BENEFIT TRUST FUND
WELFARE PLAN (501)

SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT

CCPOA
Benefit Trust Fund

This document provides information regarding the following benefit programs furnished through the CCPOA Benefit Trust Fund:

- Supplemental Life Insurance Program (New York Life Group Policy)
- Accidental Death and Dismemberment Insurance Program (New York Life Group Policy)
- Piggyback Program
- Combined Insurance Program
- U.S. Legal Family Defender Program
- LDF III
- VSP Second Pair of Eyeglasses Benefit Program

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SECTION 1
INTRODUCTION

We are pleased to provide you with a copy of this summary plan description and plan document ("Document") which provides information regarding certain benefits provided by the CCPOA Benefit Trust Fund (the "Benefit Trust Fund") under the CCPOA BTF Welfare Benefit Plan, Plan 501 (the "Welfare Benefit Plan" or the "Plan"). The Welfare Benefit Plan was formerly named the "CCPOA Benefit Trust Fund Health and Welfare Plan" and is hereby restated in its entirety effective as of April 1, 2011. The Welfare Benefit Plan consists of the benefit programs (hereinafter, "Benefit Programs") listed in Appendix C. This Document is intended to meet the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") for the Welfare Benefit Plan. The CCPOA Benefit Trust Fund was established by the CCPOA Benefit Trust Fund Board of Trustees (the "Trustees") for the exclusive benefit of eligible participants and their beneficiaries in order to provide them with various health and welfare plan benefits. The Benefit Programs provided under the Welfare Benefit Plan are more specifically described in Summary Program Booklets, Evidences of Coverage and/or Certificates of Coverage which are provided to you automatically as separate documents after enrollment in those programs.

This Document, together with the Summary Program Booklets, any applicable Evidence of Coverage or Certificate of Coverage you receive for any benefits, and any summaries of material modifications you may later receive, constitute the Welfare Benefit Plan's official plan document and Summary Plan Description. To the extent that any benefits are provided pursuant to an insurance contract or policy, the contracts and policies also constitute a part of the official plan documents of the Welfare Benefit Plan. This Document sets forth the terms of the Welfare Benefit Plan in effect as of April 1, 2011 and governs the provision of benefits for claims incurred on or after that date. Efforts have been made to provide current information in this Document, and the Trustees try to keep this information current and accurate. However, in order to obtain the most up-to-date information about a particular benefit, please contact the Benefit Trust Fund or the Claims Administrator, as appropriate, for current Summary Program Booklets, Evidences of Coverage and/or Certificates of Coverage, or with any specific questions. You will be notified if any material changes are made to the Welfare Benefit Plan. This Document does not serve as a guarantee of continued employment or benefits.

KEEP A COPY OF THIS DOCUMENT WITH YOUR SUMMARY PROGRAM BOOKLETS, EVIDENCES OF COVERAGE AND/OR CERTIFICATES OF COVERAGE FOR YOUR REFERENCE.

If you have any questions about this Document or about any Welfare Benefit Plan benefits, contact the Benefit Trust Fund office (the "Trust Office") at:

CCPOA Benefit Trust Fund
2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833-4235

Telephone Number: (916) 779-6300
Toll Free: (800) 468-6486 or (888) 779-6327
Facsimile Number: (916) 779-6355

Website: www.ccpoabtf.org

Respectfully,

The Board of Trustees of the CCPOA Benefit Trust Fund

SECTION 2
WELFARE BENEFIT PLAN – BENEFIT PROGRAMS

The Benefit Programs listed in Appendix C are available under the Welfare Benefit Plan. The Benefit Programs are either self-funded or insured and are described in separate Summary Program Booklets, in Evidences of Coverage/Certificates of Coverage, or in other booklets, all of which are provided free of charge as separate documents. These booklets describe: (1) the benefits available (e.g., benefit amounts and maximums, etc.); (2) payment requirements (including premiums); (3) claims and appeals procedure; and (4) coordination of benefits and reimbursement provisions. The Benefit Programs do not cover all expenses or pay benefits in all circumstances. Exclusions and limitations are also discussed in the applicable Summary Program Booklet, or Evidence of Coverage/Certificate of Coverage. All benefits are subject to the terms and conditions of the Welfare Benefit Plan as provided in the official plan documents.

SECTION 3
GENERAL INFORMATION

Plan Name:	CCPOA Benefit Trust Fund Welfare Benefit Plan
Type of Plan:	This plan is a welfare benefit plan that provides various welfare plan benefits which are listed in Appendix C and are further described in the applicable Summary Program/Plan Booklet or Evidence of Coverage/Certificate of Coverage.
Plan Administrator:	Board of Trustees of the CCPOA Benefit Trust Fund 2515 Venture Oaks Way, Suite 200 Sacramento, CA 95833-4235 (800) 468-6486 or (916) 779-6300
Names and Addresses of the Trustees:	See Appendix B.
Plan Sponsor's Employer Identification Number (EIN):	The EIN of the Benefit Trust Fund is 94-6459649.
Plan Number:	The three-digit number assigned to the Plan is 501.
Plan Year:	April 1 to March 31
Plan Sponsor:	Board of Trustees of the CCPOA Benefit Trust Fund 2515 Venture Oaks Way, Suite 200 Sacramento, CA 95833-4235 (800) 468-6486 or (916) 779-6300
Plan Effective Date:	April 1, 2011
Source(s) of Contributions:	The contributions necessary to finance the Benefit Programs provided by the Welfare Benefit Plan consist of participant contributions, dues deductions, employer contributions including those described in the CCPOA Memorandum of Understanding and interest accrued on investments of those funds. These contributions are calculated as necessary to cover the expected benefit payments (or insurance premiums) and to defray administrative expenses of the Welfare Benefit Plan. The rate of contributions is subject to change at any time at the sole discretion of the Board of Trustees. Any refunds, rebates, dividends, experience adjustment, or other similar payment under any group insurance contract with the Benefit Trust Fund or the Board of Trustees relating to benefits provided by the Welfare Benefit Plan are plan assets and, pursuant to the Board of Trustees' sole discretion, will be used to pay for any combination of additional benefits, Plan expenses, or insurance premiums. No participant has a vested right to receive any portion of these funds.

Agent for Service of Legal Process:	Service of legal process on the Plan may be made upon the Benefit Trust Fund's Administrator, any Trustee, or on the Plan Administrator at the Trust Office at: CCPOA Benefit Trust Fund 2515 Venture Oaks Way, Suite 200 Sacramento, CA 95833-4235
Funding Medium:	All contributions are deposited and held in the CCPOA Benefit Trust Fund which is maintained by the Board of Trustees of the CCPOA Benefit Trust Fund. The Board of Trustees pays benefits and administrative expenses of the Plan directly from the Benefit Trust Fund. Some of the Benefit Programs are provided through group insurance contracts purchased from various insurance carriers. Premiums for the group insurance contracts are paid by the Board of Trustees from the Benefit Trust Fund. Claims for benefits under those Benefit Programs are sent directly to the insurance carriers for administration and benefits are paid by the insurance carriers pursuant to the group insurance contracts and policies with the Benefit Trust Fund. The insurers (not the Benefit Trust Fund) are financially responsible for the payment of claims under such insured programs.

3.1 Amendment or Termination of the Welfare Benefit Plan or a Benefit Program

There is no guarantee that the Welfare Benefit Plan or a Benefit Program will last indefinitely. Although there is no present intention of doing so, the Board of Trustees reserves the right, in its absolute and unlimited discretion, to amend or terminate the Welfare Benefit Plan or any Benefit Program or to eliminate any benefits, at any time and for any reason, without advance notice to any person by a written instrument signed by the Board of Trustees. If a benefit is provided pursuant to an insurance policy or contract, the Board of Trustees may amend the applicable Benefit Program by changing the insurer or the applicable policy or contract. Any amendment to or termination of the Welfare Benefit Plan, or any Benefit Program will not reduce the benefits to which a participant may be entitled for a claim that is incurred prior to the effective date of such amendment or termination, to the extent the Benefit Trust Fund is funded as of that date.

In the event of a termination or partial termination of the Benefit Trust Fund, the assets remaining in the Benefit Trust Fund after providing for the expenses of the Plan and for the payment of benefits approved as of that date, may be allocated among the participants and beneficiaries in the manner determined by the Board of Trustees and in accordance with applicable law, or transferred to a plan operated by an Internal Revenue Code section 501(c)(9) trust providing similar benefits.

3.2 Administration of the Welfare Benefit Plan

The Board of Trustees of the Benefit Trust Fund is the official administrator of the Welfare Benefit Plan (the "Plan Administrator") and is the named fiduciary as provided under ERISA. The Board of Trustees makes the rules under which the Welfare Benefit Plan operates and has the maximum discretionary authority permitted by law to interpret, construe, and administer the Welfare Benefit Plan. The Board of Trustees may delegate to any agent, including an insurance carrier, the authority to act on behalf of the Board of Trustees, including the authority to make determinations regarding Benefit Program participation, enrollment, and eligibility for benefits, to grant or deny benefits, and to resolve ambiguities in the plan documents and any and all claims and disputes regarding the rights and entitlements of individuals to participate in the Welfare Benefit Plan and to receive benefits and payments pursuant to the Benefit Programs and applicable law. The decisions of the Trustees and its delegates will be final, conclusive, and binding on all persons, and will be given the maximum deference permitted by law.

The Board of Trustees has appointed the Benefit Trust Fund's Administrator to perform functions necessary to discharge the orders and policies of the Trustees with respect to the day-to-day responsibilities of the Welfare Benefit Plan and the Benefit Trust Fund. These functions include, but are not limited to, making initial decisions on certain benefit claims and resolving questions regarding participation in certain Benefit Programs. The Board of Trustees, and not the Benefit Trust Fund's Administrator, is the "plan administrator", as that term is defined by ERISA. The name and business address of the current Benefit Trust Fund's Administrator is set forth in Appendix B.

3.3 Capitalized Terms

Many of the capitalized terms appearing in this Document have special meaning and are defined in the Definitions section.

3.4 Conflicting Provisions

To the extent that the terms and conditions described in this Document conflict with the provisions of any insurance contract, policy, Summary Program Booklet or Evidence of Coverage/Certificate of Coverage, with regard to any insured benefits, the terms of the applicable insurance contract or policy will control. Moreover, to the extent that any statement or representation, whether oral or otherwise, of a Trustee, Benefit Trust Fund employee, CCPOA representative, or any other person regarding the benefits of the Benefit Trust Fund conflicts with this Document or any applicable insurance contract or policy, the terms of this Document, Summary Program Booklet, Evidence of Coverage/Certificate of Coverage, or the contract or policy will control. In all cases the provisions of the official Plan documents control.

SECTION 4
ELIGIBILITY AND PARTICIPATION

4.1 Eligibility Requirements

The eligibility requirements or limitations for a particular Benefit Program are described in the applicable Summary Program Booklet or Evidence of Coverage/Certificate of Coverage. These documents also include the eligibility requirements for dependents, including the requirements applicable to dependents who are disabled and the applicable maximum age for coverage. The Benefit Programs are generally available to the following groups of individuals and their eligible dependents as described in further detail in the applicable Summary Program Booklet or Evidence of Coverage/Certificate of Coverage:

- Full-time permanent employees and Permanent Intermittent Employees of the State of California Bargaining Unit 6 who are members in good standing of the CCPOA;
- Employees of CCPOA;
- Employees of CCPOA Benefit Trust Fund; and
- Members in good standing of the Retiree Chapter of the CCPOA.

You may not be eligible to enroll yourself or your dependents in all of the benefit programs provided by the Welfare Benefit Plan - eligibility to participate in certain benefit programs may depend on certain variables, such as whether you are an active employee or a retiree. You will be provided information about the Benefit Programs upon your enrollment in those Benefit Programs. Contact the Trust Office at (800) 468-6486 to request copies of the Summary Program Booklets and/or Evidences of Coverage/Certificates of Coverage for the Benefit Programs in which you are interested.

4.2 Effective Date of Coverage

Participation in a Benefit Program of the Welfare Benefit Plan will generally commence on the later of the effective date of the Benefit Program or the date you become eligible for coverage under the Benefit Program, subject to the Benefit Program's enrollment requirements and the timely payment of any required contributions. Specific information regarding the effective date of coverage under a particular Benefit Program is described in the applicable Summary Program Booklet or Evidence of Coverage/Certificate of Coverage.

4.3 Enrollment Requirements

Specific enrollment requirements for a particular Benefit Program are described in the applicable Summary Program Booklet or Evidence of Coverage/Certificate of Coverage. You will be required to complete and submit an enrollment form or application to obtain coverage for yourself and your dependents, if available.

4.4 Domestic Partner Coverage

Unless otherwise provided for in this Document or in the Summary Program Booklet or Evidence of Coverage/Certificate of Coverage for a particular Benefit Program, an eligible dependent will include a Domestic Partner of an employee, or the child(ren) of the Domestic Partner. For these purposes, the term "Domestic Partner" is defined by reference to California Family Code Section 297 et seq. "Domestic partners" generally are two persons of the same sex (or of the opposite sex if at least one opposite sex partner is over the age of 62 and meets the eligibility criteria of 42 U.S.C. Section 402(a) for old-age Social Security insurance benefits or 42 U.S.C. Section 1381 for Social Security aged benefits) who meet all of the following requirements:

- Share a common residence;
- Neither is currently legally married to another person nor a member of another domestic partnership;
- Not a blood relative to each other any closer than would prohibit legal marriage in the state of California;
- Are at least 18 years of age;
- Are capable of consenting to the domestic partnership; and
- Have filed a valid Declaration of Domestic Partnership with the Secretary of the State of California.

The Trustees reserve all rights to determine a person's status as a Domestic Partner and his/her eligibility to participate in any of the Benefit Programs.

SECTION 5
TERMINATION OF COVERAGE

The rules described in this section are general and may differ for a particular Benefit Program. Specific provisions related to termination of coverage in a particular Benefit Program may be described in the applicable Summary Program Booklet or Evidence of Coverage/Certificate of Coverage. Refer to the applicable Summary Program Booklet or Evidence of

Coverage/ Certificate of Coverage for more information.

Your coverage under the Welfare Benefit Plan will generally terminate on the earliest to occur of the following:

- The date you cease to satisfy the eligibility requirements of the Welfare Benefit Plan, or any Benefit Program with respect to coverage under such Benefit Program; or
- The date the Welfare Benefit Plan and/or a Benefit Program is terminated or is amended so that you are no longer eligible to participate; or
- The date a Benefit Program is terminated as a result of the termination of the group insurance contract or policy and no replacement contract or policy is procured; or
- The date the Welfare Benefit Plan ceases to provide coverage for your class of participants (e.g., employees of CCPOA, employees of CCPOA Benefit Trust Fund, retirees, etc.); or
- The last day of a period for which contributions for the cost of coverage have been made, if the contributions for the next period are not made on a timely basis; or
- The date on which you request termination of coverage under a Benefit Program with respect to coverage under such Benefit Program; or
- The date you die.

An eligible dependent's coverage under the Welfare Benefit Plan or any Benefit Program will generally terminate upon the occurrence of the earliest of the following:

- The date you cease to participate in the Welfare Benefit Plan or a particular Benefit Program; or
- The last day of a period for which contributions for the cost of coverage have been made, if the contributions for the next period are not made on a timely basis; or
- The date you cease to satisfy the eligibility requirements of the Welfare Benefit Plan or a particular Benefit Program with respect to coverage under such Benefit Program (e.g. reaching a limiting age); or
- The date the Welfare Benefit Plan and/or applicable Benefit Program is terminated or is amended so that the dependent is no longer eligible to participate; or

- The date a Benefit Program is terminated as a result of the termination of the group insurance contract or policy and no replacement contract or policy is procured; or

- The last day of a period for which contributions for the cost of coverage have been made, if the contributions for the next period are not made on a timely basis; or

- The date on which you request termination of the dependent's coverage under the Welfare Benefit Plan or any Benefit Program with respect to coverage under such Benefit Program; or

- The date the eligible dependent dies.

In certain limited circumstances, you or your eligible dependent may be able to convert coverage to a conversion policy under the Benefit Program after the dates listed above. See the applicable Summary Program Booklet or Evidence of Coverage/Certificate of Coverage and the section below for information.

SECTION 6
CONTINUATION OF COVERAGE – PIGGYBACK PROGRAMS

THIS IS A VERY IMPORTANT NOTICE REGARDING YOUR RIGHT TO CONTINUE COVERAGE UNDER THE PIGGYBACK PROGRAMS FOLLOWING THE TERMINATION OF SUCH COVERAGE.

This is an explanation of your rights under the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"). COBRA is a federal law that requires group health plans, including some of the Benefit Programs offered under the Benefit Trust Fund, to allow employees and their dependents to continue group health-type coverage at their own expense for a period of time after coverage would end. This notice provides COBRA information for the benefits offered under the Piggyback Program. For additional information about your rights and obligations under the Piggyback Program and under federal law, you should review the applicable Summary Program Booklet for the Piggyback Program or contact the Benefit Trust Fund.

COBRA Coverage is available under the Piggyback Program to the employees and dependents who are covered by the Piggyback Program on the day before the event that qualifies them for COBRA. Such individuals are considered "qualified beneficiaries" under COBRA. Because COBRA does not provide domestic partners with the right to elect to continue coverage, Domestic Partners who are eligible for coverage under the

Benefit Trust Fund are not eligible to elect to continue coverage when their coverage terminates.

If you have questions about COBRA, contact the Benefit Trust Fund, (see Appendix B for the Administrator's contact information).

6.1 COBRA Events

If you are an ***employee*** of the state of California, Benefit Trust Fund or CCPOA participating in the Piggyback Program, you have a right to pay for and continue group coverage under COBRA ("COBRA Coverage") if you lose your coverage because of one of the following "qualifying events":

- Termination of your employment for reasons other than your gross misconduct; or

- Reduction in the hours of your employment. If you are on an approved leave of absence protected by the Family and Medical Leave Act (FMLA) and/or the California Family Rights Act, only the failure to return to work at the end of the approved leave constitutes a "qualifying event", subject to any limitations of such laws.

If you are the ***spouse*** or ***dependent child*** of an employee (or retiree) participating in the Piggyback Program, you have the right to elect and pay for COBRA Coverage if you lose your coverage because of any of the following "qualifying events":

- The death of the employee;

- A termination of the employee's employment for reasons other than his or her gross misconduct;

- A reduction in the employee's hours of employment;

- Divorce or legal separation of the employee; or

- In the case of a ***dependent child***, the dependent ceases to be a "dependent child" under the Piggyback Program.

A spouse or dependent children who do not have dependent coverage under a COBRA Benefit Program on the day before a qualifying event are not eligible for COBRA Coverage.

However, a child born to or placed for adoption with an employee during a period of COBRA Coverage is a qualified beneficiary. The covered employee or family member must notify the Benefit Trust Fund within 31 days after the birth or placement for adoption to enroll the child for COBRA Coverage. Additionally, if a spouse loses coverage in anticipation of divorce, the spouse may be a qualified beneficiary upon actual divorce despite having been removed from coverage prior

to the qualifying event, but the spouse, within 60 days of the divorce, must inform the Benefit Trust Fund of the divorce to protect his or her right to COBRA Coverage.

6.2 Maximum Coverage Period for Each Qualifying Event

For any qualified beneficiary, the COBRA Coverage period is up to **18 months** if the qualifying event is an employee's termination of employment or reduction in hours. For a spouse or dependent child, the COBRA Coverage period is up to **36 months** for any qualifying event other than an employee's termination of employment or reduction in hours. These coverage periods may be extended or shortened under the following circumstances:

- If an employee or covered dependent is disabled at the time of the qualifying event, or within the first 60 days after the qualifying event, an 18 month COBRA Coverage period is extended for all qualified beneficiaries for up to an additional 11 months (29 months in total from the date of the termination of employment or reduction in hours). Pursuant to Title II or Title XVI of the Social Security Act, the Social Security Administration will determine whether the disability exists and when it began. The employee or eligible dependent must give the Benefit Trust Fund a copy of this determination within 60 days after the determination is made and within the initial 18 months of coverage.

- If a dependent covered under COBRA experiences a second qualifying event (for example, the employee dies, gets divorced or legally separated, or the dependent child stops being eligible under a COBRA Benefit Program as a dependent child) within the 18-month or 29-month coverage period, the maximum coverage period will be extended to 36 months. An event is a "second qualifying event" only if the event would have caused the dependent to lose coverage under a COBRA Benefit Program had the first qualifying event not occurred. The Benefit Trust Fund must receive notice of the second qualifying event within 60 days after the event. A termination of employment that follows a reduction in hours that was a qualifying event is never a second qualifying event.

- If the employee is entitled to Medicare within 18 months prior to a termination of employment or reduction in hours that is a qualifying event, the employee's spouse and dependent children may extend coverage for up to 36 months from the date of Medicare entitlement. To receive either of the extensions, the qualified beneficiary must provide notice to the Benefit Trust Fund of Medicare entitlement and must provide a copy of his or her Medicare card.

6.3 Your Notice Obligations

You or a dependent are obligated to inform the Benefit Trust Fund about the following situations:

- **Disability of a Qualified Beneficiary.** To extend the COBRA Coverage period to 29 months because of a qualified beneficiary's disability, you or your dependent must be or become disabled within the first 60 days after the COBRA "qualifying event," and you must notify the Benefit Trust Fund of the Social Security disability determination within 60 days after the latest of (a) the date of the Social Security Administration ("SSA") disability determination; (b) the date of the qualifying event (i.e., the employee's termination of employment or reduction of hours); (c) the date on which the Qualified Beneficiary loses or would lose coverage under the Plan as a result of the qualifying event; or (d) the date on which the Qualified Beneficiary is informed, through the furnishing of this Plan Document & Summary Plan Description or COBRA initial notice, of both the responsibility to provide the notice of disability determination and the procedures for providing such notice to the Benefit Trust Fund. The SSA notice of determination of disability must be enclosed with your notification to the Benefit Trust Fund.

- **Qualifying Events and Second Qualifying Events**. You or your dependent must inform the Benefit Trust Fund about a divorce, legal separation, entitlement to Medicare, a child's loss of dependent status under the COBRA Benefit Program(s), or a former employee's death. If one of these events happens, you must send notice to the Benefit Trust Fund within 60 days of the date of the event or within 60 days of the date that you would coverage lose coverage under the COBRA Benefit Program if COBRA is not elected (if later). If any of these events occurs while you or your dependent is receiving COBRA for an 18 or 29 month period as a result of a termination of employment or reduction in hours of employment, the event is a second COBRA qualifying event. As such, notice of the second qualifying event must be provided to the Benefit Trust Fund within 60 days after the event.

- **COBRA Terminating Events.** You or a dependent must inform the Benefit Trust Fund as soon as practicable about entitlement to Medicare or enrollment in another group health plan offering similar coverage if that event would terminate COBRA Coverage (see Section 6.6 for these events). You must also notify the Benefit Trust Fund within 30 days after the SSA's final determination that you are no longer disabled. If you fail to provide this notice, the Benefit Trust Fund is entitled to

reimbursement for expenses paid during periods when you were not entitled to COBRA Coverage and may impose a lien or reduce future benefit payments to offset for these amounts.

Your notice should be sent to the Benefit Trust Fund at the address noted in this Summary Plan Description. The Benefit Trust Fund has a form that you should complete to provide required notices. If you do not already have the form, please call the Benefit Trust Fund at the number listed in Appendix B to request a copy. Your notice must include the name and address of the individual experiencing the event, the name and social security number of the employee, the date of the qualifying event, and the type of qualifying event.

IMMEDIATELY INFORM THE BENEFIT TRUST FUND WHENEVER YOU OR ANY OF YOUR DEPENDENTS HAVE A CHANGE of ADDRESS, SO NOTICES CAN BE SENT TO THE CORRECT ADDRESS. FAILURE TO PROVIDE A CURRENT ADDRESS COULD CAUSE A LOSS OF COBRA RIGHTS.

6.4 Election of COBRA Coverage

You and/or your dependents may elect COBRA Coverage by filing a COBRA election form with the Benefit Trust Fund within 60 days after the later of (1) the date on which your coverage ended because of a qualifying event, or (2) the date you are notified about your COBRA rights. Your election form will be included in your COBRA election notice. Additional election forms may be obtained by calling the Benefit Trust Fund at the number listed in Appendix B. Election forms should be mailed to the Benefit Trust Fund at the address shown in this Summary Plan Description. Assuming you elected COBRA Coverage within the required time period, your COBRA Coverage will be retroactively reinstated to the date that your coverage otherwise ended once your election and first payment are received. If a service provider or payor calls for verification of eligibility or benefits during the election period or during a period when you have not made payment by the due date, but you are in your payment grace period (described below), the provider or payor will be told that you do not have coverage, but that coverage will be retroactively reinstated if a proper election and payment is made.

A covered employee or spouse of the covered employee may elect COBRA Coverage for all eligible family members and a parent may make an election for a child, but each qualified beneficiary has an independent election right for each type of benefit coverage and the right is not dependent on the other family members' elections. Thus, if the employee does not elect COBRA Coverage, his or her eligible dependents may still choose (and pay for) COBRA Coverage on their own.

IF YOU DO NOT ELECT COBRA COVERAGE WITHIN THE ELECTION PERIOD, YOUR COVERAGE WILL END.

6.5 Payments

You will not have to show that you are insurable to elect COBRA, but you will have to pay the full cost of coverage plus a 2% administrative fee. A disabled qualified beneficiary and his or her family whose COBRA is extended due to disability will have to pay 150% of the full cost of coverage during the 11-month disability extension (i.e., months 19 – 29).

The first COBRA payment must be made not later than 45 days after the date COBRA Coverage is elected (this is the date the Election Notice is post-marked, if mailed.). If the first payment is not timely made, all COBRA rights will be lost. The amount of the first payment is equal to the amount owed for COBRA Coverage starting on the day COBRA Coverage commences through the month preceding the month in which you make the actual payment. This may be as little as one (1) month or over three (3) months of COBRA Coverage, depending on when you elect COBRA and when you make the first payment. Although you are encouraged to contact the Benefit Trust Fund if you are unclear about the amount due, you are responsible for making sure that the amount of your first and subsequent payments are correct.

Failure to pay the premium within 45 days of electing COBRA Coverage will result in loss of your COBRA Coverage.

- After you make the first payment, COBRA payments are due on the first day of the month and are considered late if they are not received within 30 days after the due date. COBRA Coverage will be provided for each month as long as payment for that month is made prior to the end of the 30-day grace period for that payment, but the Benefit Trust Fund may terminate coverage if you do not make payment by the due date. If you make payment after the due date, but before the end of the grace period, your coverage will be retroactively reinstated. If any of your COBRA payments are not made prior to the end of the grace period, you will lose all of your COBRA Coverage rights.

Any invoice or bill that you receive is considered a courtesy reminder and non-receipt of the invoice does not affect the payment due date. If the COBRA payment is not received on the due date, a notice may be sent to you indicating that such payment has not been received and that coverage may be cancelled if it is not received by the end of the grace period. Your coverage will be irrevocably cancelled at the end of the grace period if payment is not received whether or not you received the reminder notice.

Your first payment and all subsequent monthly payments for COBRA Coverage should be sent to:

CCPOA Benefit Trust Fund
2515 Venture Oaks Way, #200
Sacramento CA 95833

6.6 End of COBRA Coverage

COBRA Coverage ends when your 18, 29-or 36month COBRA period ends, but it may end earlier upon any of the following events:

- Failure to make a timely payment for your COBRA Coverage;
- Becoming covered under another group health plan with similar coverage that has no preexisting condition exclusions or limitations that apply to you after electing COBRA Coverage. If the other plan has applicable exclusions or limitations, your COBRA Coverage will terminate after the exclusion or limitation no longer applies;
- Becoming entitled to Medicare (Part A or Part B) coverage after electing COBRA Coverage (applies only to the person who became entitled to Medicare, not his or her family members);
- If you or your dependent became entitled to an 11-month extension of coverage period due to a disability of a qualified beneficiary, a final determination by the Social Security Administration that the qualified beneficiary is no longer disabled (however, COBRA Coverage will not be terminated for this reason during the first 18 months, and COBRA Coverage will not end until the month that begins more than 30 days after the determination);
- Any event that that would terminate coverage of a participant not on COBRA (e.g., fraud); or
- The applicable COBRA Benefit Program's termination.

6.7 Consider COBRA Coverage Carefully

Under Federal law (the Health Insurance Portability and Accountability Act or HIPAA), pre-existing condition exclusions or limitation of your new group health plan might not apply at all to you, depending on the length of your creditable health plan coverage under the COBRA Benefit Program prior to enrolling in the other group health plan. However, if there has been a break of 63 days or more after you lose plan coverage and before you are covered by any new plan, the benefit of HIPAA creditable coverage would be lost. Your new plan could disregard your old coverage prior to this break, and it could

enforce pre-existing condition limitations against you or your dependents. Therefore, carefully consider electing COBRA Coverage, before letting this 63day period expire. Finally, special enrollment rights might apply to other group health plan coverage available to you due to loss of program coverage or loss of COBRA Coverage.

SECTION 7
UNIFORMED SERVICES EMPLOYMENT AND

Reemployment Rights Act of 1994 – Piggyback Program

It is the intent of the Benefit Trust Fund to comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). The following USERRA rules apply to the benefits provided under the Piggyback Program.

If you take a leave of absence because of voluntary or involuntary service in the uniformed services for a period that is less than 31 days, you must continue to pay your contributions towards your Piggyback Program coverage. If your military leave of absence is between 31 days and five years, you may elect to continue coverage under the Piggyback Program for yourself and your eligible dependents for up to 24 months or for the period ending on the day after the date you fail to apply for or return to employment with your employer as determined under section 4312(e) of the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), whichever is earlier. This provision applies to:

- Eligible employees on active duty; and
- Eligible employees on active duty for training; and
- Eligible employees on initial active duty for training and inactive duty training in the Armed Forces (including Reserve components), the Army or Air National Guard and the commissioned corps of the Public Health Service, and to full-time National Guard duty; and
- Absences needed to determine the employee's fitness for duty in the uniformed service.

7.1 Your Notice Obligations

To continue coverage under the Piggyback Program pursuant to USERRA, you must provide your employer with advance notice of your military service. If you fail to provide advance notice to your employer, you will lose your right to continue coverage pursuant to USERRA unless the requirement to provide advance notice has been excused in accordance with USERRA because such notice was impossible, unreasonable or precluded by military necessity.

Because your rights to COBRA coverage are also triggered when you go on a USERRA protected leave, your election of COBRA will be treated as an election of USERRA coverage. The election procedures and payment procedures, including applicable deadlines, that apply to COBRA coverage apply to USERRA coverage. If you do not timely elect COBRA coverage, your right to elect that coverage and USERRA coverage will be lost. Your COBRA coverage will run concurrently with your USERRA coverage to the extent your rights under both laws overlap. [Note: If your requirement to provide advance notice to your employer of your USERRA leave has been properly excused, the deadline for you to elect continuation coverage will be extended. Your coverage under the Piggyback Program will be reinstated retroactive to the date that your coverage was terminated upon your submission of your COBRA election form and all unpaid premium payments to the Benefit Trust Fund at any time during your USERRA coverage period.]

7.2 End of USERRA Coverage

Continuation coverage pursuant to USERRA ends on the earliest to occur of the following:

- The date you fail to return from protected military service or apply for a position of reemployment as provided under USERRA;
- The end of the 24-month period beginning the date your military leave of absence began;
- Your failure to make a timely payment for your COBRA/USERRA coverage;
- The date you are discharged from military service under other than honorable conditions or if you are dismissed or dropped from military rolls under conditions that result in a loss of reemployment rights under USERRA;
- Any event that would terminate coverage of a participant not on COBRA/USERRA (e.g., fraud); or
- Termination of the Piggyback Program or the Plan.

7.3 Returning From a Military Leave of Absence

If your Piggyback Program coverage terminated by reason of your service in the uniformed services, your employer-paid coverage will be reinstated upon your return from leave and reemployment in accordance with USERRA. Your coverage will be reinstated without the application of any pre-existing condition exclusions or waiting periods unless you have an injury or illness that the Secretary of Veterans Affairs has determined to have been incurred in, or aggravated during, performance of service in the uniformed services.

SECTION 8
CIRCUMSTANCES WHICH MAY AFFECT BENEFITS

Eligibility for Welfare Benefit Plan benefits for covered individuals will terminate upon the occurrence of any of the events listed in the Termination of Coverage section of this Document, or as otherwise described below or in the applicable Summary Program Booklet or Evidence of Coverage/Certificate of Coverage. Other circumstances may result in the termination, reduction, loss, offset or denial of benefits (for example, exclusions for any losses relating to an illegal activity). Refer to the applicable Summary Program Booklet or Evidence of Coverage/Certificate of Coverage for further information regarding the circumstances which may affect benefits under a particular Benefit Program.

8.1 Beneficiary Designations

To the extent that any Benefit Program provides for a benefit payable upon your death, the benefit will generally be payable to the individual you named as your beneficiary on the applicable beneficiary designation form on file with the applicable administrator of the Benefit Program at the time of your death, provided such individual has not predeceased you. Please be sure to update your beneficiary designation form whenever you experience a change in status event you deem appropriate (e.g., marriage, divorce, etc.) or at any other time you deem appropriate. If you do not have a surviving named beneficiary, any death benefit will be payable in accordance with the preference beneficiary rules described in the applicable Summary Program Booklet or Evidence of Coverage/Certificate of Coverage.

8.2 The Welfare Benefit Plan's Right of Reimbursement

The Welfare Benefit Plan has the right of reimbursement—that is, the Welfare Benefit Plan has the right to recover benefits or expenses paid by the Welfare Benefit Plan under certain circumstances including instances when the Welfare Benefit Plan has overpaid benefits, paid benefits in error, when the Welfare Benefit Plan has a right to coordinate benefits, or when benefits are payable from another source, including workers' compensation benefits, CalPERS benefits, or another plan. You or your dependent, as applicable, must set aside any amount that you receive which may be subject to the Welfare Benefit Plan's right of reimbursement in a separate account over which you have possession and hold such amount for the benefit of the Welfare Benefit Plan. The Welfare Benefit Plan may undertake any reasonable means to recover benefits or expenses in furtherance of its right of reimbursement, including, but not limited to, filing a lien or bringing a civil suit against you or on your behalf against any entity that may be liable or responsible for reimbursing the Welfare Benefit Plan.

The Welfare Benefit Plan also has the right to withhold benefits due to you under a particular Benefit Program by applying them to offset your liability to the Welfare Benefit Plan due to overpayments, a coordination of benefits provision, or payments mistakenly made to that participant or his or her beneficiary under that or another Benefit Program of the Benefit Trust Fund or where benefits are payable from another source, including workers' compensation benefits or another plan.

The Benefit Programs may contain similar or additional rights of recovery. Refer to the applicable Summary Program Booklet or Evidence of Coverage/Certificate of Coverage for further information regarding the Trust's (or an insurance carrier's) rights of recovery under the particular Benefit Program.

8.3 Termination of Coverage for False or Incomplete Representations

If you make a false or incomplete representation related to your participation in the Welfare Benefit Plan, the Board of Trustees has the right to permanently terminate coverage for you and all of your eligible dependents. The Board of Trustees may also seek reimbursement from you for all claims or expenses paid by the Welfare Benefit Plan as a result of the false or incomplete representation, and may pursue legal action against you. False representation includes, but is not limited to, submitting a falsified application or claim to a Benefit Program or obtaining coverage for an individual who is ineligible (for example, adding a spouse before you are married or after you are divorced, or adding a child who does not meet the particular Benefit Program's definition of an eligible dependent).

SECTION 9
CLAIMS AND APPEALS

9.1 Claims and Appeals

The Benefit Trust Fund, for the self-funded programs, and the applicable insurance carriers for the insured benefits, are responsible for evaluating benefit claims. To the extent permitted by law, the Board of Trustees has delegated to various insurance carriers the discretionary authority to interpret and apply terms relating to the benefits that they have contracted with the Benefit Trust Fund to provide, and to make factual determinations in connection with their review of claims and appeals under the applicable Benefit Program. Such discretionary authority may include the determination of the eligibility of persons desiring to enroll in or claim benefits under the applicable Benefit Program, the determination of whether a person is entitled to benefits under the applicable Benefit Program, and the computation of any and all applicable Benefit Program payments. Where such delegation has

occurred, the insurance carrier has sole discretionary authority to determine eligibility, interpret Plan terms, and review and decide claims.

The Benefit Trust Fund, for the self-funded programs, will decide all claims in accordance with its claims procedures, as required by ERISA and as described in this Document and the applicable Summary Program Booklet. The insurance carriers will decide all claims and appeals in accordance with their claims and appeals procedures, as required by ERISA and as described in this Document and the applicable Summary Program Booklet or Evidence of Coverage/Certificate of Coverage.

The applicable Claims Administrators and insurance carriers have the right to seek independent medical advice and to require you to provide other evidence as they deem necessary to decide your claims.

Contact information for the insurance carriers for the insured benefits can be found in Appendix D.

9.2 Filing A Claim

To file a claim, you or your authorized representative must complete the proper claim form and send it to the applicable Claims Administrator within the time frame specified in the claims procedure described in the Summary Program Booklet or Evidence of Coverage/Certificate of Coverage. You may obtain claim forms by contacting the applicable Claims Administrator. For all self-funded benefits (Piggyback Program, VSP Second Pair of Eyeglasses Benefit Program, LDF III), contact the Trust Office at:

CCPOA Benefit Trust Fund
2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833-4235
Telephone Number: (916) 779-6300
Toll Free: (800) 468-6486 or (888) 779-6327

For insured benefits, contact the following, as applicable:

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010

Combined Services

Joe Gonsalves,
CA Lic. OC28986
Regional Benefit Specialist
Phone: (949) 521-4267

For U.S. Legal Services benefits, contact the following:

U.S. Legal Services
8133 Baymeadows Way, Suite 102
Jacksonville, FL 32256
Phone: 1-800-356-5297

You must provide any other document required by the Claims Administrator to process your claim, including any proof of loss or a death certificate.

9.3 If Your Claim Is Denied

If the applicable Benefit Program administrator or insurance carrier denies your claim, in whole or in part, you will receive a notice of the denial and an explanation of how you may appeal the decision, as required by ERISA, within the time limit for the type of claim.

- The denial notice will include:
- Specific reason(s) for the denial;
- Specific references to plan provisions on which the denial is based;
- A description of any additional material or information necessary for you to complete your application and an explanation of why the material or information is necessary;
- A statement that you will be provided, upon request, reasonable access to and free-of-charge, copies of all documents, records and other information relevant to your claim subject to any legal privilege; and
- An explanation of the procedure for appealing the adverse benefit determination.

9.4 Filing an Appeal

If you do not agree with the claims decision, you may request that the decision be reviewed by sending your request to the Claims Administrator within the time limit specified in the chart that follows. Contact the Benefit Trust Fund for information regarding the appeals process for all self-funded benefits. For all insured benefits, contact the insurer Claims Administrator for information regarding the appeals process. Contact information for the insurers can be found in **Appendix D.**

Your request must state all the reasons why you believe the benefits should be paid, including any documents, records or other information relevant to or that support your claim. You may obtain reasonable access to, or copies of, all documents and information relevant to your claim free of charge, subject to any legal privilege.

Following a full and fair review of your appeal by the Claims Administrator, a decision will be made on your claim within the time limit for appeal determinations (see the following pages and your Summary Program Booklet or Evidence of Coverage/ Certificate of Coverage). If the appeal involves a medical determination, the Claims Administrator will consult with an appropriate professional who was not involved in the initial denial of your claim. The Claims Administrator will not afford deference to the initial claim denial. The Claims Administrator will provide written notification of its decision within the appeals time period applicable to the claim.

If the original denial is upheld, you will receive a written notice stating:

- Specific reason(s) for the denial.
- Specific references to plan provisions on which the denial is based.
- A statement that you will be provided, upon request, reasonable access to and free-of-charge, copies of all documents, records and other information relevant to your claim, subject to any legal privilege.
- A statement regarding your rights to bring an action under Section 502(a) under the Employee Retirement Income Security Act of 1974 (ERISA).

9.5 Claims and Appeals Time Limits

Piggyback Programs and Closed Accident, Cancer, Heart/Stroke Programs	
Time Limit to Provide Notice of Claim Decision	Refer to your Summary Program Booklet or Evidence of Coverage/Certificate of Coverage.
Participant Time Limit to Provide Additional Information and Adjusted Deadline for Claims Decision	Refer to your Summary Program Booklet or Evidence of Coverage/Certificate of Coverage.
Participant Time Limit to File Appeal If Claim Is Denied	180 days after receipt of notice of adverse benefit determination.
Time Limit to Determine Appeal of Appeal Decision	Refer to your Summary Program Booklet or Evidence of Coverage/Certificate of Coverage.

U.S. Legal Family Defender Program	
Time Limit to Provide Notice of Claim Decision	90 days after Claim Administrator's receipt of claim, unless an extension of up to 90 days is necessary due to matters beyond the control of the Claims Administrator. Notice of any extension will be provided before the end of the initial 90-day period. Such notice will explain why the extension is necessary and when the Claims Administrator expects to notify you of its decision.
Participant Time Limit to Provide Additional Information and Adjusted Deadline for Claims Decision	Dates specified in extension notice.
Participant Time Limit to File Appeal If Claim Is Denied	90 days after receipt of adverse benefit determination.
Time Limit to Determine Appeal of Appeal Decision	60 days after Claim Administrator's receipt of claim, unless an extension of up to 60 days is necessary due to matters beyond the control of the Claims Administrator. Notice of any extension will be provided before the end of the initial 60-day period. Such notice will explain why the extension is necessary and when the Claims Administrator expects to notify you of its decision.
CCPOA Legal Defense Fund III	
Time Limit to Provide Notice of Claim Decision	Refer to your Summary Program Booklet.
Participant Time Limit to Provide Additional Information and Adjusted Deadline for Claims Decision	Refer to your Summary Program Booklet.
Participant Time Limit to File Appeal If Claim Is Denied	60 days after receipt of notice of adverse benefit determination.
Time Limit to Determine Appeal of Appeal Decision	Refer to your Summary Program Booklet.
Life Insurance and Accidental Death and Dismemberment Insurance– all claims except for disability premium waivers where available	
Time Limit to Provide Notice of Claim Decision	90 days after claim administrator's receipt of Claim, unless an extension of up to 90 days is necessary due to matters beyond the control of the Claims Administrator. Notice of any extension will be provided before the end of the initial 90-day period. Such notice will explain why the extension is necessary and when the Claims Administrator expects to notify you of its decision.

Participant Time Limit to Provide Additional Information and Adjusted Deadline for Claims Decision	Dates specified in extension notice.
Participant Time Limit to File Appeal If Claim Is Denied	60 days after receipt of adverse benefit determination.
Time Limit to Determine Appeal of Appeal Decision	60 days after Claim Administrator's receipt of claim, unless an extension of up to 60 days is necessary due to matters beyond the control of the Claims Administrator. Notice of any extension will be provided before the end of the initial 60-day period. Such notice will explain why the extension is necessary and when the Claims Administrator expects to notify you of its decision.
Disability premium waiver claims where available for Life Insurance, and Accidental Death and Dismemberment Insurance	
Time Limit to Provide Notice of Claim Decision	45 days after Claim Administrator's receipt of claim, unless an extension of up to 30 days is necessary due to matters beyond the control of the Claims Administrator. A second 30-day extension period is available if needed by the Claims Administrator. Notice of any extension will be provided before the end of the initial 45-day period or 30-day extension period, as applicable. Such notice will explain why the extension is necessary and when the Claims Administrator expects to notify you of its decision.
Participant Time Limit to Provide Additional Information and Adjusted Deadline for Claims Decision	45 days to provide requested information. Notice of the claim decision will be provided within 15 days after receipt of the additional information or within 15 days after the 45-day deadline to provide the additional information, whichever is earlier.
Participant Time Limit to File Appeal If Claim Is Denied	180 days after receipt of adverse benefit determination.
Time Limit to Determine Appeal of Appeal Decision	45 days after Claim Administrator's receipt of claim, unless an extension of up to 45 days is necessary due to matters beyond the control of the Claims Administrator. Notice of any extension will be provided before the end of the initial 45-day period. Such notice will explain why the extension is necessary and when the Claims Administrator expects to notify you of its decision.

9.6 Legal Action

No legal action for benefits under the Plan may be brought until you (i) have submitted a written claim for benefits in accordance with the procedures described above; (ii) have

been notified by the Claims Administrator that the claim is denied; (iii) have submitted an appeal in accordance with the appeal procedure described above; and (iv) have been notified that your appeal has been denied. *No legal action may be commenced or maintained against the Plan more than three years after your appeal was denied.*

SECTION 10
MISCELLANEOUS

10.1 Proof of Age, Marriage and Dependent Status

Participants and their eligible dependents may be required to furnish satisfactory proof of age or other information and may require participants and their spouses or Domestic Partners to furnish satisfactory proof of marital or Domestic Partnership status (as applicable) as a condition of maintaining coverage of such eligible dependents under the Plan.

10.2 Notice

Any notice to be delivered to participants under this Plan by the Benefit Trust Fund shall be given in writing and delivered, personally or by first-class mail to the participant or any beneficiaries, as the case may be, at their last known address on file with the Trust Office.

Notices which participants or their beneficiaries must provide to the Welfare Benefit Plan must be sent via first class mail or delivered personally to the Trust Office:

CCPOA Benefit Trust Fund
2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833-4235
Telephone Number: (916) 779-6300
Toll Free: (800) 468-6486 or (888) 779-6327
Facsimile Number: (916) 779-6355

10.3 No Guarantee of Tax Consequences

The Plan Administrator does not make any commitment or guarantee that any amounts paid to or for the benefit of any person under the Welfare Benefit Plan will be excludable from that person's gross income for federal, state, and/or local income tax purposes, or that any other federal, state, or local tax treatment will apply or be available to any person. It is the obligation of each person to determine whether any payment under the Welfare Benefit Plan is excludable from gross income for federal, state, and/or local income tax purposes.

10.4 Governing Law

This Plan shall be construed and enforced in accordance with ERISA and, to the extent it is not preempted by ERISA, with applicable state law.

10.5 No Waiver of Terms

No term, condition or provision of the Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of the Plan, except by written agreement of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

10.6 Limitation of Rights

The Welfare Benefit Plan does not give you or any other person any legal or equitable right against CCPOA, the Trustees (whether collectively or individually), or the Welfare Benefit Plan, except as expressly provided in the official Plan Documents.

10.7 No Transfer of Rights

No participant or beneficiary may sell, transfer, anticipate, assign, hypothecate, or otherwise dispose of his or her benefits, or any right or interest under the Welfare Benefit Plan or any Benefit Program, except as expressly provided in the official Plan Documents (and the Board of Trustees shall not recognize or be required to recognize any such disposition); nor may any benefit, right or interest under the Welfare Benefit Plan or any Benefit Program be subject to the voluntary transfer or transfer by operation of law or otherwise, and shall be exempt from claims of creditors or other claimants, or liable to attachment, execution or other legal process, except as expressly provided in the official plan documents.

Unless specifically provided otherwise in the Summary Program Booklet or Evidence of Coverage/Certificate of Coverage or as required by law, the Board of Trustees will only make payments directly to the person entitled to benefits under the Benefit Program (the "beneficiary"), except when the beneficiary is a minor or considered (in good faith) by the Board of Trustees to be incompetent or otherwise incapacitated, in accordance with the terms of the CCPOA Benefit Trust Fund Agreement and Declaration of Trust or Plan documents. The Board of Trustees may make any arrangements for payment on the beneficiary's behalf that it determines will be beneficial to the beneficiary, including the payment of such amounts to a representative payee such as the guardian, conservator, spouse or dependent of the beneficiary, or an institution providing care to the beneficiary.

SECTION 11
STATEMENT OF YOUR ERISA RIGHTS

As a participant in the CCPOA Benefit Trust Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Welfare Benefit Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits. Examine, without charge, at the trust administration office, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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 the summary annual report.

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 create your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in Federal Court. In such case, the Court may require the plan administrator to provide the materials and pay up to $110 per 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. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights,

you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal Court. The Court will decide who should pay court costs and legal fees. If you are successful, the Court may order the person you have sued to pay these costs and fees. If you lose, the Court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

* * * * *

The Board of Trustees is pleased to provide you with this document which provides information about your CCPOA Benefit Trust Fund benefits and hopes that you find it helpful. If you have any questions, please call the Trust Office at (916) 779-6300 or toll free at (800) 468-6486.

APPENDIX A
DEFINITIONS

Benefit Trust Fund means the CCPOA Benefit Trust Fund.

CCPOA means the California Correctional Peace Officers Association.

Claims Administrator means the entity that decides benefit claims and appeals. For the self-funded programs, the Claims Administrator is the Benefit Trust Fund. For the insured benefits, the Claims Administrator is the insurance carrier providing the benefits.

ERISA means the Employee Retirement Income Security Act of 1974, as amended, and any regulations issued thereunder.

Plan means the CCPOA Benefit Trust Fund Welfare Benefit Plan

Plan Documents means the official documents and instruments governing the CCPOA Benefit Trust Fund Welfare Benefit Plan, including the CCPOA Benefit Trust Fund Agreement

and Declaration of Trust, this Summary Plan Description and Plan Document (including the applicable Summary Program Booklet or Evidence of Coverage/Certificate of Coverages), and any contracts entered into between the Benefit Trust Fund and insurance carriers to provide benefits under the Welfare Benefit Plan.

Summary Plan Description or SPD means this document, any Summaries of Material Modifications (SMMs), and each of the Summary Program Booklets or Evidences of Coverage/ Certificates of Coverage which apply to the Benefit Program(s) in which you are enrolled, together compose your Summary Plan Description for the Welfare Benefit Plan.

Summary Program Booklet means those documents which provide more information about the various Benefit Program(s) offered under the Welfare Benefit Plan, including specific eligibility and benefit information.

Trust Office means the office that administers the CCPOA Benefit Trust Fund, which you may contact at the following: CCPOA Benefit Trust Fund, 2515 Venture Oaks Way, Suite 200, Sacramento, CA 95833-4235, Telephone Number: (800) 468-6486 or (916) 779-6300, Facsimile Number: (916) 779-6355

APPENDIX B
TRUSTEES AND TRUST'S ADMINISTRATOR

Names and Address of the Trustees	
James Baumiller *Chair*	CCPOA Benefit Trust Fund 2515 Venture Oaks Way, Suite 200 Sacramento, CA 95833-4235 Telephone: (916) 779-6300 (Sacramento) Toll Free: (800) IN UNIT 6 or (800)-468-6486
Daniel Beaman *Vice Chair*	
Patrick Day *Trustee*	
Steven Herrera *Trustee*	
Wes Cherry *Trustee*	
Ex-Officio Trustee	
Chuck Alexander *State President, CCPOA*	755 Riverpoint Drive West Sacramento, CA 95605-1635
Jim Martin *State Treasurer, CCPOA*	

Name and Address of the Trust's Administrators	
Michael E. Smalley, *Administrator*	CCPOA Benefit Trust Fund 2515 Venture Oaks Way, Suite 200 Sacramento, CA 95833-4235 Telephone: (916) 779-6300 (Sacramento) Toll Free: (800) IN UNIT 6 or (800)-468-6486

APPENDIX C
CCPOA BTF – BENEFIT PROGRAMS UNDER THE WELFARE BENEFIT PLAN

The following Benefit Programs are available under the CCPOA Benefit Trust Fund Welfare Benefit Plan:

- Supplemental Life Insurance Program (New York Life Group Policy)
- Accidental Death and Dismemberment Insurance Program (New York Life Group Policy)
- Piggyback Program
- Combined Insurance Program
- U.S. Legal Family Defender Program
- LDF III
- VSP Second Pair of Eyeglasses Benefit Program

The following group insurance programs which are closed to new participants:

- Allstate – Accident Policy
- Allstate – Cancer Policy
- Allstate – Heart/Stroke Policy
- Cancer (through Bay Bridge)

- Fidelity Security Life – Decreasing Spouse
- First Penn Pacific – Universal Life (for eligible children)
- First Penn Pacific – Universal Life (for eligible members)
- First Penn Pacific – Universal Life (for eligible spouses)
- Group Life – 06
- Hartford – Ordinary Life
- Hartford – Universal Life
- National Foundation Life (Cancer)
- National Foundation Life (Heart Attack)
- National Foundation Life (Intensive Care)
- Reassure Policy

APPENDIX D
CONTACT INFORMATION FOR INSURED BENEFITS

Some of the benefits under the Welfare Benefit Plan are provided through insurance carriers. The insurers for the insured benefits and their contact information are listed below (contact information for all other carriers may be found on your Evidence of Coverage or Certificate of Coverage or by contacting the Trust Office):

For all Life Insurance, and Accidental Death & Dismemberment Insurance Provided by New York Life:

New York Life Insurance Company
P.O. Box 2999
Hartford, CT 06104
Phone: (888) 563-1124

For U.S. Legal Services benefits, contact the following:

U.S. Legal Services
8133 Baymeadows Way, Suite 102
Jacksonville, FL 32256
Phone: 1-800-356-5297

For Vision Benefits

VSP
Phone: (800) 877-7195

For Combined Insurance
Combined Services
Joe Gonsalves
CA Lic. OC28986
Regional Benefit Specialist
Phone: (949) 521-4267

APPENDIX E
HIPAA

In accordance with the requirements of the privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA", "Privacy Rule" and "Security Rule"), this appendix includes the CCPOA Benefit Trust Fund's Notice of Privacy Practices and the amendment which permits the Benefit Trust Fund's Board of Trustees to create, receive, use and disclose protected health information on behalf of the Benefit Trust Fund. Because Congress recognized that advances in electronic technology could erode the confidentiality of protected health information, Congress mandated the adoption of the privacy and security protections for individually identifiable health information.

Although the privacy and security provisions of HIPAA generally cover medical, dental, hearing aid and vision benefits, the Benefit Trust Fund is required to comply with HIPAA with respect to its self-funded dental and vision benefits only, including the Piggyback Program. Hence, the Notice of Privacy Practices on the following page is a brief summary of how the Privacy Rule applies to these benefits only. Non-health plan benefits such as life insurance and disability benefits are not subject to HIPAA.

CCPOA BENEFIT TRUST FUND
NOTICE OF PRIVACY PRACTICES

SECTION 1: PURPOSE OF THIS NOTICE AND EFFECTIVE DATE

THIS NOTICE DESCRIBES HOW DENTAL AND VISION INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date.

The effective date of this Notice is April 1, 2011. This Notice was first issued as of April 14, 2003 and was later amended effective as of January 1, 2010.

This Notice is required by law. The CCPOA Benefit Trust Fund (the "Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- The Plan's uses and disclosures of Protected Health Information (PHI),
- Your rights to privacy with respect to your PHI,
- The Plan's duties with respect to your PHI,
- Your right to file a complaint with the Plan and with the Secretary of the United States Department of Health and Human Services (HHS), and
- The person or office you should contact for further information about the Plan's privacy practices.

This Notice only applies to the healthcare components of the Plan. It does not apply to the non-healthcare components of the Plan, including the Disability Benefit Program, the Life Insurance and the Accidental Death and Dismemberment benefits and the Legal Services benefits.

Privacy Official.
The Plan's Privacy Official may be contacted at:

The Privacy Official or the
Benefit Administration Supervisor
CCPOA Benefit Trust Fund
2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833
Phone: (800) 468-6486

SECTION 2: YOUR PROTECTED HEALTH INFORMATION

2.1 Protected Health Information (PHI) Defined.
The term "Protected Health Information" (PHI) includes all individually identifiable health information related to your past, present or future physical or mental health condition or to payment for health care. The term also includes genetic information (such as family medical history and information about an individual's receipt of genetic services or tests). PHI includes information maintained by the Plan in oral, written, or electronic form.

When the Plan May Disclose Your PHI.

- Under the law, the Plan may disclose your PHI without your consent or authorization, or the opportunity to agree or object, in the following cases:

- At your request. If you request it, the Plan is required to give you access to certain PHI in order to allow you to inspect and/or copy it.

- As required by HHS. The Secretary of the United States Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Plan's compliance with the privacy regulations.

- For treatment, payment or health care operations. The Plan and its business associates will use PHI in order to carry out Treatment, Payment, or Health care operations activities.

Treatment is the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations).

For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. If we contract with third parties to help us with payment operations, such as a medical review organization that reviews medical claims, we will also disclose information to them. These third parties are known as "business associates."

Health care operations includes but is not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example, the Plan may use information about your claims to refer you to a disease management program, a well-pregnancy program, project future benefit costs or audit the accuracy of its claims processing functions.

2.2 Disclosure to the Plan's Trustees.

The Plan will also disclose PHI to the Board of Trustees for the CCPOA Benefit Trust Fund for purposes related to treatment, payment, and health care operations, and has amended the Plan Documents to permit this use and disclosure as required by federal law. For example, we may disclose information to the Board of Trustees to allow them to decide an appeal or review a subrogation claim. Therefore, we do not need authorization for these purposes.

2.3 When the Disclosure of Your PHI Requires Your Written Authorization.

Unless the Privacy Rule permits or requires the use or disclosure as summarized in this Notice, the Plan must obtain your written authorization prior to using or disclosing your PHI, subject to your right to revoke your authorization. For example, although the Plan does not routinely obtain psychotherapy notes, it must generally obtain your written authorization before the Plan will use or disclose psychotherapy notes about you. However, the Plan may use and disclose such notes when needed by the Plan to defend itself against litigation filed by you.

- Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

- Chapter Presidents are also required to obtain written authorization in order to obtain PHI.

2.4 Use or Disclosure of Your PHI That Requires You Be Given an Opportunity to Agree or Disagree Before the Use or Release.

Disclosure of your PHI to family members, other relatives, your close personal friends, and any other person you choose is allowed under federal law if:

The information is directly relevant to the family or friend's involvement with your care or payment for that care, and

You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

2.5 Use or Disclosure of Your PHI When You Are Not Present.

Disclosure of your PHI to family members, other relatives, your close personal friends, or other persons is allowed if you

are not present and, if in the Plan's professional judgment: (1) such a disclosure is directly related to such person's involvement with your health care or payment related to your health care, and; (2) it is in your best interests.

If you do not want the Plan to make these types of disclosures to your spouse or others on this basis, you may request the Plan to restrict disclosures of your Protected Health Information. See Section 3 of this Notice for more information.

2.6 Use or Disclosure of Your PHI For Which Consent, Authorization or Opportunity to Object Is Not Required.

The Plan is allowed under federal law to use and disclose your PHI without your consent or authorization under the following circumstances:

When required by applicable law.

- Public health purposes. To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

- Domestic violence or abuse situations. When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.

- Health oversight activities. To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor).

- Legal proceedings. When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order.

- Law enforcement health purposes. When required for law enforcement purposes (for example, to report certain types of wounds).

- Law enforcement emergency purposes. For certain law enforcement purposes, including: (1) identifying

or locating a suspect, fugitive, material witness or missing person, and (2) disclosing information about an individual who is or is suspected to be a victim of a crime.

- Determining cause of death and organ donation. When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. We may also disclose PHI for cadaveric organ, eye or tissue donation purposes.

- Funeral purposes. When required to be given to funeral directors to carry out their duties with respect to the decedent.

- Research. For research, subject to certain conditions.

- Health or safety threats. When, consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

- Workers' compensation program. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

2.7 Other Uses or Disclosures.

The Plan may contact you to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

SECTION 3: YOUR INDIVIDUAL PRIVACY RIGHTS

All requests to exercise any of the individual rights described below should be sent in writing on the appropriate form to the Privacy Official specified below. All such forms are available at the Trust office and may be requested by contacted the Privacy Official below:

The Privacy Official
CCPOA Benefit Trust Fund
2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833
Phone: (800) 468-6486

3.1 You May Request Restrictions on PHI Uses and Disclosures.

You may request the Plan to:

- Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or
- Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Plan, however, is not required to agree to your request.

3.2 You May Request Confidential Communications.

The Plan will accommodate an individual's reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Make such requests to the Privacy Official listed above.

3.3 You May Inspect and Copy PHI.

Generally, you have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI.

If your request is granted, the Plan must provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to your PHI in a designated record set. A reasonable fee may be charged. Requests for access to PHI should be made to the Privacy Official listed above.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights (if applicable) and a description of how you may complain to the Plan and/or HHS.

Designated Record Set includes your dental or vision records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for

quality control or peer review analyses and not used to make decisions about you is not included.

3.4 You Have the Right to Amend Your PHI.

You have the right to request that the Plan amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set subject to certain exceptions. You should make your request to amend PHI to the Privacy Official listed above. You or your personal representative will be required to complete a written form to request amendment of the PHI and include a reason to support the requested amendment.

The Plan has 60 days after receiving your request to act on it. The Plan is allowed a single 30-day extension if the Plan is unable to comply with the 60-day deadline. If the Plan denied your request in whole or part, the Plan must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of that PHI.

3.5 You Have the Right to Receive an Accounting of the Plan's PHI Disclosures.

You have the right to request an accounting of the Plan's disclosure of your PHI. Please note that you are not entitled to an accounting of all disclosures made by the Plan. For example, we will not provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing. You or your personal representative should make your request for an accounting on the requisite form to the Privacy Official listed above.

The Plan has 60 days to provide the accounting. The Plan is allowed an additional 30 days if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

3.6 Your Personal Representative.

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Plan will generally recognize certain individuals as personal representatives. For example, the Plan will consider a parent or guardian as the personal representative of an unemancipated minor unless applicable law requires otherwise.

You should also review the Plan's Policy and Procedure for the Recognition of Personal Representatives for a more complete description of the circumstances where the Plan will automatically consider an individual to be a personal representative.

SECTION 4: THE PLAN'S DUTIES

4.1 Maintaining Your Privacy.
The Plan is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices.

This notice has been restated effective as of April 1, 2011. The original notice was effective as of April 14, 2003 and was subsequently restated effective as of January 1, 2011. The Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to you and to all past and present participants and beneficiaries for whom the Plan still maintains PHI via mail.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to:

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Plan, or
- Other privacy practices stated in this notice.

4.2 Disclosing Only the Minimum Necessary Protected Health Information.
When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Disclosures made to the Secretary of the United States Department of Health and Human Services pursuant to its enforcement activities under HIPAA,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Plan's compliance with the HIPAA privacy regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that (1) does not identify you; and (2) with respect to which there is no reasonable basis to believe that the information can be used to identify you.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health Plan. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

Notification of Breach of Unsecured PHI. If PHI that the Plan or any of its business associates uses or discloses is "breached" within the meaning of the notification requirements of the Privacy Rule, then, in accordance with HIPAA and the Plan's policies and procedures, the Plan will provide the required notifications to those individuals who have been affected by the breach, the Department of Health and Human Services and to any other necessary parties.

Compliance with the Genetic Information Nondisclosure Act of 2008. In accordance federal law, the Plan does not intend to use or disclose genetic information for any underwriting purposes.

SECTION 5: YOUR RIGHT TO FILE A COMPLAINT WITH THE PLAN OR THE SECRETARY OF HHS

If you believe that your privacy rights have been violated, you may file a written complaint with the Secretary of the United States Department of Health and Human Services or with the Plan in care of the following:

The Benefit Administration Supervisor
CCPOA Benefit Trust Fund
2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833

The Plan will not retaliate against you for filing a complaint.

SECTION 6: IF YOU NEED MORE INFORMATION

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following official at the Trust Office:

The Privacy Official or the
Benefit Administration Supervisor
CCPOA Benefit Trust Fund
2515 Venture Oaks Way, Suite 200
Sacramento, CA 95833
Phone: (800) 468-6486

SECTION 7: CONCLUSION

PHI use and disclosure by the Plan is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice.

HIPAA PRIVACY AND SECURITY RULE AMENDMENT

In conformity with the regulations at 45 C.F.R. Parts 106 and 164 (the "Health Insurance Portability and Accountability Act of 1996 ("HIPAA") regulations"), this Amendment governs the extent to which the Board of Trustees of the CCPOA Benefit Trust Fund as plan sponsor, may receive, use and/or disclose and shall safeguard, Protected Health Information from the CCPOA BTF ("Plan").

- **1. Applicability of Amendment.** The Plan is a Hybrid Entity for the purposes of the HIPAA Regulations. Accordingly, this Amendment only applies to the components of the Plan that provide health care benefits, such as the following: dental and vision care benefits. This Amendment does not apply to the following component benefits provided under the Plan: life insurance benefits, accidental death and dismemberment benefits, the disability benefit

plan and legal services benefits ("non-healthcare components") and any health benefit provided pursuant to an insurance contract or policy. The Plan will not use or disclose PHI to the non-healthcare component in circumstances in which the HIPAA regulations would prohibit such uses and disclosures.

- **2. Uses and Disclosures of PHI.** The Plan may disclose a Participant's PHI to the Board of Trustees for the purpose of performing Plan administration functions as described in 45 CFR 164.504(a), to the extent permitted under the HIPAA regulations. Such Plan administration functions may include, but are not limited to, hearing appeals of denied claims, arranging for legal services, handling the financial activities of the Plan, and performing fiduciary functions. The Board of Trustees will not use or further disclose PHI other than as permitted or required in accordance with this stated purpose or as required by applicable law.

- **3. Restriction on Plan Disclosure to the Board of Trustees.** Neither the Plan nor any of its Business Associates will disclose PHI to the Board of Trustees except upon the Plan's receipt of the Board's certification that the Plan Documents have been amended as required by the HIPAA regulations.

- **4. Privacy Agreements of the Board of Trustees.** The Board of Trustees agrees it will:

  a. Not use or further disclose such PHI other than as permitted by paragraph 3 of this Amendment, as permitted by 45 CFR 164.508, 45 CFR 164.512, and other sections of the HIPAA regulations, or as required by law;

  b. Ensure that any of its agents, including a subcontractor, to whom it provides the PHI agree to the same restrictions and conditions that apply to the Board of Trustees with respect to such information;

  c. Not use or disclose the PHI for employment-related actions of the entity appointing a member of the Board of Trustees, or in connection with any other benefit or benefit plan sponsored by the Board of Trustees or the entity appointing a member of the Board of Trustees;

  d. Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which the Board of Trustees becomes aware;

e. Make the PHI of a particular Participant available for purposes of the Participant's requests for inspection or copying, in accordance with HIPAA regulation 45 CFR 164.524;

f. Make the PHI of a particular Participant available for purposes of the Participant's requests to amend PHI and incorporate any amendment to PHI in accordance with HIPAA regulation 45 CFR 164.526;

g. Make the PHI of a particular Participant available for purposes of required accounting of disclosures by the Plan pursuant to the Participant's request for such an accounting in accordance with HIPAA regulation 45 CFR §164.528;

h. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA regulations; and

i. If feasible, return or destroy all PHI maintained in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

- **5. HIPAA Security Rule Requirements.** The Board of Trustees will reasonably and appropriately safeguard electronic protected health information ("EPHI") that it creates, receives, maintains or transmits on behalf of the Plan, other than EPHI that is summary health information disclosed pursuant to 45 C.F.R. 164.505(f)(1)(ii), enrollment or disenrollment information disclosed pursuant to 45 C.F.R. 164.504(f)(1)(iii), or information disclosed pursuant to an authorization under 45 C.F.R. 164.508. In implementing such safeguards, the Board of Trustees is required to do the following:

  - a. Safeguards. The Board of Trustees will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the EPHI that it creates, receives, maintains or transmits on behalf of the Plan.

  - b. Adequate Separation. The Board of Trustees will ensure that the adequate separation between the Plan and the Board as required by 45 C.F.R. 164.504(f)

(2)(iii) of the HIPAA Security Rule is supported by reasonable and appropriate security measures.

- c. Agents. The Board of Trustees will ensure that any agents (including subcontractors) to whom it provides EPHI received from the Plan agrees to implement reasonable and appropriate security measures.

- **6. Adequate Separation**. The Board of Trustees will ensure that there is adequate separation between the Plan and the Board of Trustees as required by the HIPAA regulations. The following is a description of the employees or classes of employees or other persons under the common control of the Board of Trustees that will be given access to PHI: the individual members of the Board of Trustees, the Plan's administrator and his/her assistant, the Controller and his/her assistant, the benefits administrator, the Trust Counsel and his/her assistants, and the Trust Consultants. The access to and use by the persons described in the preceding sentence will be limited to plan administration functions that the Board of Trustees performs for the Plan. In the event there are any issues of noncompliance by such persons, the Board of Trustees will take all necessary and appropriate action that is consistent with its disciplinary policy.

- **7. Definitions.** All capitalized terms within this Amendment not otherwise defined by the provisions of this Amendment shall have the meaning given them in the Plan or, if no other meaning is provided in the Plan, the term shall have the meaning provided under the HIPAA regulations.

- **8. Miscellaneous.**

  - d. Rights. This Amendment shall not be construed to establish requirements or obligations beyond those required by the HIPAA regulations. Any portion of this Amendment that appears to grant any additional rights not required by the HIPAA regulations shall not be binding upon the Board of Trustees.

  - e. Amendment. The Board of Trustees reserves the right to amend or terminate any and all provisions set forth in this Amendment at any time to the extent permitted under the HIPAA regulations.

  - f. Delegation. The Board of Trustees may delegate or allocate any authority or responsibility with respect this Amendment. The Board of Trustees (or its delegate) has discretion to construe and interpret the terms, provisions and requirements of this

Amendment. All decisions of the Board of Trustees (or its delegate) with respect to this Amendment will be given the maximum deference permitted by law.

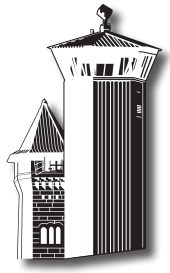
- g. Document Retention. If a communication under this amendment is required by the HIPAA regulations to be in writing, the Board of Trustees will maintain such writing, or electronic copy, as documentation. If an action, activity, or designation is required by the HIPAA regulations to be documented, the Board of Trustees will maintain a written or electronic record of such action, activity or designation. The Board of Trustees will retain the required documentation for six (6) years from the date of its creation or the date when it last was in effect, whichever is later.

- h. Construction. The terms of this Amendment shall be construed in accordance with the requirements of the HIPAA Privacy and Security Rules and in accordance with any applicable guidance on the HIPAA Privacy and Security Rules issued by the Department of Health and Human Services.

We've Got You Covered.

1-800-In-Unit-6

1-800-468-6486



CCPOA
Benefit Trust Fund

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www.ccpoabtf.org

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