Burr Plumbing and Pumping Employee Health & Welfare Plan

Plan Document & Summary Plan Description Wrap Document

This booklet contains a summary in English of your plan rights and benefits under Burr Plumbing and Pumping Employee Health & Welfare Plan, sponsored by Burr Plumbing and Pumping. This booklet, in conjunction with the Evidence of Coverage issued by the Insurer, constitute the written plan and summary plan description to the extent required by Section 102 of the Employee Retirement Income Security Act of 1974 (ERISA). The Evidence of Coverage, along with other important notices, is available to you at http://benefits.filice.com/burrplumbing. If you have difficulty understanding any part of this booklet, contact a member of the Human Resources Department at 1645 Almaden Road, San Jose, CA 95125, (408) 287-2877.

Plans Covered

Plan Name:	Kaiser Pernanente HMO
Plan Type:	Fully Insured Group Medical Insurance
Plan Number:	501
Policy Number:	92136
Plan Administration:	Shared between Burr Plumbing & Pumping and Kaiser Permanente
Insurance Carrier Address:	PO Box 23219, San Diego, CA 92193
Insurance Carrier Phone:	800 464-4000
Insurance Carrier URL:	www.kp.org

Plan Name:	Blue Shield PPO
Plan Type:	Fully Insured Group Dental Insurance
Plan Number:	501
Policy Number:	W0045910
Plan Administration:	Shared between Burr Plumbing and Pump and Blue Shield
Insurance Carrier Address:	PO Box 272540, Chico, CA 95927-2540
Insurance Carrier Phone:	888 679-8928
Insurance Carrier URL:	www.blueshieldca.com

Plan Name:	SunLife Life
Plan Type:	Fully Insured Group Life Insurance
Plan Number:	501
Policy Number:	237846
Plan Administration:	Shared between Burr Plumbing and Pump and SunLife
Insurance Carrier Address:	One Sun Life Executive Park PO Box 81365 Wellesley Hills, MA 02481
Insurance Carrier Phone:	800 247-6875
Insurance Carrier URL:	www.sunlife.com

Plan Sponsor, Plan Administrator, & Agent for Service of Legal Process

Plan Sponsor

Burr Plumbing and Pumping
1645 Almaden Road, San Jose, CA 95125
(408) 287-2877

Plan Administrator

Burr Plumbing and Pumping
1645 Almaden Road, San Jose, CA 95125
(408) 287-2877
alicia@bp2inc.com

The Plan Administrator is a “named fiduciary” with respect to the Plan while exercising discretionary control over its administration. Within this role, the Plan Administrator has the power and authority to interpret, manage, and administer the Plan in accordance with established policies and in accordance with the requirements of ERISA and other applicable laws.

The Plan Administrator has delegated certain day-to-day administration of the Plan. Claims fiduciary responsibility for the processing and review of claims for benefits under the Plan, including COBRA, have been delegated to certain third parties listed herein.

Agent for Service of Legal Process

Alicia Rosas
1645 Almaden Road, San Jose, CA 95125
(408) 287-2877
alicia@bp2inc.com

Service of Legal Process may also be made on the Plan Administrator.

Employer Identification Number – 651196592

Financing & Administration

Plan Year – The Plan follows a non-calendar year cycle, from 12/1 – 11/30 for Medical & Dental; 09/1 – 08/31 for Life.

Funding Medium – Benefits provided under the Plan are fully insured under a group contract entered between the employer and the Insurance Companies indicated above.

Employee Contribution Levels – Employees are not required to contribute towards employee premium, but employees are required to contribute 100% of the dependent premium for medical and dental coverage. Life insurance premiums are paid 100% by the Company. All contributions will be paid through a weekly payroll deduction. Actual contribution rates will be published each year during Company’s Open Enrollment Period.

Eligibility & Benefits

Eligibility Requirements – All full-time active employees of Burr Plumbing and Pumping, working an average of 30 hours or more per week, are eligible to participate in the Burr Plumbing and Pumping Employee Health & Welfare Plan effective first of the month following 30 days after hire date.

You may also enroll eligible family members in the. Eligible family members include:

- Legal Spouse or Registered Domestic Partner
- Child(ren) up to the age of 26
- Unmarried child(ren) of any age who depend upon the employee for support because of a mental or physical disability

Your benefits eligibility may be affected if your status changes to Inactive due to a family, medical or personal leave of absence. Please refer to the Burr Plumbing and Pumping Employee Handbook for details as to how a particular type of leave would affect your benefits eligibility.

Medical and dental, benefits will terminate on the last day of the month in which full-time active employment ends. Life and AD&D benefits will terminate upon the date on which eligible status is lost.

Should your benefits be terminated, Federal & State law requires Burr Plumbing and Pumping, as an employer sponsoring a group health plan, to offer you and your covered dependents the opportunity to elect a temporary extension of health coverage, called Continuation or COBRA Coverage. You do not have to show that you are insurable to elect continuation coverage. However, you may have to pay all or part of the premium for your continuation coverage. At the end of the maximum coverage period, you must be allowed to enroll in an individual conversion health plan if it is otherwise available under the Plan.

Enrollment Procedures – Enrollment forms must be completed and returned to the Burr Plumbing and Pumping Human Resource Department within 30 days of the initial eligibility date for an employee to participate in the Plans.

Legislative rules dictate that the benefit choices made will remain in effect for the entire plan year unless the employee experiences a *Qualified Change in Status*. While many of the guidelines relating to eligibility and enrollment are determined by Burr Plumbing and Pumping and its insurance carriers, the ability to make changes to your benefit plans is governed by the IRS and the Internal Revenue Code.

Under the Code you must enroll within a reasonable time from your eligibility date. Once you are enrolled you may only make changes to your benefit elections during Open Enrollment or if you have a Change in Status that affects the eligibility of you or your dependents, *and* the requested election change corresponds with the effect on your eligibility.

A Qualified Change in Status includes:

- A change in your *Legal Marital Status* such as marriage, death of a spouse, divorce, legal separation, or annulment.
- A change in your *Number of Dependents* such as birth, adoption, placement for adoption, or death of a child.
- A change in *Employment Status* such as commencement or termination of employment for you, your spouse or your dependent.
- A change in *Work Schedule* such as a reduction or increase in hours including a switch between part-time and full-time, a strike or lockout, or commencement or return from an unpaid leave of absence for you, your spouse or your dependent.
- If your *Dependent Satisfies or Ceases to Satisfy the Requirements for Dependents* due to factors such as age and student status.
- A change in *Residence or Worksite* for you, your spouse or your dependent.
- The receipt of a *Qualified Child Support Order*.
- A change in *Entitlement to Medicare or Medicaid* for you, your spouse or your dependent.
- A change in *Eligibility for COBRA* for you, your spouse or your dependent while you are still an active employee.

In addition, under limited circumstances, Burr Plumbing and Pumping may permit you to make a mid-year election change that corresponds to changes made by your spouse's or dependent's employer plan (i.e., during the other plan's open enrollment period). However, all election changes must be requested within 30 days of the event in question, except for a loss of coverage under a Medicaid plan which allows you to request a change within 60 days of the loss.

To make an election change, contact your Plan Administrator listed above.

Benefit Plan Provisions – All documents relating to the Burr Plumbing and Pumping Employee Health & Welfare Plan, including the Evidence of Coverage for each plan, Listing of Network Providers, Summary of Benefits Coverage, Contribution Rates, General COBRA Notice, Medicare Creditable/Non-Creditable Coverage Notice, Notice of Special Enrollment Rights, Children's Health Insurance Program Notice, HIPAA Notice of Privacy Practices and any other relevant Plan documents or notices, are available to Burr Plumbing and Pumping employees and their dependents at http://benefits.filice.com/burrplumbing. Plan participants may receive a paper copy of any of the above documents free of charge by contacting the Plan Sponsor indicated above.

Please refer to the Evidence of Coverage for each plan's specific details, including a description of benefits, cost-sharing provisions, requirements for use of network providers, and circumstances by which benefits may be denied.

Claims Procedure

Under the terms of the insurance contracts issued for the Plan, the Insurer has full discretionary authority to make all benefit decisions concerning the payment of claims or benefits and the handling of appeals. The Plan Administrator does not guarantee the payment of any benefit provided under the Plan and has delegated this authority to the Insurer. Please refer to the Evidence of Coverage for each plan's specific procedures. The claims and appeals procedures are also furnished automatically, without charge, as a separate document.

COBRA

The following terms in this section provide general information regarding the federal right to continue coverage under COBRA. The Evidence of Coverage and the COBRA General Notice also contain a description of the federal and state rights to continue coverage under the Plan.

The Plan Administrator has delegated authority for administering COBRA continuation coverage to the following COBRA Administrator:

COBRA is offered to anyone who is considered a qualified beneficiary under the federal law. This includes employees who lose their group health plan coverage due to termination of employment (unless due to gross misconduct) or a reduction in hours who were covered under the group health plan on the day before the event.

A spouse or dependent covered under group health plan on the day before one of the following events that causes a loss of coverage is a qualified beneficiary. The spouse and dependents are eligible for COBRA for a loss of coverage due to the termination of the employee's employment (other than for gross misconduct) or the reduction of the employee's hours of employment, the death of the employee, divorce or legal separation or loss of dependent status under the written terms of the Plan.

A COBRA Election Notice will be sent to the last known address on file with your employer within 44 days of the loss of coverage. To elect continuation coverage, a participant must complete the Election Form and return it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. You have 60 days from the later of the post mark date on your COBRA Election Notice or the date coverage terminated to enroll in COBRA.

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (in the case of an extension of continuation coverage due to a disability a Benefit Plan may charge 150 percent) of the cost for coverage under the Plan.

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to

Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

A I I-month extension of coverage may be available for all family members covered if any of the qualified beneficiaries is determined under the Social Security Act (SSA) to be disabled. The disability must have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18- month period of continuation coverage. See the important notice procedures below.

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available regardless of events is 36 months. The second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. See the important notice procedures below.

Notices Due from Participants - You, your spouse or covered dependent(s) must notify the Plan Administrator of one of the following events to be offered COBRA Continuation:

- The occurrence of a qualifying event that is a divorce or legal separation of a covered employee from his or her spouse, or a dependent who loses eligibility under the plan.
- The occurrence of a second qualifying event.
- A qualified beneficiary has been determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation coverage: and
- A qualified beneficiary has subsequently been determined by the Social Security Administration to no longer be disabled.

Where the Notice is Sent - Notice must be mailed or otherwise delivered to the Plan Administrator or, in the case of a disability determination by the SSA, to the COBRA Administrator.

When Notice is Due – Notice of a qualifying event that is either the divorce or legal separation from a spouse or a dependent who loses eligibility under the Plan must be delivered within 60 days of the date of the qualifying event.

Notice of a disability determination by the SSA must be delivered within 60 days of the later of 1.) the date on which the determination is made; 2.) the date on which a qualifying event occurs; 3.) the date on which the qualified beneficiary would lose coverage under the Plan as a result of the qualifying event; or, 4.) the date on which the qualified beneficiary is informed, through the furnishing of the summary plan description of the General Notice, of the responsibility to provide the Notice.

What the Notice Must Contain - The written notice must contain at least the name of the person(s) that will be losing coverage, the event that will cause the loss of coverage (referred to as a qualifying event) and the date the qualifying event occurs. If you have any question about what type of information is required, you should contact the Plan Administrator.

Patient Protection Disclosure

HMO health plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in your network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. Until you make this designation, the HMO plan designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator or visit http://benefits.filice.com/burrplumbing.

You do not need prior authorization from the HMO plan, or from another person (including a primary care provider), to obtain access to obstetrical or gynecological care from a health care professional in your network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator, or visit http://benefits.filice.com/burrplumbing.

Disclosures and Notices

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

Notice of Women's Health & Cancer Rights Act – Group health plans, insurance companies and health maintenance organizations offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

Changes in Eligibility for Medicaid or CHIP – If coverage for an employee or his or her qualifying dependent under Medicaid or Children's Health Insurance Program (CHIP) terminates as a result of loss of eligibility and a request for enrollment is made within 60 days after the date of termination; or, An employee or their qualifying dependent becomes eligible for premium assistance subsidy under Medicaid or CHIP and a request for enrollment is made within 60 days after the date the employee or dependent becomes eligible for the premium assistance.

Qualified Medical Child Support Orders (QMCSO) – The Plan Administrator is required to determine whether a Medical Child Support Order it receives is qualified. The Plan Administrator will make this determination within a reasonable period and will first notify the participant and any alternate recipient when a MCSO is received and will provide them copies of the Plan's procedures for determining whether it is qualified. The Plan Administrator will then notify the parties of its determination.

Uniformed Services Employment and Reemployment Rights Act (USERRA) – If you are called to active duty in the uniformed services, you may be able to continue your coverage under this Plan for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form within 60 days after your call to active duty. Please contact the Plan Administrator to find out how to elect USERRA coverage and how much you must pay.

Refund Allocation – Under ERISA, the Plan Administrator of the group health plan may have fiduciary responsibilities regarding distribution of dividends, demutualization, and use of the Medical Loss Ratio rebates from group health insurers. Some or all any rebate may be an asset of the plan, which must be used for the benefit of the participants covered by the policy. Participants should contact the Plan Administrator directly for information on how the rebate will be used.

Statement of ERISA Rights

The Employee Retirement Income Security Act of 1974 (ERISA) provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, all documents governing the plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor. Obtain, upon written request to the plan 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. Receive a summary of the Plan's annual financial report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan because of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interests 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 (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If 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, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (EBSA), 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 Pension and Welfare Benefits Administration.

Disclaimers

Notice of Grandfathered Status – Burr Plumbing and Pumping believes Kaiser: HMO 15 copay, HMO 30 copay, & 30/1500 Deductible HMO to be a "grandfathered health plan" under the Patient Protection and Affordable Care Act (ACA). As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was in effect when the ACA was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections afforded under the ACA that apply to other, non-grandfathered plans. However, grandfathered health plans must comply with certain other consumer protections under the ACA; for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272. A chart summarizing the protections that apply to grandfathered health plans can be found at: www.dol.gov/ebsa/healthreform.

Plan Amendment and Termination – Burr Plumbing and Pumping reserves the right to amend any feature of the Plan at any time and, to the extent permitted by law, without the consent of or prior notice to any participant. Burr Plumbing and Pumping is not legally bound to continue the Plan indefinitely, and it reserve the right to terminate the Plan or any feature thereof at any time without liability. Upon termination of the Plan or any feature thereof, all elections and reductions in compensation relating to the Plan or feature will terminate, and the rights of a participant under the Plan will be limited to the payment of eligible expenses incurred prior to termination. The right to amend or terminate, in whole or in part, also extends to the insurance contract between Burr Plumbing and Pumping and the Insurer. Any material modification, amendment, or termination will be timely communicated to participants under the Plan.

Conflicting Terms – If the terms of this document conflict with the terms of the insurance contract between Burr Plumbing and Pumping and the Insurer, the insurance contract shall control.

No Contract of Employment –This Plan does not constitute a contract of employment with Burr Plumbing and Pumping.

Paper Copy

If providing a paper copy for an employee, attach the following items, as applicable, that are referenced above:

- Evidence/Certificate of Coverage for Each Plan
- Summaries of Benefits & Coverage
- Listing of Network Providers
- Contribution Rates
- General COBRA Notice
- Medicare Creditable/Non-Creditable Coverage Notice
- Notice of Special Enrollment Rights
- Children's Health Insurance Program Notice (if employees in other states)
- HIPAA Notice of Privacy Practices
- Any Other Relevant Plan Documents or Notices