Summary Plan Description

of the

WECA ATC Health and Welfare Plan

AMENDED AND RESTATED EFFECTIVE DECEMBER 1, 2014

TABLE OF CONTENTS

ARTICLE I. INTRODUCTION

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 1, 2014. The coverages summarized in this SPD are provided through various insurance companies ("Insured Program") referenced in Appendix A. The following pages summarize for you the Plan. 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 Kaiser Permanente Traditional Plan for Small Business Evidence of Coverage, the Anthem Blue Cross HMO Certificate of Insurance, the Anthem Blue Cross PPO, the Anthem Blue Cross Dental Complete PPO Dental Certificate of Insurance, the Anthem Blue Cross Life Insurance Company Certificate of Insurance, the Anthem Blue Corss Life Insurance Company Disability Certificate of Insurance, and the Anthem Blue Cross Life Insurance Company EAP Certificate of Insurance (together, the "Summary of Benefits Booklets"). This document, the applicable Summary of Benefits Booklet, and any 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 Booklets 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.]

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. 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 a 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.

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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group Plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, 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. 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.

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
Plan Year:	The 12-month period beginning September 1 and ending on August 31.
Contract Administrator's name, address, and phone	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 Apprenticeship Training Committee:

Greg Anderson, Chairman	Darryl Vasko
Clint Alessandro	Lee Sanders
Ian Vander Linden	Tim Bosley
John Funderberg	Dan Carlton
John Pavletich	Dave Frechette
Phil Stites	Kelly Yost

Address: The address for all of 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. A description of your benefits is contained in the Summary of Benefits Booklets you have already received or that are enclosed with this summary.

B. Eligible Apprentice Coverage.

Only Eligible Apprentices are eligible for coverage under this Plan. You are an Eligible Apprentice if you are an Apprentice employed by an employer who is a member of WECA and who are 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 Subscription 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 reveals 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.

If no medical provider is chosen at time of enrollment, default enrollment will be as follows:

- Northern California applicants will default to Anthem Blue Cross
- Southern California applicants will default to Kaiser South

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:

1. 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; and

2. the Apprentice and the Apprentice's eligible Dependents (if applicable) have been issued evidence of insurability if so required by the Insurance Company.

D. Dependent Coverage.

Individuals who qualify for Dependent coverage may only be added to medical coverage at the time the Apprentice is enrolled, 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 opposite-sex spouse.

2. An Employee's domestic partner who meets and continues to meet all of the requirements of Section 297 of the California Family Code. California Family Code Section 297 currently defines "domestic partner" as follows:

California Family Code Definition:
297. (a) Domestic partners are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring. **(**b) A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State pursuant to this division, and, at the time of filing, all of the following requirements are met: (1) Both persons have a common residence. (2) Neither person is married to someone else or is a

member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity. (3) The two persons are not related by blood in a way that would prevent them from being married to each other in this state. (4) Both persons are at least 18 years of age. (5) Either of the following: (A) Both persons are members of the same sex. (B) One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both of the persons are over the age of 62. (6) Both persons are capable of consenting to the domestic partnership. (c) "Have a common residence" means that both domestic partners share the same residence. It is not necessary that the legal right to possess the common residence be in both of their names. Two people have a common residence even if one or both have additional residences. Domestic partners do not cease to have a common residence if one leaves the common residence but intends to return.

3. Adult 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, Adult Children include a son, daughter, step-son, step-daughter 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 all information about any Dependent to the Plan Administrator. A spouse does not qualify as a Dependent while in the armed forces of any country. Wards of the state are not considered eligible Dependents.

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 any other newly acquired Dependents in the Plan. 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.

   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 any other newly acquired Dependents in the Plan. 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.

   If you timely enroll a new Dependent, you and your Dependents will be offered all of the medical benefit packages available to similarly situated individuals who enroll when they are first eligible. This means that you will be able to change your medical option (e.g., the Apprentice will be able to switch from Kaiser to Anthem Blue Cross or from Anthem Blue Cross to Kaiser). Such change will be permissible as long as you and your Dependents are eligible for such coverage.

2. Loss of other plan coverage. If you did not enroll your Dependent in the Plan at the time of your initial eligibility because 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 upon losing such other coverage. Enrollment in this Plan pursuant to this special enrollment event is available if the coverage lost was either of the following:

   a. COBRA continuation coverage that was exhausted; or

   b. Coverage that terminated because of a "loss of eligibility" or a termination of employer contributions.

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 medical benefit packages available to similarly situated individuals who enroll when they are first eligible. This means that an Apprentice who timely adds a Dependent who has lost other coverage will be able to change his or her medical option (e.g., the Apprentice will be able to switch from Kaiser to Anthem Blue Cross or from Anthem Blue Cross to Kaiser). Such change will be permissible as long as you and your Dependents are eligible for such coverage.

3. 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. This means that an Apprentice and/or Dependent who becomes eligible for a premium assistance subsidy will be able to change his or her medical option (e.g., the Apprentice will be able to switch from Kaiser to Anthem Blue Cross or from

Anthem Blue Cross to Kaiser). Such change will be permissible as long as you and your Dependents are eligible for such coverage.

G. 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.

H. 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 employee'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.

I. Payment of Premiums.

1. As of the Effective Date of this Plan, each Participating Employer is required to pay premiums which will be deposited into the Trust. As of December 1, 2010, each Participating Employer must contribute the sum of four dollars and fifty cents ($4.50) per Credited Hour for each Participant it employs. These contributions are used to pay insurance premiums as well as administration, legal, accounting and other costs associated with operating the Plan.

2. You may elect to purchase health coverage under the Plan for your eligible Dependents. Eligible Dependents may only be enrolled with the same health provider selected by the Apprentice as their health provider. The rate of Participating Employer contributions for health and welfare benefits and the cost of health coverage for eligible Dependents may change from time to time. Coverage for eligible Dependents may only be obtained if you are also covered.

J. 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 purchase one months' full coverage; or

For example, if there are insufficient hours in your April account to buy June coverage, your insurance 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 and the Employer Rules; or

c. the date on which the Plan terminates.

2. Dependent coverage will terminate when your coverage terminates, when the Dependent is no longer eligible to participate in 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 services used.

K. 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 health coverage under a federal law known as the Consolidated Omnibus Budgetary Reconciliation Act ("COBRA"). Pursuant to WECA policy, an Employee's California Family Code Section 297 domestic partner who is covered by the Plan on the day before a COBRA qualifying event occurs is also eligible to enroll in continuation coverage that is similar to COBRA. 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.

2. Your Obligation To Provide Notice Under COBRA

You are responsible for notifying the plan administrator within sixty (60) days of the later of one of the following events:

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

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

c. You or one of your qualified beneficiaries is determined, under Title 11 or XVI of the Social Security Act, to have been disabled at the time of your termination of employment or reduction of hours of employment.

d. After your employer 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.

e. 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

f. 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 child, spouse, or former spouse to elect to continue coverage.

3. 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.

4. 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, 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.

e. 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.

5. 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.

L. 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 Employee Participant's who perform service in the Uniformed Services of the United States for less than 31 days as provided under USERRA, will not exceed the Employee share, if any, with respect to an Employee for whom a Qualifying Event has not occurred.

M. 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.

N. Benefits While on a Leave of Absence Subject to the Family and Medical Leave Act of 1993.

If you take a leave of absence that is subject to the Family and Medical Leave Act of 1993 ("FMLA"), you will be entitled to continue to participate in the Plan as long as the law requires. 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 leave of absence ends, you may be eligible to enroll in COBRA continuation coverage at that time.

O. 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.

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 Expense 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 Claims for Medical Expense Benefits.

You do not need to submit a claim for medical expense benefits under the Employee Assistance Program ("EAP") as these claims are submitted automatically on your behalf. 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 Expense Benefits.

a. Urgent Care Claims

If you do not follow the proper procedure when you file an Urgent Care Claim the Insurance Company will notify you of the improper filing and how to correct it within 24 hours after the claim was received.

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. Note: Effective as of July 1, 2011, for an Urgent Care Claim that is filed in accordance with the proper procedure, the Insurance Company must notify you of the initial decision with 24 hours from the time of receipt of a proper initial claim.

If the initial claim is not complete, the Insurance Company must notify you within 24 hours after receiving the claim stating the information that is necessary to complete the claim. 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

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

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 Expense Benefits.

In the event that any claim for payment of medical expense 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.

Note: Effective no later than July 1, 2011 (or such later date as permitted by the Department of Labor and/or Internal Revenue Service), 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), 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 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 Benefits Under the Group Disability Insurance Plan.

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.

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. This written notice will explain, in an understandable manner, specific reasons for such denial, specific references to the Plan and 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.

E. 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.

ARTICLE VI. REVIEW 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. Review of Denied Claims for Medical Expense 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 Medical Expense 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 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.

2. Request for Review of Denied Claims for Medical Expense Benefits.

The request for review 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 expense) such additional facts, documents or other material as the Insurance Company deems necessary or advisable in making its review.

3. Rights on Review of Denied Claims for Medical Expense Benefits.

On review, 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 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 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;

g. 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

h. 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 evidence or rationale.

For a request for a review of an Urgent Care Claim, you have the right to an expedited review process pursuant to which your request for an expedited review may be submitted orally or in writing and all necessary information, including the decision on review, 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. Urgent Care Claim on Review

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. Pre-Service Claim on Review

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.

c. Post-Service Claim on Review

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.

5. Contents of Notice on Review.

In the event that the Insurance Company denies the claim for medical expense benefits on review, 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.

If the denial on review 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 review 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.

Note: Effective no later than July 1, 2011 (or such later date as permitted by the Department of Labor and/or Internal Revenue Service), 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. For a claim denial, 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 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.

6. Right to External Review

Effective December 1, 2010, 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.

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

The review 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.

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 Review of Denied Group Disability Insurance Plan Claims.

The request for review 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 Review of Denied Group Disability Insurance Plan Claims.

On review, 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 Review of Denied Group Disability Insurance Plan Claims.

The Insurance Company shall act on each request for a review 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 for review 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 on Review of Denied Group Disability Insurance Plan Claims.

In the event that the Insurance Company denies the disability claim on review, in whole or in part, the Insurance Company will notify you in writing of such denial. The written notice will inform you, in an understandable manner, 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.

If the denial on review 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 review 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 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 Review of Denied Life Insurance and Accidental Death and Dismemberment Claims.

The request for review shall set forth all of the grounds upon which it is based, all facts in support thereof and any other matters that you deems 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 Review of Denied Life Insurance and Accidental Death and Dismemberment Claims.

On review, 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 Review of Denied Life Insurance and Accidental Death and Dismemberment Claims.

The Insurance Company shall act on each request for a review 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 for review 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 on Review of Denied 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 review, 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.

E. 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.

F. 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

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.

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 Committee. 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 Committee. 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

Anthem Blue Cross
Group No. 277498
P.O. BOX 60007
Los Angeles, CA 90060
Member Services: 1-800-888-8288
www.anthem.com/ca

Kaiser
Group No. c268585-0000
393 S. Walnut Street
Pasadena, CA 91188-8527
Member Services: 1-800-464-4000
www.kaiserpermanente.org

B. Dental Benefits

Anthem Dental
Attn: Dental Claims
P.O. Box 1115
Minneapolis, MN 55440-1115
Member Services: 1-800-567-1804
www.anthem.com/ca/mydental

C. Life Insurance

Anthem Blue Cross Life Insurance Company
P.O. Box 105448
Atlanta, GA 30348-5448
Member Services: 1-800-552-2137
email: lifeclaims@wellpoint.com

D. Short & Long Term Disability Insurance

Anthem Blue Cross Life Insurance Company
Disability Claims Service Center
P.O. Box 105426
Atlanta, GA 30348-5426
Member Services: 1-800-813-5682
email: lifeanddisabilityclaims@anthem.com

E. Employee Assistance Program

Anthem Blue Cross Resource Advisor Member Services: 1-888-290-7840
www.resourceadvisorca.anthem.com