Summary Plan Description

of the

WECA ATC Health and Welfare Plan

AMENDED AND RESTATED EFFECTIVE December 9, 2021

WECA Commercial Apprentice Version

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ARTICLE I. INTRODUCTION

This document is the Summary Plan Description ("SPD") for your health coverage plan. This Summary Plan Description ("SPD") summarizes certain health and welfare coverages provided by the WECA ATC Health and Welfare Plan ("the Plan") and is hereby restated effective as of December 9, 2021. The coverages summarized in this SPD are provided through various insurance companies ("Insured Program") referenced in Appendix A. The Plan benefits full-time employees and apprentices and is described in separate component SPDs depending on your classification as a full-time employee or apprentice. The following pages summarize for you the Plan benefits available to apprentices. This summary has been prepared by the Trustees of the WECA ATC Health and Welfare Trust which administers the Plan.

The summary is designed to communicate the important information and facts concerning your health plan. Federal regulations entitle you to know what benefits your Plan provides, who is responsible for the operation of the Plan, and your rights and obligations under the Plan.

The specific benefits of each Insured Program (and additional information regarding who is eligible to received such benefits) are described in the following applicable documents: the UnitedHealthcare Insurance Company HMO Medical Certificate of Coverage, the UHC of California dba UnitedHealthcare of California, PPO Medical Certificate of Coverage, the UnitedHealthcare Benefits Plan of California PPO Dental Certificate of Coverage, the UnitedHealthcare Insurance Company, Group Life Accidental Death and Dismemberment Certificate of Coverage, the Unimerica Life Insurance Company, Group Short Term Disability and Long Term Disability Certificate of Coverage Unimerica Life Insurance Company, and Vision Certificate of Coverage UnitedHealthcare Insurance Company. These documents, as well as Summaries of Benefits and Coverages, Summaries of Material Modification, including annual open enrollment guides and letters to participants from WECA, together constitute your SPD for the WECA ATC Health and Welfare Plan ("the Plan"), as required under the Employee Retirement Income Security Act of 1974 ("ERISA"). Please read these documents carefully. These documents should be read and kept together. [NOTE: The Insurance Companies for the Plan's insured medical benefits are required to comply with the coverage requirements of the Affordable Care Act. Please refer to the applicable Summary of Benefits documents for the description of the available coverage for preventive care, emergency care, routine costs in connection with participation in approved clinical trials, limits on out-of-pocket costs, any other limit on coverage and the description of the procedures applicable to claims, appeals and external review. Such Insurance Companies have the sole and complete discretion for determining and applying the coverage requirements of the Affordable Care Act, provided however the Plan Administrator will comply with the Affordable Care Act with regards to any determinations involving eligibility for coverage. Your employer is responsible for determining any obligation to offer you coverage under applicable law, including but not limited, to Section 4980H of the Internal Revenue Code.]

The summary of the Plan is intended to explain in a simple and direct manner the provisions of the Plan and if you do not understand any part of the summary, we will be happy to provide an explanation to you. However, please be advised that any oral representations made to you or your authorized representative (including your medical provider) regarding coverage of, or payment level for benefits by a Plan representative will not be binding on the Plan. The Plan is

legally governed by a Plan document and trust agreement which have been submitted to and approved by the Internal Revenue Service. The Plan document, trust agreement and applicable insurance contracts supersede any contrary or conflicting language which may be contained in this summary. If the terms of the Plan document or this SPD conflict with the terms of an Insured Program, the terms of the Insured Program will control for purposes of that Insured Program, unless superseded by applicable law.

Certain provisions of the Plan are summarized in this SPD. This description does not state all of the Plan terms and conditions. In all cases, the Plan and trust documents and the applicable insurance contracts – and not this SPD – will govern the benefits paid from the Plan.

The Plan is established and maintained solely for the benefit of the participants and their beneficiaries, and all the provisions of the Plan will be applied uniformly and consistently. Interested participants may see a copy of the Plan and Trust agreement at the Administrative Office, WECA, 3695 Bleckely Street, Rancho Cordova, CA 95655. You will also find pertinent information about the Plan and Plan sponsors in this booklet.

Please be advised that assignments are not permitted for any participant rights under the Plan or ERISA including but not limited to, the rights to request plan documents under Section 104(b)(4) or file suit against the plan under ERISA Section 502(a).

ARTICLE II. YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a participant in the WECA ATC Health and Welfare Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Plan Coverage

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

your COBRA continuation coverage rights.

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, 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. [NOTE: The Plan Administrator is the named fiduciary for the Plan, and as such has the discretionary power and authority to act with respect to the administration of the Plan.]

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court, however any lawsuit must be brought within one year after the date the Insurance Company or Plan Administrator (as applicable) renders its final adverse benefit determination. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plans' money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

Remember: This SPD does not attempt to cover every detail of the Plan. Also, only the Plan Administrator, insurance carriers, and HMOs, to which the authority to determine and pay claims for benefits have been delegated, are authorized to make administrative interpretations of the provisions of any plan or applicable insurance policy or evidence of coverage or certificate of coverage, as applicable, and will do so **only** in writing. You should not rely on any representation – whether oral or in writing – that any other individual may make concerning Plan provisions and your entitlement to benefits under the Plan.

ARTICLE III. PERTINENT INFORMATION IN REGARD TO THE HEALTH AND WELFARE PLAN

SPONSORING ASSOCIATION INFORMATION

Association's Name:	Western Electrical Contractors Association, Inc. (WECA)
Association's Address:	3695 Bleckely Street Rancho Cordova, CA 95655
Association's Tax Identification Number:	94-0453910
Fiscal Year End:	August 31

PLAN INFORMATION

Plan Administrator's Name:	The Trustees of the WECA ATC Health and Welfare Trust
Telephone Number:	(916) 453-0112
Effective Date:	June 30, 1992; Restated effective December 9, 2021.
Plan Year:	The 12-month period beginning September 1 and ending on August 31
Contract Administrator's Name, Address, and Telephone Number:	Western Electrical Contractors, Assn., Inc. 3695 Bleckely Street Rancho Cordova, CA 95655 (916) 453-0112
Type of Plan:	Medical and other health related benefits
Type of Plan Administration:	Contract Administration for various Insured Programs
Plan Number:	001

TRUSTEES

Names:	Members of the WECA ATC Health and Welfare Board of Trustees: Clint Alessandro, Chair Jay Taylor, Vice Chair Jeremy Alessandro Nathan Gosink Dustin Phillips
Address:	The address for all the above is: 3695 Bleckely Street Rancho Cordova, CA 95655

The Plan is administered by the Trustees of the WECA ATC Health and Welfare Trust at the address designated above. The Trust Fund is designated as the agent for service of process at the same address. Service of legal process may also be made upon any Plan Trustee.

ARTICLE IV. ELIGIBILITY AND PARTICIPATION REQUIREMENTS

A. Benefits.

The benefits under this Plan include major medical coverage, dental coverage, vision, short term disability coverage, long term disability coverage, life insurance, accidental death and dismemberment insurance, an Employee Assistance Program, and such other health and welfare benefits as provided under the Summary of Benefits Booklets and/or other agreements. This SPD component of the Plan describes the benefits available to eligible apprentices (hereinafter, "Eligible Apprentices"). A description of your benefits is contained in the Summary of Benefits Booklets you have already received or that are enclosed with this summary. [NOTE: If you are a Full-Time Employees or an Electrical Employment Fast Track Trainee (EEFTT) Employee, your benefits are described in a separate SPD of the Plan. Contact the Plan to obtain a copy if you fall within either of these categories and received this SPD in error.] A description of your benefits is contained in the Summary of Benefits Booklets you have already received.

B. Eligible Apprentice Coverage.

Only Eligible Apprentices are eligible for coverage under this Plan.

You are an Eligible Apprentice if you are a Commercial Apprentice employed by an employer who meets the following criteria:

- is a member of WECA and;
- who is approved to train by WECA and;

- registered with the state and federal apprenticeship bureaus to train in the Commercial Training Program and.

- who enters into a Participation Agreement which provides for participation in the WECA ATC Health and Welfare Trust and this WECA ATC Health and Welfare Plan.

C. Initial Coverage.

Insurance coverage shall become effective on the first day of the second calendar month following the month in which the contractor's report of hours worked indicates that the Eligible Apprentice has accumulated at least **one hundred and thirty (130)** Credited Hours. Health coverage under the Plan offered by WECA is mandatory for all commercial/industrial training program Apprentices.

The contractor's report refers to the "Monthly Hours Worksheet" submitted by the contractor to WECA by the 15th of each month. The Worksheet does not necessarily report all of the hours worked in a calendar month but shall cover at least a four (4) consecutive week period.

Credited Hours are reported hours worked by an Apprentice for any employer who is approved to participate in the Plan and has agreed to make health and welfare contributions to the Plan.

An Eligible Apprentice who has satisfied the participation requirements described above shall not commence participation unless and until such Apprentice has completed and returned to the Plan Administrator an enrollment card and any additional required forms, and has submitted to any health or medical examinations required by the Administrator (with regards to enrollment in non-medical benefits only); and

D. Dependent Coverage.

Individuals who qualify for Dependent coverage may only be added to medical coverage at the time the Apprentice is initially enrolled in coverage, during the annual Open Enrollment period (Oct. 1 – Oct. 30) or when a HIPAA Special Enrollment Event (as described below in subsection (G)) takes place. Dependent coverage premium is the responsibility of the Apprentice.

Qualified Dependents who may be covered under the Plan include the following people:

1. Lawfully married spouse.

2. An Apprentice's domestic partner. Domestic partners are defined as same-sex and opposite-sex couples registered with any state or local government agency authorized to perform such registrations. There are no requirements for proof of relationship or waiting periods that are not also applied to married couples

3. Children who are under the age of 26 in accordance with Section 1001(5) of the Patient Protection and Affordable Care Act, and Section 2301(b) of the Health Care and Education Reconciliation Act of 2010. For this purpose, Children include a son, daughter, stepson, stepdaughter or eligible foster child as defined in Section 152(f) of the Code, a child who has been adopted by or placed for adoption with the Participant, and a child who is an "alternate recipient" under a Qualified Medical Child Support Order pursuant to Section 609 of ERISA (see subsection (F) for more information on QMCSOs).

4. Unmarried children of any age who are unable to support themselves due to a mental or physical disability, who reside with the Participant for over half of the year and receive over half of their support from the Participant.

The Participant is required to provide any information about any Dependent that is required to substantiate their eligibility for coverage to the Plan Administrator. A spouse does not qualify as a Dependent while actively serving in the armed forces of any country.

E. Automatic Coverage Due to a QMCSO.

If a child support order is submitted to the Plan providing for the coverage of a child as a Dependent, it will be reviewed by the Plan Administrator. If the Plan Administrator determines that the order is a QMCSO, the child's enrollment as a Dependent in your Plan will be automatic. If the order was issued in the form of a "National Medical Support Notice" and is subsequently determined to be qualified, you (and your child) will automatically be enrolled in the plan option chosen by the applicable state child support enforcement agency.

You may obtain detailed information on the procedures governing QMCSO determinations, without cost, by contacting WECA's Administrative Office.

F. HIPAA Special Enrollment Events.

1. Acquisition of a new Dependent. You may also enroll new Dependents whom you acquire by marriage, birth, adoption, placement for adoption, or domestic partnership. If you are eligible for coverage and acquire a Dependent as a result of marriage, birth, adoption, placement for adoption, or domestic partnership, you may obtain coverage for such Dependent, provided you request enrollment within 30 days of the date of the marriage, birth, adoption, placement for adoption, or domestic partnership. The following conditions apply with respect to this special enrollment event:

    a. Marriage. If you acquire a new Dependent through marriage, you may enroll your new spouse and/or any other newly acquired Dependents in the Plan. Coverage will begin no later than the first day of the first calendar month next following the date you request enrollment in the Plan.

b. New Dependent child. If you acquire a new Dependent child through birth, adoption, or placement for adoption, you may enroll the new Dependent child and/or your spouse (if not previously enrolled). Coverage will begin no later than the date of the child's birth or the earlier of the date of adoption or placement for adoption.

c. New domestic partner. If you acquire a new domestic partner (as defined in Section IV(E) above), you may enroll your new domestic partner and/or any other newly acquired Dependents in the Plan. Coverage will begin no later than the first day of the first calendar month next following the date you request enrollment in the Plan.

If you timely enroll a new Dependent, you and your Dependents will be offered the same medical, dental and vision coverage available to similarly situated individuals who enroll when they are first eligible.

2. Loss of other plan coverage. If you did not enroll your Dependent(s) in the Plan because at the time of your initial eligibility for coverage, or the most recent open enrollment period your Dependent(s) were covered under another group health plan or had other health insurance, your Dependent(s) may later obtain coverage under this Plan, outside of Open Enrollment, upon losing such other coverage. Enrollment in this Plan pursuant to this special enrollment event is available if the coverage in another group health plan or other health insurance was lost due to the following reasons:

a. Exhaustion of COBRA continuation coverage; or

b. Termination of group health plan or health insurance coverage because of a "loss of eligibility" (as defined below).

For purposes of this special enrollment event, "loss of eligibility" includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, a reduction in hours of employment, ceasing to reside, live or work in the service area of an HMO if no other coverage is available under the other plan, or a dependent ceasing to qualify as a dependent under the other plan. A "loss of eligibility" does not include a loss resulting from a failure to pay premiums on a timely basis or a termination for cause (such as making a fraudulent claim or an intentional misrepresentation).

To obtain coverage under this special enrollment event, you must request enrollment in the Plan within 30 days of losing coverage under the other group health plan or other health insurance. Coverage will begin no later than the first day of the first calendar month coinciding with or next following the date you request enrollment in the Plan.

Special enrollees will be offered all of the same medical, dental and vision coverage available to similarly situated individuals who enroll when they are first eligible. Special Enrollment Events under the Children's Health Insurance

Program Reauthorization Act of 2009. Effective as of April 1, 2009, you or your Dependent may enroll in medical coverage under the Plan if you or your dependent, as applicable:

a. Lose eligibility for coverage under Medicaid or the Children's Health Insurance Program or CHIP (formerly known as SCHIP or State Children's Health Insurance Program); or

b. Become eligible for premium assistance under the Plan pursuant to Medicaid or CHIP.

To obtain coverage under this special enrollment event, you or your Dependents must request enrollment in the Plan within 60 days of losing eligibility for Medicaid or CHIP coverage or gaining eligibility for premium assistance under Medicaid or CHIP, as applicable. Coverage will begin no later than the first day of the first calendar month coinciding with or next following the date you or your Dependent requests enrollment in the Plan.

Special enrollees will be offered all of the medical benefit packages available to similarly situated individuals who enroll when they are first eligible. Credited Hours Account.

A Credited Hours Account ("Account") will be established and maintained on your behalf. Once you have satisfied the participation requirements described in Section B. above, each month **one hundred and thirty (130)** Credited Hours will be deducted from the total number of Credited Hours accumulated and held in your Account to purchase one month's health and welfare benefits for you for the second following calendar month.

For example, **one hundred and thirty (130)** Credited Hours from February's Account would be deducted to purchase Health and Welfare coverage for the month of April.

Credited Hours will be deducted from your Account as described herein until insufficient Credited Hours remain in your Account for one full month's coverage. In this event, see Section H. for information on how to continue coverage.

G. Maximum Reserve.

All hours in excess of **130** credited each month shall be used as follows: One hundred percent (100%) of such excess hours shall be credited to the Apprentice's reserve account until **520** hours for **four** month's premiums) have been accumulated. All hours in excess of 520 shall revert to the Plan to pay for administrative costs of the Plan.

H. Payment of Premiums.

Each Participating Employer is required to deposit with the Trust a sum as determined by the Plan Administrator per Credited Hour for each Participant it employs. A Participant may elect to purchase health coverage under the Plan for one dependent at a cost as determined by the Plan Administrator. A Participant may elect to purchase health

coverage under the Plan for two or more dependents at a cost as determined by the Plan Administrator. A Participant may elect to purchase dental only coverage for his eligible dependents at a total cost as determined by the Plan Administrator. The rate of Participating Employer contributions for health and welfare benefits and the Apprentice's cost of health coverage for eligible Dependents may change from time to time. Any such change in costs will be communicated to Participating Employers and Apprentices by the Plan Administrator. In the event any check is returned by the Apprentice's financial institution for any reason, a returned check fee will be imposed by the Plan Administrator.

I. Termination of Coverage.

1. Your coverage under the Plan terminates on whichever of the following dates occurs first:

   a. the last day of the month following the month in which there are insufficient Credited Hours in your Account to qualify you to receive one months' full coverage; or

      For example, if there are insufficient hours in your April account to qualify you to receive June coverage, your coverage will terminate at the end of May; or

   b. the last day of the month for which the last required Premium payment has been made in accordance with the terms of the Plan; or

   c. the date on which the Plan terminates.

2. Dependent coverage will terminate when your coverage terminates, when the Dependent ceases to be a Dependent as defined by the Plan, or for non-payment of the Dependent coverage premium, whichever occurs first. If Dependent coverage will terminate for non-payment, Dependent coverage will be retroactively canceled back to when the first monthly premium became due, and you will be held financially responsible for any claims incurred by the ineligible Dependent.

J. Continuation of Health Coverage.

1. Under most circumstances, if your health coverage terminates, you and any covered Dependents will be offered an opportunity to pay for a temporary extension of group health plan coverage (i.e., medical, dental, vision and EAP coverage) under a federal law known as the Consolidated Omnibus Budgetary Reconciliation Act ("COBRA"). COBRA-like continuation coverage is available to domestic partners and their children to the same degree and in the same manner as continuation coverage is available to spouses and stepchildren A description of your rights under COBRA is contained in the "Notice Regarding Continuation of Group Health Benefits Under the WECA ATC Health and Welfare Plan" which you have already received or that is enclosed with this summary.

COBRA Coverage will be offered to each person losing coverage who is a "Qualified Beneficiary." You, your spouse, your Domestic Partner, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost due to a Qualifying Event (as defined below).

2. COBRA Qualifying Events.

COBRA "Qualifying Event" is an event that causes you and/or your covered Dependents to lose group health coverage.

If you are an Apprentice, you'll be entitled to elect COBRA if you lose your group health coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an Apprentice, you'll be entitled to elect COBRA if you lose your group health coverage under the Plan because of the following qualifying events:

- Your spouse dies.
- Your spouse's hours of employment are reduced.
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced or legally separated from your spouse. Also, if your spouse (the Apprentice) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

A person enrolled as the Apprentice's dependent child will be entitled to elect COBRA if he or she loses group health coverage under the Plan because of the following qualifying events:

- The parent-Apprentice dies.
- The parent-Apprentice's hours of employment are reduced.
- The parent-Apprentice's employment ends for any reason other than his or her gross misconduct; or

- The child stops being eligible for coverage under the Plan as a "dependent child."

3. Your Obligation to Provide Notice Under COBRA for Some Qualifying Events.

You are responsible for notifying the Plan Administrator within sixty (60) days of one of the following events:

a. One of your children ceases to be a Dependent child as defined in the Plan; or

b. You become divorced or legally separated from your spouse; or

c. After your Plan Administrator is so notified by you of one of these events, the Plan Administrator will provide a notice to your Dependent child, spouse, or former spouse regarding the possible continuation of group health coverage.

You must notify the plan administrator at the following address:

Western Electrical Contractors Association, Inc.
3695 Bleckely Street
Rancho Cordova, CA 95655
Attention: Plan Administrator & Insurance Administrator

Your failure to notify the Plan Administrator of an event described above, within the sixty (60) day period described above, will result in the loss of the rights of the Dependent to elect to continue coverage.

4. Electing COBRA.

a. An election to continue coverage must be made during the period beginning on the date coverage under the Plan terminates and ending sixty (60) days after the later of (1) the date coverage under the Plan terminates; or (2) the date that the Notice is sent to the person entitled to the election. If you do not choose to continue coverage, your health plan coverage will end. If you elect not to have coverage and then change your mind during the sixty (60) day election period, you may still elect continuation of coverage provided that you notify the plan administrator of your election to continue coverage within the sixty (60) day election period.

b. The election to continue coverage for a Dependent child may be made by you or your spouse. If you or your spouse declines coverage for a Dependent child, the Dependent child is entitled to elect to continue coverage on his or her own behalf. Each family member is entitled to make a separate continuation election among the types of coverage under which he or she was previously covered.

5. COBRA Premiums.

a. If you elect to continue group health coverage at group rates, you are obligated to pay up to one hundred two percent (102%) of the premiums for the coverage. However, if the qualified beneficiary elects the extended twenty-nine (29) month period of coverage under the special provisions for totally disabled beneficiaries (as explained below), the Plan Administrator can charge the beneficiary one hundred fifty percent (150%) of the applicable premiums, rather than one hundred two percent (102%), for the nineteenth (19th) through twenty-ninth (29th) months of coverage. The Plan Administrator will inform you of the premiums to be paid.

b. If you elect COBRA continuation coverage, the Credited Hours remaining in your Account will **not** be available for COBRA premium payment. The participant will be required to pay the entire amount. The charge for COBRA coverage will be the actual monthly premium paid to the insurance carrier for the Participant and eligible Dependents (if applicable), plus two percent for administration.

c. For each additional month during which you desire to continue coverage under COBRA, you will need to make payment to the Plan in an amount and manner established by the Plan Administrator.

d. In order to continue coverage, you will need to make monthly premium payments. Premium payments will be considered timely if made within a grace period of thirty (30) days after the date the payment is due. Your coverage may be canceled if payment is not made by the end of the grace period. Notwithstanding the foregoing, no payment of any premium is required to be made before the day which is forty-five (45) days after the day on which you elected to continue health care coverage.

If your status as an apprentice does not change, then any Credited Hours remaining in your Account will be held in reserve for a period of twelve (12) consecutive months following the termination of coverage under the Plan. If you again become eligible for coverage under the Plan within this period of twelve (12) consecutive months, these Credited Hours will be applied toward the purchase of benefits under the Plan. If these Credited Hours are not used before the end of this twelve-month period, they will be forfeited.

6. How Long Does COBRA Coverage Last?

COBRA coverage is a temporary continuation of group health plan coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive up to a maximum of 36 months of coverage under the Plan's Medical and Dental components.

These "36-month" qualifying events include the death of the Apprentice, the Apprentice's divorce or legal separation, or a dependent child's losing eligibility as a dependent child.

When the qualifying event is the end of employment or reduction of the Apprentice's hours of employment, and the Apprentice became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the Apprentice) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the covered Apprentice becomes entitled to Medicare within 18 months *before* the termination or reduction of hours. Otherwise, when the qualifying event is the end of employment or reduction of the Apprentice's hours of employment, COBRA coverage generally can last for only up to a total of 18 months.

a. Disability extension of COBRA coverage.

If a qualified beneficiary is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, all of the qualified beneficiaries in your family may be entitled to get up to an additional 11 months of COBRA coverage, for a maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the Apprentice's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the Apprentice's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above).

The disability extension is available only if you notify the Plan Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination.
- the date of the Apprentice's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered Apprentice's termination of employment or reduction of hours.

b. Second qualifying event extension of COBRA coverage.

If your family experiences another qualifying event while receiving COBRA coverage because of the Apprentice's termination of employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the spouse, Domestic Partner and/or dependent children receiving COBRA coverage can get up to 18 additional months of COBRA coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse, Domestic Partner and/or any dependent children getting COBRA coverage if the Apprentice or former Apprentice dies or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse, Domestic Partner and/or dependent child to lose coverage under the Plan had the first qualifying event not occurred. (This extension is not available under the Plan when an Apprentice becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

This extension due to a second qualifying event is available only if you notify the Plan Administrator in writing of the second qualifying event within 60 days after the date of the second qualifying event. **Failure to notify the Plan Administrator within 60 days after the date of the second qualifying event will result the loss of the right of a qualified beneficiary to elect an extension of COBRA coverage.**

7. CAL-COBRA.

If you receive coverage under an insurance contract or HMO, you may be entitled to extend your COBRA continuation coverage period for a total of 36 months under state law if you were initially only entitled to 18 or 29 months of COBRA continuation coverage. Contact your insurer or HMO for further details regarding this extension.

K. Special Rule for Periods of COBRA Continuation Coverage Subject to the Uniformed Services Employment and Reemployment Rights Act of 1994.

Medical coverage for you and/or your Dependents may be continued through COBRA continuation coverage while you are on a leave of absence that is subject to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Coverage shall begin on the date of the Qualifying Event which results in you or your Dependent becoming eligible for COBRA continuation coverage and shall end on the earliest of the following dates:

- The 24-month period beginning on the date on which your absence for military service begins; or

- The period ending on the day after the date on which you fail to apply for or return to a position of employment with the Participating Employer, as determined under § 4312(e) of USERRA.

During this time, you will be required to pay for COBRA continuation coverage provided that, the COBRA Contributions for continued coverage for Apprentices who perform service in the Uniformed Services of the United States for less than 31 days as provided under USERRA, will not exceed the Apprentice's share, if any, with respect to an Apprentice for whom a Qualifying Event has not occurred.

L. Conversion Rights.

If your coverage under an insured program offered under this Plan is reduced or terminated, you may be entitled to convert your coverage. The terms and conditions of such conversion right, and the amount and nature of the insurance coverage provided pursuant to such conversion right, if any, shall be as set forth in the Insurance Contract.

M. Benefits While on a Leave of Absence Subject to the Family and Medical Leave Act of 1993 or California Family Rights Act.

If you take a leave of absence that is subject to the Family and Medical Leave Act of 1993 ("FMLA") or the California Family Rights Act ("CFRA"), you will be entitled to continue to participate in the Plan as long as the law requires (generally up to twelve weeks). If you want to continue Dependent coverage, you must continue to timely pay your monthly Dependent premium. When you return from a leave of absence subject to FMLA, you will be entitled to have your health benefits reinstated or continue as if you had never left.

If you fail to return to covered employment when your FMLA or CFRA leave of absence ends, you may be eligible to enroll in COBRA continuation coverage at that time.

Please contact your employer for more information regarding your rights under the FMLA or CFRA.

N. Death Benefits.

When you become eligible for group life insurance and accidental death and dismemberment coverage, you should designate a Beneficiary or Beneficiaries for such purposes. If you die while covered by the Plan, your benefits will be awarded to the designated Beneficiary or Beneficiaries, or if none, then to your spouse, or if none, then to your estate.

It is important to keep your Beneficiary designation up to date. For example, if you designate one person and later marry another person, the first person would still be entitled to collect any benefit if you die before changing the Beneficiary.

ARTICLE V. CLAIMS PROCEDURE FOR THE PLAN

A. Eligibility Questions.

If you have a question relating solely to eligibility under the Plan that is not connected to a claim for benefits under the Plan, you must file a written inquiry with the Plan Administrator within 30 days of the event that gives rise to the question. The Plan Administrator will make a determination of your eligibility within 60 days after the written request is received. Decisions of the Plan Administrator shall be conclusive and binding. The Plan Administrator will treat a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at that time) as an adverse benefit determination subject to the claims and appeals procedures described in this section.

B. Claim for Insured Benefits.

If you have a claim for benefits under an Insurance Contract, your claim must be made directly to the Insurance Company in accordance with the terms of the Insurance Contract. If the Insurance Company denies any claim, you or your Beneficiary shall follow the Insurance Company's claims review procedure, as specified in the Insurance Contract or the Certificate of Insurance, Certificate of Coverage, Evidence of Coverage, or other similar documents that are provided by an Insurance Company to Participants and Beneficiaries.

C. Claims for Medical Plan Benefits.

The claims procedure described here will only apply when there are no alternate procedures described in the Evidence of Coverage or similar documents that are provided by an Insurance Company to Participants and Beneficiaries.

As part of a full and fair review of your claim for medical plan benefits the Insurance Company is required to ensure that its decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as claims adjudicator or medical expert) will not be made based upon the likelihood that the individual will support the denial of benefits.

The Plan Administrator will treat a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at that time) as an adverse benefit determination subject to the claims and appeals procedures described in this section.

1. Notice of Claims for Medical Expense Benefits.

All other claims for payment of medical expense benefits must be submitted to the Insurance Company for the particular plan for which the claim is being made. All claims for payment of benefits must be submitted in the form prescribed by the Insurance Company and must include the required information and substantiation. The Insurance Company may require that itemized bills, receipts, and other proof of loss be submitted in addition to the claim form. You must

submit all claims for payment, including complete proof of the claim, within 12 months of the date the expense is incurred, otherwise no claim for payment will be accepted.

2. Timing of Decisions on Claims for Medical Plan Benefits.

a. Urgent Care Claims.

An "Urgent Care Claim" is a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

For an Urgent Care Claim that is filed in accordance with the proper procedure, the Insurance Company must notify you of the initial decision within 72 hours from the time of receipt of a proper initial claim. The notice of denial may be oral with a written or electronic confirmation to follow within three days.

If you do not follow the proper procedure when you file an Urgent Care Claim or your claim is not complete, the Insurance Company will notify you of the improper filing and how to correct or complete the claim within 24 hours after the claim was received. You must provide the Insurance Company with the required information within 48 hours. The Insurance Company will notify you of its decision within 48 hours from the time you provide the required information or from the end of the 48-hour deadline for you to provide the required information, whichever is sooner. For Urgent Care Claims involving an extension of an ongoing treatment or a course of treatment over a period of time (*i.e.*, a Concurrent Care Claim that is also an Urgent Care Claim), the Insurance Company must provide notice of a decision to you within 24 hours of the receipt of the claim so long as the claim was made at least 24 hours prior to the expiration of the previously approved prescribed period of time or number or treatments.

b. Pre-Service Claims.

A "Pre-Service Claim" means any claim for a benefit with respect to which the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

If you do not follow the proper procedure when you file a Pre-Service Claim (other than one that qualifies as an Urgent Care Claim), the Insurance Company will notify you of the improper filing and how to correct it within five days after the claim was received. For a Pre-Service

Claim (other than one that qualifies as an Urgent Care Claim) that is filed correctly, you will be notified of the initial decision by Insurance Company within 15 days of receipt of the initial claim unless an extension, of up to 15 days, is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified of the extension within the initial 15 days. If an initial claim is determined to be incomplete, the Insurance Company must notify you within 15 days of receiving the initial claim what information is required to complete the claim, and you will have 45 days to provide the required information. The Insurance Company will notify you of its decision within 15 days from the time you provide the required information or from the end of the 45-day deadline for you to provide the required information, whichever is sooner.

c. Post-Service Claims.

A "Post-Service Claim" means any claim for a benefit that is not a Pre-Service Claim (including Urgent Care Claims).

For Post-Service Claims, the Insurance Company must notify you within 30 days of receipt of the initial claim unless an extension, up to 15 days, is necessary due to matters beyond the control of the Plan. If an extension is necessary, you shall be notified of the extension within the initial 30 days. If an initial claim is determined to be incomplete, the Insurance Company must notify you within 15 days of receiving the initial claim what information is required to complete the claim. Once such notification is made, you will have 45 days to provide the required information. The Insurance Company will notify you of its decision within 15 days from the time you provide the required information or from the end of the 45-day deadline for you to provide the required information, whichever is sooner.

d. Concurrent Care Claims.

If a Concurrent Care Claim is not an Urgent Care Claim, and there is a reduction or termination of the previously approved on-going course of treatment provided over a period of time or number of treatments (other than by Plan amendment or termination), you will be notified by the Insurance Company sufficiently in advance of the reduction or termination to allow you to appeal the denial and receive a determination on appeal before the reduction or termination of the benefit. To appeal a denial of a Concurrent Care Claim, you must follow the review procedures described in the next section, entitled "Review Procedures."

3. Notice of Denied Claims for Medical Plan Benefits.

In the event that any claim for payment of medical plan benefits is denied in whole or in part, the Insurance Company shall notify you in writing of such denial and of the right to a review thereof. Such written notice shall set forth, in an

understandable manner, specific reasons for such denial, specific references to the Plan or Insurance Contract provisions on which such denial is based, a description of any information or material necessary to perfect the claim, an explanation of why such material is necessary and an explanation of the Plan's review procedure.

If the claim for benefits is denied based on an internal rule, guideline, protocol, or other similar criterion, the notice will either state the specific rule, guideline, protocol, or other similar criterion; or include a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge upon request.

If the claim for benefits has been denied based on a medical necessity or experimental treatment or a similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the applicable plan to your medical circumstances, or include a statement that such explanation will be provided to you free of charge upon request. If the claim involves urgent care the notice will include a description of the expedited review process applicable to such claims. The notice will state how and when to request a review of the denied claim. The notice will also state that you have a right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination after completion of all levels of review required by the Plan but that any lawsuit must be brought within one year from the date of the final adverse benefit determination.

Notices will be provided in a culturally and linguistically appropriate manner and will also include the following information, as appropriate:

1. Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; and

2. For a claim denial, the denial code, and its corresponding meaning, as a well as a description of the Plan's on Insurance Contract's standard, if any, that was used in denying the claim; and

3. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and

4. A description of the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act section 2793.

D. Claims for Dental, Vision or EAP Benefits.

The claims procedure described here will only apply except to the extent that there are no alternate procedures described in the Evidence of Coverage or similar documents that are provided by an Insurance Company to Participants and Beneficiaries.

The Insurance Company will notify you within 30 days of receipt of the initial claim unless an extension, up to 15 days, is necessary due to matters beyond the control of the Insurance Company. If an extension is necessary, you shall be notified of the extension within the initial 30 days. If an initial claim is determined to be incomplete, the Insurance Company must notify you within 15 days of receiving the initial claim what information is required to complete the claim. Once such notification is made, you will have 45 days to provide the required information. The Insurance Company will notify you of its decision within 15 days from the time you provide the required information or from the end of the 45-day deadline for you to provide the required information, whichever is sooner.

E. Notice of Denied Dental, Vision or EAP Claim

In the event that any claim for payment of dental, vision or EAP benefits is denied in whole or in part, the Insurance Company shall notify you in writing of such denial and of the right to a review thereof. Such written notice shall set forth, in an understandable manner, specific reasons for such denial, specific references to the Plan or Insurance Contract provisions on which such denial is based, a description of any information or material necessary to perfect the claim, an explanation of why such material is necessary and an explanation of the Plan's review procedure.

If the claim for benefits is denied based on an internal rule, guideline, protocol, or other similar criterion, the notice will either state the specific rule, guideline, protocol, or other similar criterion; or include a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge upon request.

If the claim for benefits has been denied based on a medical necessity or experimental treatment or a similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the applicable plan to your medical circumstances, or include a statement that such explanation will be provided to you free of charge upon request. The notice will state how and when to request a review of the denied claim. The notice will also state that you have a right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination after completion of all levels of review required by the Plan, but that any lawsuit must be brought within one year from the date of the final adverse benefit determination.

F. Claims for Disability Benefits.

The claims procedure described here will only apply when there are no alternate procedures described in the Certificate of Coverage or similar documents that are provided by an Insurance Company to Participants and Beneficiaries.

The Insurance Company will ensure that all claims for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, the Insurance Company's decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as claims adjudicator or medical or vocational expert) must not be made based upon the likelihood the individual will support the denial of benefits.

NOTE: The Plan Administrator will make the determination regarding the eligibility of a dependent child over the age of 26 who may be eligible for coverage because of a disability. The Plan Administrator will comply with all requirements in this section in adjudicating these eligibility claim (including timing and notice requirements). The procedure below will not apply if the denial of eligibility for a dependent child over the age of 26 is not accompanied by a claim and is strictly a question of eligibility.

1. Notice of Claim for Disability Benefits.

As a condition to the receipt of benefits under the Group Disability Insurance Plan, if you have a claim for disability benefits, you must give notice of such claim to the Insurance Company in accordance with the procedures established by the Insurance Company.

2. Timing of Decisions on Disability Claims.

When you make a claim for disability benefits, the Insurance Company will send you a written notice of its decision on the claim within 45 days after receipt of the claim, unless an extension of up to an additional 30 days is necessary due to circumstances beyond the control of the Plan. The Insurance Company will notify you of the reason for the delay prior to expiration of the initial 45-day period and give a date by when it expects to make a decision. If, prior to the end of the first 30-day extension period, the Insurance Company determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making such determination may be extended for up to an additional 30 days. The Insurance Company will notify you of the reason for the delay prior to expiration of the first 30-day extension period and give a date by when it expects to render a decision.

If the claim for disability benefits is not complete, the Insurance Company will notify you within 45 days after receiving the claim stating the information that is necessary to complete the claim. You will have 45 days to provide the required information. The Insurance Company will notify you of its decision within 30 days after receiving the required information from you or within 30 days after the

45-day deadline for you to provide the required information expires, whichever is sooner.

3. Notice of Denied Disability Claims.

If the Insurance Company denies the claim for disability benefits, in whole or in part, the Insurance Company will send you a written notice of the denial. The notice of the denial will:

a. Give the specific reason(s) for the denial, including a discussion of the decisions and the basis for disagreeing with or not following the (1) views presented by the claimant to the plan of health care professionals treating the claimant and vocational professional who evaluated the claimant, (2) views presented by the medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with a claimant's denial, and (3) the claimant's disability determination made by the Social Security Administration that was presented by the claimant to the Insurance Company (if applicable);

b. Reference the specific Plan or Insurance Contract provision(s) on which the determination is based.

c. Contain a statement that you are entitled to receive upon request, free access to and copies of documents, records, and other information relevant to your claim.

d. Describe any additional information needed to perfect the claim and an explanation of why such added information is necessary.

e. Provide an explanation of the appeal procedure along with time limits.

f. Contain a statement that you have the right to bring civil action under ERISA Section 502(a) following an appeal.

g. Describe any applicable contractual limitation periods on benefit disputes, including the limitation that all lawsuits brought under ERISA Section 502(a) must be brought within one year of the final adverse benefit determination.

h. If the denial was based on an internal rule, guideline, protocol, standard, or similar criterion, a statement will be provided that such rule, guideline, protocol, standard, or criteria that was relied upon will be provided free of charge to you, upon request.

i. If the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and

j. Include a statement that if a Participant is not proficient in English and has questions about a claim denial, they should contact the Insurance Company to find out if assistance is available.

G. Claims for Life Insurance and Accidental Death and Dismemberment Benefits.

The claims procedure described here will only apply when there are no alternate procedures described in the Evidence of Coverage or similar documents that are provided by an Insurance Company to Participants and Beneficiaries.

1. Notice of Claim for Life Insurance and Accidental Death and Dismemberment Benefits.

As a condition to the receipt of life insurance or accidental death and dismemberment benefits, a Participant who has a claim for such benefit must give notice of such claim to the Insurance Company in accordance with the procedures established by the Insurance Company.

2. Timing of Decision on Life Insurance and Accidental Death and Dismemberment Claims.

When you make a claim for life insurance or accidental death and dismemberment benefits, the Insurance Company will send you a written notice of its decision on the claim within 90 days after receipt of the claim. The period for making such determination may be extended for up to an additional 90 days if special circumstances require an extension of time for processing the claim. If such an extension of time for processing the claim is required, written notice of the extension shall be furnished to you prior to the termination of the initial 90-day period. This notice of extension shall indicate the special circumstances requiring the extension of time and the date by which the Insurance Company expects to render its decision.

3. Notice of Denied Life Insurance and Accidental Death and Dismemberment Claims.

In the event any claim for life insurance or accidental death and dismemberment benefits is denied, in whole or in part, the Insurance Company shall notify you of such denial in writing. Such written notice shall set forth, in a manner calculated to be understood by you, the specific reason(s) for the denial and references to the specific Plan and Insurance Contract provisions upon which the denial is based. If the claim was denied because you did not furnish complete information or documentation, the notice will specify the additional material or information needed to perfect the claim and an explanation of why such information or material is necessary. The notice will also describe the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination after completion of all levels of review required by the Plan

but that any lawsuit must be brought within one year from the date of the final adverse benefit determination.

ARTICLE VI. APPEAL PROCEDURE

A. Named Fiduciary.

Each Insurance Company is a named fiduciary that has the discretionary power and authority to act with respect to any appeal from a denial of a claim for payment of Plan benefits that are provided pursuant to an Insurance Contract**.** The Insurance Company shall perform a full and fair review of denied claims arising under these insured plans and the Insurance Company's actions shall be final and binding on all persons.

B. Appeal of Denied Claims for Medical Plan Benefits.

The appeal procedure described here only applies when there are no alternate procedures described in the Evidence of Coverage or similar documents that are provided by an Insurance Company to Participants and Beneficiaries.

1. Right of Appeal for Medical Plan Benefits.

If your claim for payment of medical expense benefits is denied in whole or in part, you, or your duly authorized representative, may appeal from such denial by submitting to the Insurance Company a written request for an appeal of the denial within 180 days after receiving written notice of such denial from the Insurance Company. If the Plan has two levels of review and the claim is denied in whole or in part on the first level of review, you or your duly authorized representative, may appeal from such denial by submitting to the Insurance Company a written request for a second level of review within 60 days after receiving written notice of the denial on the first level of review. The request for review (both the initial review, and if applicable, the second level of review) must be in writing and shall be addressed to the Insurance Company. Please refer to the applicable Evidence of Coverage or Insurance Policy for information regarding the appeals process, including the levels of review.

2. Request to Appeal Denied Claims for Medical Plan Benefits.

The request for appeal shall set forth all of the grounds upon which it is based, all facts in support thereof and any other matters that you deem pertinent. The Insurance Company may require you to submit such additional facts, documents or other material as the Insurance Company deems necessary or advisable in making its review of your appeal.

3. Rights on Appeal of Denied Claims for Medical Plan Benefits.

On appeal, you will be provided with the following rights, as applicable:

a. the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits – this includes but is not limited to, evidence and written testimony that supports your appeal.

b. upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (excluding those protected by legal or medical privilege) relevant to the claim for benefits.

c. the Insurance Company will take into account all comments, documents, records and other information submitted by you relating to the claim, even if that information was not submitted or considered when you filed the initial claim.

d. the review on appeal will not afford deference to the initial claim denial and the review will be conducted by an appropriate named fiduciary who is neither the individual who denied the initial claim nor the subordinate of that individual.

e. the Insurance Company will ensure that its decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as claims adjudicator or medical expert) will not be made based upon the likelihood that the individual will support the denial of benefits.

f. if the review on appeal is based in whole or in part on a medical judgment, including determination with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and that health care professional will not be an individual who was consulted in connection with the adverse benefit determination that is the subject of the review nor a subordinate of that individual;

g. upon request, the Insurance Company will provide the identification of any medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination on review.

h. during the course of the Insurance Company's determination of your appeal, you will be provided (free of charge) with any new or additional evidence considered, relied upon, or generated by the Insurance Company in connection with the claim and a reasonable opportunity to respond to such new evidence; and

i. you will be provided with any new or additional rationale for a denial at the appeals stage and a reasonable opportunity to respond to such new rationale.

For a request for an appeal of an Urgent Care Claim, you have the right to an expedited review process pursuant to which your request for an expedited appeal may be submitted orally or in writing and all necessary information, including the decision on appeal, will be transmitted between the claimant and the Insurance Company by telephone, facsimile, or other available similarly expeditious method.

4. Action on Request for Review of Denied Claims for Medical Expense Benefits.

The Insurance Company shall act on each request for a review of a denied claim for medical expense benefits within the time period specified below based on the claim type. If the claim is denied on review, the Insurance Company shall give you prompt, written notice of its decision. The deadlines for making a determination with respect to each claim type are as follows:

a. Appeal of an Urgent Care Claim Denial.

You will be notified by the Insurance Company of the decision within 72 hours from receipt of a request for review of a denied claim.

b. Appeal of a Pre-Service Claim Denial.

If the particular benefit plan only provides for one level of review, you will be notified by the Insurance Company of the decision within 30 days from receipt of a request for review. If the particular benefit plan provides for two mandatory levels of review, you will be notified by the Insurance Company of the decision on the first level of review within 15 days from receipt of a request for review. If you appeal that decision, a second level of review will be conducted and you will be notified by the Insurance Company of the decision within 15 days from receipt of a request for review of the first level review decision. Please refer to the applicable Evidence of Coverage or Insurance Policy for information regarding the appeals process, including the levels of review.

c. Appeal of a Post-Service Claim Denial.

If the particular benefit plan only provides for one level of review, you will be notified by the Insurance Company of the decision within 60 days from receipt of a request for review. If the particular benefit plan provides for two mandatory levels of review, you will be notified by the Insurance Company of the decision on the first level of review within 30 days from receipt of a request for review. If you appeal that decision, a second level review will be conducted and you will be notified by the Insurance Company of the decision within 30 days from receipt of a request for

review of the first level review decision. Please refer to the applicable Evidence of Coverage or Insurance Policy for information regarding the appeals process, including the levels of review.

5. Contents of Notice of Appeal Denial.

In the event that the Insurance Company denies the claim for medical expense benefits on appeal, in whole or in part, the Insurance Company will notify you in writing of such denial. The written notice will inform you of the specific reasons for the denial and a reference to the specific Plan and Insurance Contract provisions on which the benefit determination is based. It will also include a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (excluding those protected by legal or medical privilege) relevant to your claim for benefits, and a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination after completion of all levels of review required by the Plan, but that any lawsuit must be brought within one year from the date of the final adverse benefit determination.

If the denial on appeal is based on an internal rule, guideline, protocol, or other similar criterion, the notice will either state the specific rule, guideline, protocol, or other similar criterion, or include a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge upon request.

If the denial on appeal is based on a medical necessity or experimental treatment or a similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or include a statement that such explanation will be provided to you free of charge upon request. The notice will also describe any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures.

Notices shall be provided in a culturally and linguistically appropriate manner and shall also include the following information, as appropriate:

1. Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning; and

2. The denial code and its corresponding meaning, as a well as a description of the Plan's standard, if any, that was used in denying the claim; and

3. A description of available external review processes, (if applicable) including information regarding how to initiate an external appeal; and

4. A description of the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act section 2793.

6. Right to External Review for Certain Medical Claims.

If you receive a claim denial either at the claim level or any of the mandatory levels of appeal, you have the option to file a written request for an external review with the Insurance Company. This external review will comply with all applicable state and federal laws. Please review the applicable Summary of Benefits Booklet for more information on your right to external review.

You must exhaust the internal claims and appeals process before you can request an external review of certain medical claims.

Non-Expedited Requests for External Review

If you have exhausted (or have been deemed to have exhausted) the internal claims and appeals process, you (or your authorized representative) may file a written request for an external review with the Insurance Company, provided the request is filed within four months after the date of your receipt of the denial notice. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice.

External review is available for any claim that involves a medical judgment and for rescissions of coverage. External review is not available for any other type of claim, including claims that are denied because you fail to meet the requirements for coverage under the terms of the Plan.

Within 5 business days of the Insurance Company's receipt of the request for external review, a preliminary review will be conducted to determine whether the request is suitable for external review. The following determinations will be made:

a. Whether you were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided.

b. Whether the denial of your appeal relates to your failure to meet the requirements for eligibility under the terms of the Plan.

c. Whether the denial of your appeal denial qualifies for external review because it involves a medical judgment or a rescission of coverage, as applicable.

d. Whether you have exhausted the Insurance Company's internal appeal process; and

e. Whether you have provided all the information and forms required to process an external review.

Within one business day after completion of the preliminary review, a written notification will be provided to you (or your authorized representative) as to whether the request is eligible for external review. If the request is complete but not eligible for external review, the notification will include the reason(s) for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is NOT complete, the notification will describe the information or materials needed to make the request complete. The required information must be provided no later than the last day of the four-month period after the date of the denial notice (for example, not later than February 28,2021 for a denial notice dated October 30, 2020) or 48 hours after receipt of the preliminary review notification, whichever is later.

Requests that are eligible for external review will be reviewed by an accredited independent review organization ("IRO"). The IRO will not provide any deference to any prior determination and will not be bound to any decisions or conclusions that were reached by the Insurance Company. The assigned IRO will provide you (or your authorized representative) with a notice inviting you (or your authorized representative) to submit any additional information that you (or you authorized representative) wish the IRO to consider within 10 business days after the date of the notice. (NOTE: The IRO will not be required to consider any additional information that is submitted after 10 business days.) Any additional information that the IRO receives from you (or your authorized representative) will be provided to the Insurance Company. The Insurance Company may reconsider its prior denial on the basis of such information. If the denial is reversed and coverage or payment is provided, you (or your authorized representative) will be notified in writing and the external review will be terminated.

The IRO will review any timely received additional information you (or your representative) provide and the documents and information that the Insurance Company reviewed in connection with its denial (for example, medical records, attending health care professional's recommendation, the terms of the plan or Insurance Policy, appropriate practice guidelines, any applicable clinical review criteria developed and used by the Plan, the opinion of the IRO's clinical reviewer(s), etc.). The IRO will provide you (or your authorized representative) and the Insurance Company with its final external review decision in writing within 45 days after the IRO's receipt of the request for external review. The IRO's final external review decision is binding. If the IRO's decision reverses the Insurance Company's adverse benefit determination or final internal adverse benefit determination, the Insurance Company will provide the coverage or

payment for the claim. Any lawsuit brought under Section 502(a) of ERISA following the IRO's adverse final external review must be brought within one year from the date of the final external review determination.

Expedited Requests for External Review

If the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, you (or your authorized representative) may file a request for an expedited external review of your claim by an IRO, provided you (or your authorized representative) file a request for an internal appeal of the denied claim with the Insurance Company at the same time.

You (or your authorized representative) may also file a request for an expedited external review by an IRO if your final level of appeal has been denied and the appeal involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or concerns an admission, availability of care, continued stay or health care item or service for which the claimant received emergency services and you have not been discharged from a facility.

The standards and processes described above regarding the preliminary review for eligibility and review by the IRO also apply to expedited requests except that the IRO will provide you (or your authorized representative) and the Plan with its final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the assigned IRO's receipt of the request for external review. If the notice is not in writing, the IRO will provide written confirmation of its decision within 48 hours after the date it provided you (or your authorized representative) with oral notice of its decision.

C. Appeal of Denied Claims for Dental, Vision or EAP Benefits.

1. Right of Appeal for Dental, Vision or EAP Benefits.

If your claim for payment of dental, vision or EAP benefits is denied in whole or in part, you or your duly authorized representative, may appeal from such denial by submitting to the Insurance Company a written request for a review of the denial within 180 days after receiving written notice of such denial from the Insurance Company. If the Plan has two levels of review and the claim is denied in whole or in part on the first level of review, you or your duly authorized representative, may appeal from such denial by submitting to the Insurance Company a written request for a second level of review within 60 days after receiving written notice of the denial on the first level of review. The request for review (both the initial review, and if applicable, the second level of review) must

be in writing and shall be addressed to the Insurance Company. Please refer to the applicable Evidence of Coverage or Insurance Policy for information regarding the appeals process, including the levels of review.

2. Request to Appeal Denied Claims for Dental, Vision or EAP Benefits.

The request for appeal shall set forth all of the grounds upon which it is based, all facts in support thereof and any other matters that you deem pertinent. The Insurance Company may require you to submit such additional facts, documents or other material as the Insurance Company deems necessary or advisable in making its review of your appeal.

3. Rights on Appeal of Denied Claims for Dental, Vision or EAP Benefits.

On appeal, you will be provided with the following rights, as applicable:

a. the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits – this includes but is not limited to, evidence and written testimony that supports your appeal.

b. upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (excluding those protected by legal or medical privilege) relevant to the claim for benefits.

c. the Insurance Company will take into account all comments, documents, records and other information submitted by you relating to the claim, even if that information was not submitted or considered when you filed the initial claim.

d. the review on appeal will not afford deference to the initial claim denial and the review will be conducted by an appropriate named fiduciary who is neither the individual who denied the initial claim nor the subordinate of that individual.

e. if the review on appeal is based in whole or in part on a medical judgment, including determination with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and that health care professional will not be an individual who was consulted in connection with the adverse benefit determination that is the subject of the review nor a subordinate of that individual;

f. upon request, the Insurance Company will provide the identification of any medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, without regard to

whether the advice was relied upon in making the benefit determination on review.

4. Action on Request for Review of Denied Claims for Dental, Vision or EAP Benefits.

The Insurance Company shall act on each request for a review of a denied claim for medical expense benefits within the time period specified below based on the claim type. If the claim is denied on review, the Insurance Company shall give you prompt, written notice of its decision.

If the particular benefit plan only provides for one level of review, you will be notified by the Insurance Company of the decision within 60 days from receipt of a request for review. If the particular benefit plan provides for two mandatory levels of review, you will be notified by the Insurance Company of the decision on the first level of review within 30 days from receipt of a request for review. If you appeal that decision, a second level review will be conducted, and you will be notified by the Insurance Company of the decision within 30 days from receipt of a request for review of the first level review decision. Please refer to the applicable Evidence of Coverage or Insurance Policy for information regarding the appeals process, including the levels of review.

5. Contents of Notice of Appeal Denial.

In the event that the Insurance Company denies the claim for dental, vision or EAP benefits on appeal, in whole or in part, the Insurance Company will notify you in writing of such denial. The written notice will inform you of the specific reasons for the denial and a reference to the specific Plan and Insurance Contract provisions on which the benefit determination is based. It will also include a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (excluding those protected by legal or medical privilege) relevant to your claim for benefits, and a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination after completion of all levels of review required by the Plan, but that any lawsuit must be brought within one year from the date of the final adverse benefit determination.

If the denial on appeal is based on an internal rule, guideline, protocol, or other similar criterion, the notice will either state the specific rule, guideline, protocol, or other similar criterion, or include a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge upon request.

If the denial on appeal is based on a medical necessity or experimental treatment or a similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the

Plan to your medical circumstances, or include a statement that such explanation will be provided to you free of charge upon request. The notice will also describe any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures.

D. Review of Denied Claims for Disability Benefits Under the Group Disability Insurance Plan.

The appeal procedure described here only applies when there are no alternate procedures described in the Certificate of Coverage or similar documents that are provided by an Insurance Company to Participants and Beneficiaries.

NOTE: The Plan Administrator will make the determination for an appeal regarding the denial of eligibility of a dependent child over the age of 26 who may be eligible for coverage because of a disability. The Plan will comply with the appeals procedures as described in this section when making this determination on appeal. The procedure below will not apply if the denial of eligibility for a dependent child over the age of 26 is not accompanied by a claim and is strictly a question of eligibility.

1. Right of Appeal for Group Disability Insurance Plan Benefits.

If your claim for payment of disability benefits is denied in whole or in part, you, or your duly authorized representative, may appeal from such denial. In order to appeal, you or your duly authorized representative must submit a written request for a review of the denial to the Insurance Company within 180 days after receiving written notice of such denial from the Insurance Company.

2. Request for Appeal of Denied Group Disability Insurance Plan Claims.

The request for appeal shall set forth all of the grounds upon which it is based, all facts in support thereof and any other matters that you deem pertinent. The Insurance Company may require you to submit such additional facts, documents or other material as the Insurance Company deems necessary or advisable in making its review.

3. Rights on Appeal of Denied Group Disability Insurance Plan Claims.

On appeal, you will be provided with the following additional rights, as applicable:

a. Upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for disability benefits.

b. The opportunity to submit written comments, documents, records and other information relating to the claim for disability benefits.

c. A full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination.

d. Automatically and free of charge, provided any new or additional evidence considered, relied upon, or generated by the Insurance Company in connection with the denied disability claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of decision on appeal is required to be provided) to give you a reasonable opportunity to respond prior to that date.

e. Additionally, before the Insurance Company issues an appeal denial based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of the appeal denial is required to be provided) to give you reasonable time to respond prior to that date.

f. If the Insurance Company receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

g. A review that does not afford deference to the initial claim denial and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial claim denial that is the subject of the appeal, nor the subordinate of such individual. The Insurance Company will ensure that all appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, the Insurance Company's decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as claims adjudicator or medical or vocational expert) must not be made based upon the likelihood the individual will support the denial of benefits.

h. In deciding an appeal of any denied claim for disability benefits that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary, or not appropriate, the Insurance Company will:

    i. Consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in

connection with the claim denial that is the subject of the appeal nor the subordinate of any such individual; and

ii. Provide the identification of medical or vocational experts whose advice was obtained in connection with the benefit determination without regard to whether the advice was relied upon in making the benefit determination.

4. Action on Request for Appeal of Denied Group Disability Insurance Plan Claims.

The Insurance Company shall act on each request for an appeal of a denied disability claim within 45 days after receipt thereof unless special circumstances require an extension of time of up to an additional 45 days for processing the request. If such an extension is granted, a notice of the extension shall be furnished to you within the initial 45-day period stating the circumstances requiring the extension and the date by which the Insurance Company expects to render its decision.

5. Contents of Notice of Denial of Appeal of Group Disability Insurance Plan Claims.

In the event that the Insurance Company denies the disability claim on appeal, in whole or in part, the Insurance Company will notify you in writing of such denial. be in a culturally and linguistically appropriate manner and will include:

a. The specific reason(s) for the adverse appeal review decision including a discussion of the decisions and the basis for disagreeing with or not following the (1) views presented by the claimant of health care professionals treating the claimant and vocational professional who evaluated the claimant, (2) views presented by the medical or vocational experts whose advice was obtained on behalf of the Insurance Company in connection with a claimant's claim denial and appeal, and (3) the claimant's disability determination made by the Social Security Administration that was presented by the claimant to (if applicable);

b. Reference the specific Plan or Insurance Contract provision(s) on which the determination is based.

c. A statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim.

d. A statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal.

e. A description of any applicable contractual limitation periods on benefit disputes and the calendar date on which the contractual limitations period expires for the claim, including that any lawsuit brought under ERISA

Section 502(a) must be brought within one year from the date of the final adverse benefit determination.

f. If the denial was based on an internal rule, guideline, protocol, standard, or similar criterion, a statement will be provided that such rule, guideline, protocol, standard, or criteria that was relied upon will be provided free of charge to you, upon request.

g. If the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and

h. A statement that if you are not proficient in English and have questions about disability benefits, filing a claim for disability benefits or about a claim denial, you should contact the Plan Administrator for assistance.

E. Appeal of Denied Claims for Life Insurance and Accidental Death and Dismemberment Benefits.

The review procedure described here only applies when there are no alternate procedures described in the Evidence of Coverage or similar documents that are provided by an Insurance Company to Participants and Beneficiaries.

1. Right of Appeal for Life Insurance and Accidental Death and Dismemberment Benefits.

If your claim for payment of life insurance or accidental death and dismemberment benefits is denied, in whole or in part, you or your duly authorized representative, may appeal from such denial by submitting to the Insurance Company a written request for a review of the denial within 90 days after receiving written notice of such denial from the Insurance Company.

2. Request for Appeal of Denied Life Insurance and Accidental Death and Dismemberment Claims.

The request for appeal shall set forth all of the grounds upon which it is based, all facts in support thereof and any other matters that you deem pertinent. The Insurance Company may require you to submit (at your own expense) such additional facts, documents or other material as the Insurance Company deems necessary or advisable in making its review.

3. Rights on Appeal of Denied Life Insurance and Accidental Death and Dismemberment Claims.

On appeal, you will be provided with the following additional rights, as applicable:

a. the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.

b. upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (excluding those protected by legal or medical privilege) relevant to the claim for benefits; and

c. the Insurance Company will take into account all comments, documents, records and other information submitted by you relating to the claim, even if that information was not submitted or considered when you filed the initial claim.

4. Action on Request for Appeal of Denied Life Insurance and Accidental Death and Dismemberment Claims.

The Insurance Company shall act on each request for an appeal of a denied life insurance or accidental death and dismemberment claim within 60 days after receipt thereof unless special circumstances require an extension of time of up to an additional 60 days for processing the request. If such an extension is granted, you will be notified within the initial 60-day period stating the special circumstances requiring the extension and the date by which the Insurance Company expects to render its decision.

5. Contents of Notice of Denial of Appeal for Life Insurance and Accidental Death and Dismemberment Claims.

In the event that the Insurance Company denies the claim for life insurance or accidental death and dismemberment benefits on appeal, in whole or in part, the Insurance Company shall notify you in writing of such denial. Such written notice shall set forth, in an understandable manner, the specific reasons for such denial, a reference to the specific Plan and Insurance Contract provisions on which the benefit determination is based, a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (excluding those protected by legal or medical privilege) relevant to your claim for benefits, and a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination after completion of all levels of review required by the Plan but that any lawsuit must be brought within one year from the date of the final adverse benefit determination.

F. Exhaustion of Remedies.

You may not bring an action at law or in equity to recover a benefit under the Plan unless and until you have:

1. Submitted a written claim for benefits to the Insurance Company; and

2. Been notified by the Insurance Company that the claim has been denied; and

3. Timely filed a written request for a review of the claim with the Insurance Company; and

4. Been notified in writing by the Insurance Company that the denial of the claim been affirmed on review; and

5. If the Plan provides for two levels of review, timely filed a written request for a second review of the claim with the Insurance Company: and

6. If the Plan provides for two levels of review, been notified in writing by the Insurance Company that the denial of the claim for benefits has been affirmed on second review.

Please refer to the applicable Evidence of Coverage or Insurance Policy for information regarding the appeals process, including the levels of review

G. Rules and Procedures.

The Plan Administrator and each Insurance Company have the discretionary power and authority to establish rules and procedures, consistent with the Plan and with ERISA, that it deems necessary or appropriate in carrying out its responsibilities under this section.

ARTICLE VII. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Group plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer from prescribing a length of stay not in excess of 48 hours (or 96 hours).

ARTICLE VIII. WOMEN'S HEALTH AND CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided by the applicable Insurance Company in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses; and

- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Plan.

If you would like more information on WHCRA benefits, call the WECA ATC Health and Welfare Trust which administers the Plan. at (877) 444-WECA.

ARTICLE IX. PATIENT PROTECTION NOTICE

A. Selection of a Primary Care Provider.

Your medical plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in your medical plan's network and who is available to accept you or your family members. If your medical plan requires designation of a primary care provider, your medical plan may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your medical plan using the contact information listed on your medical plan member identification card.

For children, you may designate a pediatrician as the primary care provider.

B. Direct Access to Obstetricians and Gynecologists.

You do not need prior authorization from your medical plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in your medical plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your medical plan using the contact information listed on your medical plan member identification card.

ARTICLE X. AMENDMENT OR TERMINATION OF THE PLAN

WECA reserves the right to amend or modify any or all of the provisions of the Plan without the consent of any employer or Participant, by written action of the WECA ATC Health and Welfare Trustees. No amendment or modification, however, shall have the effect of reducing any paid-for coverages of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, State, or local laws, statutes or regulations.

WECA reserves the right to terminate the Plan, in whole or in part, at any time by written action of the WECA ATC Health and Welfare Trustees. In the event the Plan is terminated, no further

contributions shall be made, except benefits under any Insurance Contract shall be paid in accordance with the terms of the Insurance Contract.

APPENDIX A

INSURANCE COMPANY/CONTRACT INFORMATION

A. Medical Benefits

Medical Benefits (HMO)
UHC of California dba UnitedHealthcare of California
Policy No. 0924920
Attn: Claims Department
P.O. Box 30968
Salt Lake City, Utah 84130-0968
Member Services: 1-800-624-8822
www.myuhc.com

Medical Benefits (PPO)
UnitedHealthcare Benefits Plan of California
Group No. 0924920
Attn: Claims Department
P.O, Box 30555
Salt Lake City, Utah 64130
Member Services: 1-866-633-2446
www.myuhc.com

B. Dental Benefits

UnitedHealthcare Insurance Company
Policy No. 0924920
Attn: Claims Department
P.O. Box 30567
Salt Lake City, Utah 84130-0567
Member Services" 1-877-816-3596
www.myuhc.com

C. Life and Accidental Death and Dismemberment Benefits

Unimerica Life Insurance Company
Policy No. 309268
P.O. Box 7149
Portland, ME 04112-7149
Member Services: 1-888-299-2070
Email: Unsecured FPCustomerservice support@uhc.com

D. Short- & Long-Term Disability Insurance

Unimerica Life Insurance Company
Policy No. 309268
P.O. Box 7466
Portland, ME 04112-7466
Member Services: 1-888-299-2070
Email: Unsecured FPCustomersupoort@uhc.com

E. Vision Insurance

UnitedHealthcare Insurance Company
Policy No. 0924920
Attn: Claims Department
P.O. Box 30978
Salt Lake City, Utah 84130-0978
Member Services: 1-800-638-3120
www.muyhc.com