation).

DENTAL BENEFITS

Dental Benefits are self-insured and provided through the Ameritas Group. Below is a summary of the dental benefits:

Dental Summary

Coinsurance	**In Network**	**Out of Network**
Type 1	100%	90% of UCR
Type 2	100%	90% of UCR
Type 3	100%	90% of UCR
Deductible	$0/Calendar Year Type 2,3 Waived Type 1 No Family Maximum	$0/Calendar Year type 2,3 Waived Type 1 No Family Maximum
Maximum (per person)	$1,500 per calendar year	$1,500 per calendar year

Sample Procedure List

Type 1	**Type 2**	**Type 3**
Routine exams	Restorative amalgams	Onlays
Bitewing X-ray	Restorative composites	Crowns
Cleaning	Endodontics	Implants
Space maintainers	Denture Repair	Prosthodontics

Orthodontia Summary - Adult and Child Coverage

	In Network	**Out of Network**
Coinsurance	Allowance Discounted Fee 60%	U&C 60%
Lifetime Maximum (per person)	$1,500	$1,500

LIFE INSURANCE BENEFITS

Life Insurance in the face amount of $10,000 for active employees only, is provided through an insured arrangement. The terms and conditions of the policy will govern claims and eligibility, as well as beneficiary designation. You may name anyone you wish, except your employer. If you are currently married and are naming someone other than your spouse as your beneficiary, your spouse must also sign the Beneficiary Designation Card. Your beneficiary designation will be automatically deemed revoked upon certain changes in marital status. If you are currently married and later divorced, your beneficiary designation of your spouse will be deemed revoked unless a Court Order requires you to maintain the beneficiary designation you make. If you are currently single and later marry, the beneficiary designation you made will be automatically revoked unless the person you named as your beneficiary is the person who becomes your spouse. Should your beneficiary designation be automatically revoked due to either of the foregoing events, benefits will be paid to your estate. You may also change your beneficiary at any time by filing a written change with the Trust Fund Office. When recorded, the change will take effect as of the date it was signed provided benefits have not been paid before it was received.

If you name more than one beneficiary—
And you don't state amounts or order of payment; benefits will be equally divided among the beneficiaries;

And a beneficiary dies before you, his or her share will go equally to the surviving beneficiaries. If there is no beneficiary at your death, benefits will be paid to the members of the first surviving class as follows:

- Your spouse
- Your children
- Your parents
- Your brothers and sisters
- Your estate.

Up to $500 of the benefits from the above $10,000 policy for active employees only, may be paid to anyone who pays expenses for your final illness or burial.

Any payment the insurance company makes in good faith under these provisions will discharge their liability to the extent of the payment. You are not eligible for this benefit if you retire and return to active employment at a later date.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFITS

Accidental Death and Dismemberment Insurance. The maximum amount of $10,000 for active employees only, is provided in addition to the above insurance through an insured arrangement. The terms and conditions of the policy shall prevail with regard to this benefit.

The provisions of this benefit relating to designation of beneficiaries, claims, etc., are similar to those of the Life Insurance Benefit summarized above. You are not eligible for this benefit if you retire and return to active employment at a later date.

Dependent Life Insurance. For dependents of Active Employees Only is provided through an insured arrangement. The terms and conditions of the policy will prevail as to this benefit.

Covered dependents of active eligible employees may receive life insurance coverage as follows:

Covered Dependent	**Coverage**
Spouse	$500
Dependent child	
Age: 14 days but less than 6 months	$100
6 months but less than 2 years	$200
2 years but less than 3 years	$400
3 years but less than 21 years	$500

COORDINATION OF BENEFITS

The benefits payable under the Plan for covered charges incurred will be coordinated with any other group insurance you or your dependents may have, but not with any individual insurance. Coordination means that benefits are paid so that no more than 100% of your necessary, reasonable and customary expenses will be covered under the combined benefits from all the following plans:

1. This Plan,
2. any other group, blanket or franchise insurance coverage,
3. group practice and other group prepayment coverage,
4. group service plans and
5. any coverage under labor management trusteed plans, union welfare plans, employer organization plans.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

The Plan will comply with any medical child support order (MCSO) with which it is properly served and which is a qualified medical child support order (QMCSO) under applicable federal law.

A QMCSO is any judgment, decree, or order which:

1. Issues from a court of competent jurisdiction pursuant to a state's domestic relations law;
2. Requires you to provide only the group health coverage available under the Fund for your children and
3. Clearly specifies—

- Your name and last known mailing address and the names and addresses of each child covered by the order;
- A reasonable description of the coverage to be provided;
- The length of time the order applies, and
- Each plan affected by the order.

No QMCSO may require the Plan to provide benefits to a person who is not a dependent child as defined in the Plan, and whose participant/parent has not been eligible for benefits, or to provide benefits in excess of those provided under the terms of the plan.

Upon service with an MCSO, the Trust Fund Office will review the MCSO under procedures adopted by the Trustees, and determine within a reasonable time whether or not the MCSO is a QMCSO. The determination that a MCSO is not a QMCSO is subject to the appeals procedure provided elsewhere in this Plan. You may obtain a free copy of the QMCSO procedures from the Trust Fund Office.

FAMILY AND MEDICAL LEAVE ACT

The Family and Medical Leave Act enacted by Congress in 1993 provides that in certain situations certain employers are required to grant leave to employees and that in such situations the employer is required to continue medical coverage for the employees.

It is not the role of the Trustees or Trust Fund to determine whether or not an individual employee is entitled to leave with continuing medical care under the federal statue, any state statute or the provisions of a collective bargaining agreement. Disputes as to the entitlement to leave with continuing medical benefits must be resolved by the employer, employee and where applicable, the local union.

To the extent that participants are entitled to leave with continuing medical coverage pursuant to the federal act, state legislation or provisions contained within a collective bargaining agreement, the Trust Fund will provide continuing medical coverage so long as required monthly contributions are received from the contributing employer. Rights under this section in no fashion affect rights under COBRA or rights to continuing medical care pursuant to the disability extension features contained within the Plan.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Information Required by the Health Insurance Portability & Accountability Act (HIPAA)

Notice of HIPAA Special Enrollment Rights

Under HIPAA you and/or your Dependents are entitled to special enrollment rights if you declined coverage in this Plan because you and/or your Dependents had other group health coverage and you lose that other group health coverage. Additionally, you are entitled to enroll a newly acquired Dependent. However, you must request enrollment within 30 days of either the

loss of the other coverage or the date you acquired the dependent to be eligible for this special enrollment right.

You and your Dependents may also enroll in this Plan if you (or your Dependents) have coverage through Medicaid or a State Children's Health Insurance Program (SCHIP) and you (or your Dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or SCHIP coverage ends.

You and your Dependents may also enroll in this Plan if you (or your Dependents) become eligible for a premium assistance program through Medicaid or a State Children's Health Insurance Program (SCHIP). However, you must request enrollment within 60 days after you (or your Dependents) are determined to be eligible for such assistance.

Certification of Creditable Coverage Under HIPAA

The Plan will provide written certification of creditable coverage to you when your coverage ceases (under employer coverage and/or COBRA coverage) or when requested by you if your coverage is still in effect or if requested by you within two years after your coverage ends. The certification will specify the period(s) of creditable coverage under this Fund (including COBRA, if applicable) disregarding periods of coverage before a 63-day break. The 63-day break will not include any days between the loss of coverage and any secondary opportunity date to elect COBRA under the Trade Act of 2002.

If your coverage ends (under employer coverage and/or COBRA coverage), the certificate of creditable coverage will be provided to you automatically within a reasonable period of time after your coverage ceases. If you or someone on your behalf (including another health plan or issuer) wants to request a certificate of creditable coverage, please advise the Trust Fund Office in writing.

You should provide your name and the name(s) of your dependent(s) and an address(es) to which the certificate(s) should be sent. The notice will then be processed and sent on the earliest date that the Plan, acting in a reasonable and prompt fashion, can provide it.

HIPAA Privacy Rules

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

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

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

1. Permitted Uses and Disclosures of PHI

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

2. Required Uses and Disclosures of PHI

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

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

This Plan will disclose PHI to family members, other relatives or close personal friends if the information is directly relevant to the family or friend's involvement with your health care or payment for such care and you have either agreed to the disclosure or been given an opportunity to object and have not objected.

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

This Plan will use or disclose PHI without your authorization or opportunity to object when required by law, or to law enforcement officials, public health agencies, research facilities, coroners, funeral directors and organ procurement organizations, judicial and administrative agencies, military and national security agencies, worker's compensation programs and correctional facilities. These uses and disclosures are more fully described in this Plan's Privacy

Policy Statement and Notice of Privacy Practices for Protected Health Information. Additional copies of these documents may be obtained from the Trust Fund Office.

5. Your Individual Rights

HIPAA and the Privacy Rule afford you the following rights:

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

You (or your personal representative) have the right to request to receive communications of PHI from this Plan either by alternative means or at alternative locations. This Plan may agree to accommodate any such request if it is reasonable. This Plan, however, must accommodate such a request if you clearly state that the disclosure of all or a part of the PHI could endanger you. You will be required to complete a request form to receive communications of PHI by alternative means or at alternative locations.

You (or your personal representative) have the right to request access to your PHI contained in a Designated Record Set, for inspection and copying, for as long as this Plan maintains the PHI. A Designated Record Set includes the medical billing records about you maintained by or for a covered health care provider, enrollment, payment, billing, claims adjudication, and case or medical management record systems maintained by or for this Plan or other information used in whole or in part by or for this Plan to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you are not in the Designated Record Set and therefore not subject to access. The right to access does not apply to psychotherapy notes or information compiled in anticipation of litigation. You must complete a request form to access PHI in a Designated Record Set. If access to inspect and copy PHI is granted, the requested information will be provided within 30 days if the information is maintained onsite or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if this Plan is unable to comply with the deadline. This Plan may charge a reasonable fee for the costs of copying. If access to inspect and copy your PHI is denied, a written denial will be provided setting forth the basis for the denial, a description of how you may have the denial reviewed, if applicable, and a description of how you may file a complaint with this Plan or the HHS or its OCR.

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

written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

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

6. Access by Personal Representatives to PHI

This Plan will treat your personal representative as you with respect to uses and disclosures of PHI, and all the rights afforded you by the Privacy Rule, under certain circumstances, but only to the extent such PHI is relevant to their representation. The personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to PHI or allowed to take any action.

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

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

7. This Plan's Duties

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

This Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. This minimum necessary standard, however, will not apply to disclosures to or requests by a health care provider for treatment purposes, disclosures made to you, uses or disclosures pursuant to your authorization, disclosures made to HHS or its OCR for enforcement purposes, uses or disclosures that are required by law, and uses or disclosures that are required for this Plan's compliance with HIPAA's Administration Simplification Rules.

8. Miscellaneous

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

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

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

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

This Plan will also disclose PHI to the Board of Trustees for Plan administration purposes. The Trustees have signed a certification agreeing not to use or disclose your PHI other than as permitted by the plan documents, the Privacy Rule, or as required by law.

10. Complaints

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

Brooke Misch
BeneSys, Inc.
700 Tower Drive Ste. 300
Troy, Michigan 48098
Tel: (248) 813-9800 Fax: (248) 813-9898

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

You may also file a complaint with the HHS or its OCR, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, DC 20201.

11. Security Standards Under HIPAA

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

You can contact the United States Department of Labor to seek assistance on your rights as provided by the Health Insurance Portability and Accountability Act (HIPAA). The office to contact is as follows:

United States Department of Labor
Employee Benefits Security Administration
1055 East Colorado Boulevard, Suite 200
Pasadena, CA 91106
(626) 229-1000

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Pursuant to the Newborns' and Mothers' Health Protection Act of 1996, the medical Plans in which you may enroll may not restrict benefits for any hospital length of stay for the mother or newborn child to less than 48 hours following a normal delivery or less than 96 hours following a cesarean section delivery. In accord with Federal Law, those Plans do not require that a provider obtain pre authorization under those Plans for either of the foregoing lengths of stay. However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or her newborn earlier than the applicable time period.

WOMEN'S HEALTH & CANCER RIGHTS ACT

Your medical benefits may cover medical and surgical benefits for mastectomies. This coverage includes:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; or

- Prosthesis and physical complications of all stages of mastectomy, including lymph edemas.

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

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your dependents may continue your health and dental coverage under the Plan at your own expense following certain qualifying events, which results in a loss of coverage.

If you have a newborn child, adopt a child, or have a child placed with you for adoption (for whom you have financial responsibility) while your COBRA continuation coverage is in effect, you may add such child to your coverage. You must notify the Trust Fund Office, in writing, of the birth, adoption, or placement of a child with you for adoption, in order to have this child added to your coverage.

Children born, adopted, or placed for adoption, as described above, have the same COBRA rights as a spouse or dependents who were covered by the Plan before the event that triggered COBRA continuation coverage. Like all qualified beneficiaries with COBRA, the child's continuation coverage depends on timely and uninterrupted self-contributions on their behalf.

Qualifying Events

Qualifying events include—

- Termination of your employment (for causes other than gross misconduct);
- Reduction in your hours;
- Your death;
- You become eligible for health care coverage under Medicare;
- You and your spouse are legally separated or divorced and
- Your child loses dependent status under the Plan.

Notifying the Trust Fund Office

You or your dependent must inform the Trust Fund Office of a legal separation, divorce, or a child losing dependent status under the Plan within 60 days of the qualifying event. If you do not notify the Trust Fund Office within 60 days of such an event, you will lose your right to elect COBRA continuation coverage.

Your employer will notify the Trust Fund Office of your termination of employment, reduction in hours, death, or entitlement to Medicare coverage. However, because employers contributing to the Plan may not be aware of these events, the Trust Fund Office will rely on its records for determining when eligibility is lost under these circumstances. To help ensure that you do not suffer a gap in coverage, we urge you or your family to notify the Trust Fund Office of qualifying events as soon as they occur.

COBRA Election

You must decide to elect COBRA benefits in writing within 60 days of the later—

1. the date the COBRA notice is sent to you or
2. the date your regular Plan coverage terminates.

If you do not make an election within this 60-day time period, your rights to COBRA continuation coverage will be terminated.

Paying for COBRA Continuation Coverage

The Trust Fund Office will notify you of the cost of your COBRA continuation coverage when it notifies you of your right to coverage. The cost of COBRA coverage will be determined by the Trustees on a yearly basis and will not exceed 100% of the cost to provide this coverage, plus a 2% administrative charge. The cost for extended disability coverage (from the 19th month through the 29th month) is an amount determined by the Trustees, not to exceed 150% of the cost to provide coverage, plus a 2% administrative charge.

Your first payment for continuation coverage must include payments for any months retroactive to the day you and/or your dependents' coverage under the Plan terminated. This payment is due no later than 45 days after the date you or your dependents signed the election form and returned it to the Trust Fund Office.

Subsequent payments are due on the first business day of each month for which coverage is provided, with a grace period of 30 days. If payment is not received by the due date, all benefits will terminate immediately. Once your COBRA continuation coverage is terminated it cannot be reinstated.

Period of Coverage

Coverage continues for 18 months. You may elect to purchase continued coverage for yourself and your dependents for up to 18 months if coverage ends due to your termination of employment or your reduction in hours.

Coverage continues for 29 months. If your eligibility ends due to your termination of employment or reduction in hours and within 60 days of the event, you or one of your dependents is totally disabled (as determined by the Social Security Administration), 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 Fund Office within 60 days of the date of the Social Security Administration's disability determination.

Coverage continues for 36 months. Your dependents may elect to continue coverage for up to 36 months if coverage ends because of your—

- Death;
- Entitlement to health care coverage under Medicare;
- Legal separation or divorce; or
- Dependent child no longer qualifies for dependent coverage under the Plan.

Termination of COBRA Continuation Coverage

COBRA continuation coverage terminates on the earliest of the following events:

1. The last day of the period for which COBRA continuation coverage may be elected.
2. The date a required COBRA payment premium due and payable is not received by the Trust Fund.
3. The date all Trust Fund-sponsored medical plans are terminated.
4. The date the individual receiving coverage pursuant to COBRA first becomes covered under another group medical plan, which does not contain any exclusion or limitation with respect to any preexisting condition of such person. This date may vary for different members of the same family.
5. The date the person on COBRA continuation coverage first becomes entitled to Medicare coverage. The right to COBRA continuation coverage terminates only for the person who becomes entitled to Medicare coverage.
6. For individuals who are receiving the special 11 month extended coverage period due to disability, the first day of the month that begins more than 30 days after such a person is no longer disabled.
7. The expiration of the applicable 18 month, 29 month or 36 month COBRA continuation period.

If at the time of your termination from employment or reduction in hours of employment, you were working for an employer whose collective bargaining agreement included the required contributions for retiree medical coverage, the election of COBRA continuation coverage may serve as a bridge in creating eligibility for retiree coverage. In these situations the period of COBRA coverage elected will be viewed as employment with an employer whose collective bargaining agreement does require contributions for retiree Health and Welfare coverage.

At the end of any COBRA continuation period elected, you will be allowed to enroll in an individual conversion health plan provided by the HMOs. Information related to individual conversion health plans may be obtained from the Trust Fund Office or from the HMOs.

If at the commencement of your COBRA Continuation Coverage you are covered by a region specific Plan, such as an HMO that covers a limited geographic area, and you subsequently relocate to another area, you are entitled to transfer your coverage to another HMO program of the Trust. Under no circumstances would such a transfer prolong the period of your COBRA Continuation Coverage.

CLAIMS AND APPEALS PROCEDURES

No participant, active or retired, dependent or beneficiary of either, or other person shall have any right or claim to benefit under the Plan, other than as specified in the Plan which may be amended from time to time as the Trustees shall determine and establish.

If any claimant shall have a dispute as to eligibility for a benefit or the amount or duration of benefits provided on a self-insured basis by the Plan (i.e., dental or disability income benefits only), the dispute shall be resolved by the Board of Trustees.

Any person whose application for benefits under the Plan has been denied in whole or in part shall be notified of such decision in writing. Such notice shall set forth the specific reason for the determination; specific references to pertinent Plan provisions upon which the denial is based; describe any additional material or information necessary for the claimant to perfect the claim and explain why such material or information is necessary; a statement that if any specific rule, guideline, protocol or other similar criteria was relied in making the determination that the rule, guideline, protocol, or other criteria is available upon request at no charge; and explain the Plan's claim review procedure, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

If the claimant desires further consideration of the decision denying the claim, he may request a review upon written application to the Plan. In connection with such request for review, the claimant shall be entitled to review pertinent Plan documents and to submit issues and comments in writing to the Trust Fund Office, which shall be considered by the Board of Trustees in arriving at a decision on review. Such request for review shall state in clear and concise terms the reason or reasons for disagreement with the decision, and shall be filed with the Trust Fund's Office within one hundred and eighty (180) days or sixty (60) days in the case of the supplemental disability benefit after the date the notice of denial was received by you. The failure to file a request for review within such one hundred and eighty (180) day or sixty (60) day in the case of the supplemental disability benefit shall constitute a waiver of the claimant's right to review of the decision and such decision shall be final and binding upon all parties thereto. Such failure shall not, however, preclude the applicant or claimant from establishing information and evidence, which was not available at the time of the decision on the claim for benefits.

Upon receipt of a request for review, the Board of Trustees shall proceed to review the administrative file, including the request for review and its contents. Upon request, you or your duly authorized representative will be provided, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. The review of the determination will take into account all comments, documents, records and other information submitted by you relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

The Board of Trustees will not afford any deference to the initial benefit determination. If the adverse benefit determination is based in whole or in part on a medical judgment, the Board of Trustees shall consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. Such consultant shall be different from

any individual consulted in connection with the initial determination and shall not be the subordinate of any such person.

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

With regard to benefits provided by the HMOs or through insurance, the claims and appeal procedures provided under the HMOs' rules and regulations and the insurance policy shall apply and the above claims and appeal procedures shall not apply.

External Claims and Appeals of adverse benefit claims will apply to loss of eligibility and prescription drug claims commencing April 1, 2016.

Generally, a Participant or Covered Dependent or an Authorized Representative of a Participant or Covered Dependent may only request an External Review after he/she has exhausted the internal review and appeal processes described above.

Only claims that involve medical judgment (including, but not limited to, issues related to the medical necessity, appropriateness, the location of services, a level of care, the effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational) and rescission of coverage are eligible for External Review. However, claims pertaining to a contractual or legal interpretation of the terms of the Plan without any use of medical judgment are not eligible for External Review.

The Independent Review Organization ("IRO") is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IRO's with which it contacts.

Request for External Review: A Participant or Covered Dependent may request an External Review within four calendar months from the date they received notice of an adverse determination or a final internal review adverse benefit determination. A notice sent via first class mail to the last known address reported to the Trust Fund Office will be considered to have been received on the third business day following the date of said notice on the premise it was mailed on said date.

Preliminary Review: Within 5 business days following receipt of a request for External Review the Plan shall complete a preliminary review of said request to determine:

a. If the claimant was a Covered Person under the Plan at the time a request for medical service(s) was requested or at the time medical service(s) were rendered;

b. If the adverse benefit determination does not relate to failure of the person submitting the request to qualify as a Covered Person under the Plan;

c. If the claimant had exhausted the Plan's Internal Appeals Process as is required by the Plan (except, in limited, exceptional circumstances when under the regulations you are not required to do so); and

d. If the claimant has provided all information and documents required to process an External Review.

Within one business day of completing the Preliminary Review the Plan will notify the claimant in writing as to whether the claimant's request for External Review meets the above requirements. This notification will inform the claimant:

a. Whether the claimant's request is complete and eligible for External Review;

b. Whether the claimant's request is complete but not eligible for External Review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)); or

c. If the claimant's request is not complete, the notice will describe the information or materials needed to complete the request, and allow the claimant to request External Review within the four (4) month filing period, or within a 48 hour period following receipt of notification, whichever is later.

Review of Standard Claims by an Independent Review Organization ("IRO")

If the request is complete and eligible for an External Review, the Plan will assign the request to an IRO. Once the claim is assigned to an IRO, the following procedures will apply:

a. The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for External Review, including directions about how the claimant may submit additional information regarding the claim (generally, the claimant will need to submit such information within ten (10) business days;

b. Within five (5) business days after the External Review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its adverse determination;

c. If the claimant submits additional information related to the claim to the IRO, the assigned IRO must, within one (1) business day, forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse determination that is subject of the External Review. Reconsideration by the Plan will not delay the External Review. However, if upon reconsideration, the Plan reverses its adverse determination, the Plan will provide written notice of its decision to the claimant and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its External Review;

d. The IRO will review all the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits;

In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from the claimant's medical records, recommendations or other information from the claimant's treating health care providers, other information from the claimant or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer;

e. The assigned IRO will provide written notice of its final External Review decision to the claimant and the Plan within 45 days after the IRO receives the request for External Review;

f. The assigned IRO's decision notice will contain:

(1) A general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, health care provider, claim amount (if applicable), and reason for previous denial;

(2) The date that the IRO received the request to conduct the External Review and the date of the IRO decision;

(3) References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;

(4) A discussion of the principal reason(s) for IRO's decision, including rational for its decision and any evidence based standards that were relied on in making the decision;

(5) A statement that the IRO's determination is binding on the Plan and claimant (unless other remedies may be available to you or the Plan under applicable Federal law.);

(6) A statement that judicial review may be available to the claimant and the Plan; and

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with External Review processes.

g. In the event a final decision of the Independent Review Organization may reverse an adverse benefit determination, in whole or in part, said decision shall be binding on the Plan which shall then process for payment all approved portions of each claim without delay even if the Plan may appeal, or seek judicial review of, the decision.

GENERAL PLAN INFORMATION

Name of the Plan: The name of this Plan is Tile Industry Health and Welfare Fund

Type of Plan: The Tile Industry Health and Welfare Fund is a health care trust, providing Hospital, Surgical, Medical, Dental, Prescription Vision Care, Drug, Disability, Life and Accidental Death and Dismemberment Insurance to eligible participants and their dependents.

Type of Administration: The Plan is administered by the Joint Board of Trustees, including Union and Employer representatives.

Method of Funding Benefits: The Plan is funded by employer contributions as provided for in the collective bargaining agreement.

Sponsoring Organizations: The Plan is maintained in accordance with collective bargaining agreements between various employers and the Bricklayers and Allied Craftworkers Local No. 4, California. Upon written request to the Trust Fund Office, participants and beneficiaries may determine whether a particular employer is a sponsor of the Plan, and, if so, the employer's address. Upon written request to the Trust Fund Office, participants and beneficiaries may obtain a complete list of the names and addresses of the employers sponsoring the plan. A copy of such list is available for examination at the Trust Fund Office. A copy of the collective bargaining agreement may be obtained by participants and beneficiaries upon written request to the Trust

Fund Office, and is available for examination by participants and beneficiaries at the office of the Plan.

Contributions: Contributions to provide Plan benefits are paid by the sponsoring employers in accordance with their bargaining agreements on a cents per hour basis.

Fiscal Year: The fiscal year of the Trust is the twelve month period ending each December 31, and the Trust's records are maintained on that basis.

Employer Identification Number: 95 1734798

Plan Number: 501

Name, Address and Telephone Number of Trust Fund Office

Tile Industry Health and Welfare Fund
1050 Lakes Drive, Ste. 120
West Covina, CA 91790

Name and Address of Agent for Service of Legal Process

Melissa W. Cook, Melissa W. Cook & Associates
3444 Camino Del Rio N. Ste. 106
San Diego, CA 92108
Service of legal process may also be made upon a Plan trustee.

Employer Trustees

Loren Rucker, Co-Chair
1050 Lakes Drive, Ste. 120
West Covina, CA 91790

Vivien Gallup
1050 Lakes Drive, Ste. 120
West Covina, CA 91790

George Ballantyne
1050 Lakes Drive, Ste. 120
West Covina, CA 91790

Andrew Games, Alternate Trustee
1050 Lakes Drive, Ste. 120
West Covina, CA 91790

Union Trustees

Chad Boggio, Chair
1050 Lakes Drive, Ste. 120
West Covina, CA 91790

Pete Gerber
1050 Lakes Drive, Ste. 120
West Covina, CA 91790

Luis Pinedo
1050 Lakes Drive, Ste. 120
West Covina, CA 91790

Stephen R. Person
1050 Lakes Drive, Ste. 120
West Covina, CA 91790

Union Trustees

Chris Schrader
1050 Lakes Drive, Ste. 120
West Covina, CA 91790

Joel Rehome
1050 Lakes Drive, Ste. 120
West Covina, CA 91790

ERISA RIGHTS

Your Rights

As a participant in the Tile Industry Health and Welfare Trust Fund 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 the following.

You can examine, without charge, at the Trust Fund Office and at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Employee Benefits Security Administration.

You can obtain, upon written request to the Trust Fund Office, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

The Trust Fund Office is required by law to furnish each participant with a copy of the summary of his/her annual financial report.

Continue Group Health Plan Coverage

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

There is a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Trust Fund Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Trust Fund Office, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

LIST OF PROVIDERS

In accordance with the disclosure requirements of the Health Insurance Portability and Accountability Act, we are informing you of the names and addresses of all Health Providers for the Trust Fund and their roles (i.e., whether they guarantee the payment of benefits or provide administrative services.)

List of Providers

Kasier Permanente
3840 Murphy Canyon Road
San Diego, CA 92123

Ameritas
475 Fallbrook Blvd.
Lincoln, NE 68521

UnitedHealthcare
5701 Katella Avenue
Cypress, CA 90630

Sav-Rx
224 N. Park Avenue
Fremont, NE 68025

VSP
3333 Quality Drive
Rancho Cordova, CA 95670

Ullico
8403 Colesville Road
Silver Spring, MD 20910